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



MODALITIES OF COUNSELLING AND FAMILY THERAPY

4

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

- इन्दिरा गांधी

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

- Indira Gandhi

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UNIT 14 FAMILY INTERVIEWING

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14.1 INTRODUCTION

This Unit is to help you in the conduct of a family interview session. Interviewing a family requires different understanding and additional skills than when working with individuals. This Unit explains the difference and gives you many examples of ways to do family therapy. The Unit is more practical than theory.

Objectives:

After studying this Unit, you will be able to:

- Enumerate features of family interviewing;
- Explain neutrality;
- Create a hypothesis of circular questions;
- Suggest an end of session message;
- Discuss issues of confidentiality; and
- Write up a family session record.

14.2 WHAT IS FAMILY INTERVIEWING?

The family therapist asks questions about the family system in order to produce information that will reveal the patterns of family interaction, that is, its systemic qualities. As the information is revealed the family becomes aware of its manner of interactions. This creates a context within which the family's capacity for change is stimulated. This questioning of the family system is called family interviewing.

14.2.1 Evolution of Family Interviewing

The interview as a way of procuring information is a relatively new phenomenon. Though questioning and answering have always existed, not so long ago, it would be strange to approach a stranger (let alone a family) and discuss personal matters. Such conversations only happened with intimates. Parents could ask children their whereabouts and the expectation was that they got answers, not a dialogue in which the children were equal participants.

The democratization of opinion: The modern interview encounter is based on new importance given to the individual as an integral member of a group, including the family member (Benney and Hughes,1956). Individuals, including children, are accepted as commentators of their own experience, able to offer meaningful descriptions and opinions without the need to have an expert, or authority figure to speak on their behalf.

14.2.2 Post-Modern Interviewing

Family therapy has been influenced by the social construction movement, in that they remain open to multiple interpretations of any problem. There is no one 'truth' – instead, a given situation can be viewed in many different ways, depending on which viewpoint was being represented. In a family interview, each member represents several viewpoints and in turn each of these members

may have several voices (different aspects of themselves) with which they speak. For example, a father concerned about his daughter's refusal to marry comes for family therapy bringing his wife and daughter with him. He may present himself and be seen as a concerned and conservative father. Other aspects of him, a man who fears he has less power in the family compared to his wife, a son-in-law who is less successful than his brothers-in-law, a businessman who negotiates a hard bargain, a just employer, a lover of classical music and animals but friendless, proud of his caste affiliations, all of these 'voices' and more are contained within him.

Which person is speaking when talking in the session? All of the people present in the session, including the therapist can speak of themselves in different ways and interact with each other 'wearing different hats'. In addition, the context in which the session is taking place will have an impact on the talking that happens. There is no 'correct' version, rather the therapist engages multiple aspects of a person, of a family, of a situation.

The influence of post modern social construction on family therapy are given below:

- There is no one truth; there are different versions. Therefore, all family members' viewpoint is sought.
- The therapist is not the expert; the clients are the expert on their situation. Thus, therapist and clients work together to solve problems.
- Concern about issues of representation – whose story is being told and what is the function of this particular version of the story?
- Therapists own self awareness of how and why they are questioning or intervening.
- Power relations are questioned, and ways to make unarticulated voices audible are a focus in family therapy.

14.2.3 Concept of 'Information' in Family Therapy

The main purpose of interviewing is to elicit new information. To understand systemic family therapy the concept of information needs to be more clearly defined than it is understood in daily life. Whenever information is exchanged, a communication system is formed comprising of an interaction between a 'sender' and a 'receiver'. The amount of information that the behaviour of one interactional partner has for another depends on them having the same 'code' (perception, mind set, familiarity with the language of each other's emotions) to interpret the communication. If one partner cannot perceive the information being conveyed then the communication has not taken place, or miscommunication has happened. When new information from one interactional partner is sent but is received as 'not new' or of a familiar pattern, it causes the 'receiver' to react in old ways, with no stimulus to change. The amount of sent and received information in a statement can be measured by how much the statement increases or reduces the possible outcomes. The reaction to information depends on whether the interactional partners recognise a difference as a difference. If so, 'information' can be said to be created. Gregory Bateson (1979) defined *information* as 'any difference that makes a difference, and brings change for the system'.

In family therapy, the manner in which a family deals with information is a decisive factor in diagnosis and therapy. The introduction of information into a system (family or individual) has the potential of changing that system. Rigid family systems ignore new information. For example, when a closed family does not recognise the developmental context of their 15 year old's, need for peer approval (new information but not received), they continue to interact with him as if he was a much younger child (old patterns of behaving). Increasing frustration with the family's inability to acknowledge his age and growing independence he runs away (new information, received). The family is shocked into responding by making more flexible rules for his time spent with friends (new information generates new possibilities). In turn the young man appreciates that his family is caring towards him (more new information) and promises not to run away.

14.2.4 Purpose of Family Interview

In family therapy, intervention is simultaneous with interviewing, that is, to understand the system and to facilitate change are the purpose of each family session. Tomm(1987) says that the 'the interview is a series of interventions'. Following are the main purposes of family interview:

1. To provide information for therapist and for the family;
2. To facilitate the family's own healing;
3. To explore hypothesis that is, discarding, formulating new hypothesis, adding to an existing hypothesis;
4. To use the session for intervening by reframing, highlighting dilemmas, unbalancing; and
5. Noticing similarity and difference between different family members' viewpoints regarding the problem in present, in the past, and what it may be in the future.

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. What is the major influence of post-modern ideas on family therapy?

.....

.....

.....

2. What is the impact of new information on a family system?

.....

.....

.....

14.3 THE THERAPEUTIC INTERVIEW

The family interview is for the purpose of solving the family's problems. Asking questions of family members is done for this purpose, and therefore, questions are seen as interventions in the family system.

14.3.1 Questions as Interventions

According to Tomm and Lannamann (1988), in family therapy the primary intervention are the questions that the therapist poses to the family thus opening up the conversation for the family members to examine their situation from all viewpoints. In the grammatical form of questions there is something that invites reflection and this creates possibilities for change, for something new to happen. Even small changes in people's thinking or behaviour can have profound change because it frees people from their habitual, stuck and rigid ways. The therapist's questions are directed to help family members generate greater flexibility and increased choices for themselves.

Everything that a therapist does is an intervention, so questions are not randomly asked. All interventions have to be based on systemic hypothesis about the family and the symptom like, is the symptom a temporary response to a perceived crisis, or does the symptom serve a function to keep the family the same, or to bring about desired change? In selecting questions the criteria for the therapist is to choose those that enhance the family's own ability to find suitable solutions for their difficulties. Consider the consequences and ramifications of an intervention for each member and for the system as a whole before you make it. Observe their responses to your questions and to each other's communication – verbal and non-verbal, analogic and digital. Feedback from each member and the family system should guide you constantly.

There are many situations where these types of questions may serve to challenge the family to explore new behaviours and beliefs. Remaining neutral to their responses may be a key at times. If your hypothesis are on target, their responses may indicate a lack of readiness for change, or that the information was heard and once they have had time to think and talk about it, they will figure out a way to work it out on their own.

14.3.2 Using Questions as Interventions

Ask questions of each family member which serves to challenge, inform, or instruct indirectly; observe the family's response to these questions or challenges or reframes.

1. Use types of circular questions only after sufficient information has been obtained from the family about their likely response and some working hypothesis have received adequate validation. Anticipate several responses.

2. Begin with questions which are least offensive or threatening, to test the family's responses.

   For example, with a family which appears comfortable with intimacy and closeness, and yet neglects to demonstrate affection to each other, ask each one how the others show family members (specific ones) that they care for them. You may want to begin by comparing the members

who seem closest to each other and, along the way, address the more distant relationships.

3. Ask questions which may prompt members to try out new behaviours, like:

   i) **Offering alternatives:** Use some of their suggestions, and make up a few others, including a desired response and possibly a paradox; observe how they assess possibilities. For example: "What do you think would help Harish (identified as withdrawn) learn to share his feelings the most; for you to ask him questions about his day, for you to share things about your lives with him, or for him to hear, the two of you share your feelings with each other?". This type of question or intervention allows members to evaluate alternatives.

   ii) **Preparing for transitions:** These types of questions often encourage families to discuss issues of transition from one life cycle stage to another, and to prepare for this transition. For example, ask how the older child is going to learn to live independently, and what responsibilities she or he needs to acquire prior to moving out. This intervention question may be used to test a hypothesis about enmeshment, to expose a teenager's desire to move out or to remain in the home, and to learn what preparations have been made, if any, and who had discussed these plans.

   iii) **Embedded suggestions for the family:** You may ask a type of question in which a suggestion, indicating what would be good for the family, is embedded. For example, ask the children what activities they enjoyed as a family over the weekend; if the family has an uninvolved parent, ask the children what they did with that parent last week.

   iv) **Challenging a rigid system:** Therapists may wish to challenge a belief or family rule which seems to be rigid. Care must be taken not to convey judgement but simply suggest other possibilities such as, "What would happen if you were to offer to help your wife take care of the children once a week?".

   v) **Embedding reframes and paradoxical interventions into questions:** Experiment with embedding reframes or paradoxes within circular questions (if one is skilled in this manner of intervention): "How did your son learn to be this creative? Who else in the family is creative (a positive connotation of "disobedient" and "mischievous")?; "What do you think your family would do if I told them that they are not ready for you to become independent, and that you should remain dependent upon them to help you with preparing for your college exams?" (paradox).

14.3.3 Guidelines for the Therapeutic Interview

There are mainly three guidelines for the therapeutic session (Selvini, Boscolo,Cecchin & Prata, 1980). These are as follows:

Neutrality: This is a desired trait for the family therapist. No family member is given the opportunity to feel that she or he has a special relationship with

the therapist. The same degree of emotional closeness or distance is maintained with each family member. It helps in preventing the therapist from being drawn into family strategies that reduce the effectiveness of the therapist in the face of stormy disturbing family events. The family therapist has empathy in relating to the distress and pain and uses circular questions to talk with the family rather than just reacting emotionally to one member's account.

Hypothesizing : This is the formulation by the therapist of a hypothesis based on the information that is known about the family that is being interviewed. It marks the starting point for the ideas that the therapist has and for the validation or discarding of these ideas. If the hypothesis are incorrect then new ones are made based on the information acquired during the testing of the first ones.

Circularity : This is the conducting of the session based on feedback received from the family in response to the information that is asked about relationships, differences and change. The term circularity or recursiveness or circular causality are used interchangeably to denote a sequence of cause and effect that loops back to the cause and according to the feedback loop can impact it to change. Cause and effect can be reversed in their impact on the individual or family (in memory, family rituals) if not in time (time cannot be reversed). For example, a family rule that was established in the past, is applied to the present, and can be continued or modified in the future, according to the feedback that the family system receives. The therapist asks circular questions to elicit information that can be used as:

1. Feedback to the therapist to formulate hypothesis; or
2. Feedback to the family to remain the same, or change.

Each of these three are described below in detail based on Nelson *et al.* (1986).

- **Neutrality**

It is desirable that:

★ The family sees the therapist as neutral:

  i. As not taking sides with any one member or subgroup,

  ii. As allied to everyone and to no one at the same time, and

  iii. As nonjudgemental and accepting of everyone.

★ The therapist asks questions of each member:

  i. Attempting to spend an equal amount of time with each, and

  ii. Qing around the circle, often with the same question or the same type of question, to investigate each person's perceptions.

★ The team or co-therapist if present, assists in neutralizing any attempt of a family member to form a special relationship or coalition with the therapist.

- **Hypothesizing**

Definition of hypothesizing: Hypothesizing can be defined as thoughts, ideas, suppositions, hunches, maps, explanations, or alternative explanations about the family and the "problem" in its relational context.

Purpose of hypothesis : Hypothesis serve the following objectives:

- ★ To make connections between family behaviours and their meaning,
- ★ To guide the therapist and help the therapist create order and method in the use of questions, and
- ★ To enable the members to develop new ideas of their relationships, beliefs, and behaviours.

Formulation of hypothesis: Hypothesis are usually formed on the basis of the following:

- ★ Based on information about the family (which is gathered during the phone intake, from the referring person and subsequent sessions):
  - i) Descriptive opinions (from family members, referral sources, others),
  - ii) Behavioural observations (interactive patterns), and
  - iii) Verbal and non-verbal data (metaphors, cue words, repeated stories and beliefs, myths, statements, expressions, secrets).
- ★ Based on previous experience and knowledge of the therapist :
  - i) About similar families (ethnicity, culture, religion),
  - ii) About similar problems, symptoms, and situations,
  - iii) About similar interactive patterns,
  - iv) About developmental and life cycle stages, and
  - v) Of theory in general(systems, psychological, socio-political, anthropological).
- ★ Based on whatever may have bearing on the situation.

Keys and Guidelines: In the context of designing and testing hypothesis, it is important to:

1. Design hypothesis which are:
   - i) Useful: There are no "right" hypothesis. The goal is not to identify "truth", rather the goal is to generate the most useful explanations of the family at that time ('useful' means that it is useful for bringing positive change).
   - ii) Ultimately systemic: The hypothesis must include all components of the family and its relational pattern.
   - iii) Related to the family's concerns: The hypothesis should address most of the questions that are relevant to the family and the issues at hand.
   - iv) Different from the family's hypothesis. The therapist's hypothesis provide new information to the system.
2. Ask questions from each member, note responses to questions and interventions (to confirm or disconfirm hypotheses).
3. Discard unconfirmed hypotheses; modify useful hypotheses as new information is provided hypotheses evolve.

4. Design interventions based on confirmed hypotheses or hypotheses which seem most useful.

5. Do not tell the family about hypotheses, unless it is part of a planned intervention.

• Circularity

Definition of the circular interview: Circular interview is based on the "capacity of the therapist to conduct her or his investigation on the basis of feedback from the family in response to the information she or he solicits about relationships, and therefore, about difference and change" (Palazzoli Selvini *et al.,* 1980, p. 8).

Purpose of circularity: Circularity serves the following objectives:

1. To introduce the family to a systemic view of itself by providing the family members with new information about their concerns, beliefs, behaviours, and relationships,

2. To develop, confirm, or deny the therapist's hypothesis about the family and the function of the problem, and

3. To intervene indirectly by raising issues neglected in the family (such as expressing appreciation, allowing independence, helping a child learn a desired trait through modeling) or by questioning the effectiveness of attempted solutions to their situation.

Keys and guidelines: Think exclusively in terms of relationships and in terms of differences or changes in behaviours between family members across time. The following are the guidelines for conduucting a circular interview:

1. Ask questions of each member, not spending too much time with any one person.

2. Ask about issues that are relevant to the problem or to your hypotheses.

3. Note the words or repeated phrases which the family members use to describe the situation and each other's behaviour, such as "tense" "nervous" "lazy," "good child" or "too much work". Use these words in questions to ask about differences between people, their relationships and behaviours; and investigate their explanations for these presumed characteristics.

4. If there is labeling of a family member by other family members, reverse the question and ask about the opposite; like, "Who was the first to believe that Sameer was lazy?" becomes, "Who believes that Sameer is not lazy?" or "When does Sameer work hard?".

5. Search for the missing links in a pattern of interactions so that the cycle is complete. The missing information may be important to change perception of the problem.

6. Do not ask a random assortment of questions without direction and purpose.

7. Use linear questions sparingly, when inquiry can lead to important information, then revert back to circular questioning.

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. Fill in the blanks below:

i) The primary intervention in family therapy are the _____ that the therapist poses to the family.

ii) The therapist's _____ helps to maintain the same emotional closeness or distance from all members of the family.

iii) A hypothesis should be useful, systemic, related to the family's_____ and different from the family's existing _____.

iv) The circular interview is based on _____ from the family in response to information that is elicited in the session.

14.4 PREPARATION FOR FIRST SESSION

14.4.1 Goals for the Session

The main goals of first interview are outlined below:

1. **Diagnosis :** The first interview has a special role in family therapy and the major task is to formulate a hypothesis about the family dynamics. The therapist tries out, validates or rejects hypothesis made prior to the first session.

   Hypothesizing prior to the session is based on information gathered through the referral process and the information given by the referring person or organisation.

2. **Motivating:** The therapist tries to understand the dynamics of the family and introduces new perspectives in the first session, thereby increasing the family's motivation to continue therapy.

3. **Making a therapeutic contract :** This can be as complex as determining with the family the direction of change required, or as simple as deciding to meet at a regular interval and fixing the next appointment.

14.4.2 Preparing the Room

Before the session, the room should be prepared. Chairs should be placed in a circle according to number of people attending. The therapist's chair should be the same as the other chairs in the circle, and not be behind a desk. It should be placed such that all the members attending can be seen and be able to see each other. Extra chairs should be put to one side. If children are attending, put out drawing material and a small selection of toys such as dolls or animal figures for younger children. Avoid noisy toys that will distract from the session or fragile ones that would break.

14.4.3 Time for Each Session and Between Sessions

Keep more than the traditional psychotherapy time of 50 minutes. The session could go on for upto 90 minutes because everyone has to be given time to speak. If working with a co-therapist or a team, an extra 30 minutes should be kept for hypothesizing prior to the arrival of the family and for reflecting at the end of the session, after the family departs. It is the therapist's responsibility to keep time. At the start of the session, talk about how much time there is and ask how the family would like to use it. It is useful to mark the half-way point, and to give another indication when 15 minutes are left, that time is nearly up and that the session is to conclude soon. Be firm about concluding, requesting the family to discuss last minute issues at the next session. Sessions can be weekly, fortnightly or even monthly depending on the family availability and the urgency of the problem being discussed.

Therapy can be brief or over a long time; depending on the nature of the difficulty – if it is only the presenting problem or if the presenting problem is one of many problems.

14.5 METHODS OF INTERVIEWING

Therapists and clients engage in special conversations that are for the purpose of relieving mental pain and suffering. While talking to others, like friends and family may serve the same purpose, the difference is that they are not considered 'therapy' unless there is an agreement that one person assumes the responsibility for guiding the conversation to be therapeutic for the other. This special responsibility also confers special privileges of being able to inquire into client's personal lives. The nature and manner of asking questions must be sensitive to the potential for healing or causing further trauma.

In conversation, the therapist uses both statements and questions. Usually a statement confirms or restates what has been said, for instance. 'Your divorce has been painful to you'. A question on the other hand, will elicit information on views, experiences and positions, for example, 'How does being divorced change your life?'. Sometimes there is an overlap between a statement and a question, for instance. 'You may be feeling shaky talking about this'. Under certain situations it is better for therapists to provide answers instead of asking clients to answer questions, for example when clients are unaware of basic information or do not have the knowledge resources to answer appropriately.

Advantages of mainly asking questions during early and middle parts of a session include the following:

1. Focus remains on the clients,

2. It motivates clients to engage in the conversation because questions set-up the necessity of answering. When the therapist also demonstrates her or his commitment of listening by active listening skills, then dialogue ensues.

3. Clients are stimulated to think about their difficulties in their own way. Thus, asking questions rather than making statements fosters client autonomy. When change takes place, the clients will feel a greater sense of achievement in their problem solving ability, instead of being dependent on the expert knowledge of the therapist.

14.5.1 Different Types of Questions

Tomm (1988) has outlined four main types of questions that therapists can ask, based on differences in therapist intentions and therapist assumptions:

1. **Lineal questions :** When therapist assumes that events being talked about in the session occur in a cause-and-effect manner, the questions asked will be lineal. Examples, of lineal questions are: 'What is the problem?', 'Who is depressed?', 'Since when?'. Such questions are useful only in the beginning of the session to join with the family.

2. **Circular questions:** The therapist explores events in the session that are recurrent, or recursive, and the questions used are circular. For example, 'Who else thinks that there is depression?', 'Who worries the most, and who worries the least?'. Questions are asked to explore relationships.

3. **Strategic questions:** When the therapist believes that it is possible to influence clients directly through giving information, or giving instructions then the questions that are used are strategic. For example, a therapist asks, 'Can you see how the anger outburst could have been prevented by talking about it to your wife?'. The directiveness of the therapist to influence the clients is indirect in the form of a question.

4. **Reflexive questions :** According to Tomm (1987), questions that the family therapist asks members of a family that are designed to challenge the family's or individual's construction of reality and views about a relationship or event are reflexive questions. The therapist adopts a facilitative stance and purposely asks those questions that generate new ways to interpret old patterns of thought and behaviour. The questions are meant to encourage members, to think about their existing belief systems, and with reflection to develop constructive patterns of cognition and behaviour. Clients are invited to see the context in which they had formulated their problem from a different point of view. Examples of reflexive questions are triadic questions, used by the Milan group , in which a family member is asked to comment on the relationship of a *dyad* (two persons in a relationship such as father-son), or a fourth person is asked to comment on the relationship of a *triad* (three people in a relationship such as mother and two children). Reflexive questions include future oriented questions, hypothetical questions, embedded suggestion questions, comparing with normal questions, distinction-clarifying questions, questions introducing hypothesis, therapy session process questions, etc. All of these questions overlap with and are incorporated in the section on circular questioning.

14.5.2 Advantages and Disadvantages of Different Types of Questions

The advantages and disadvantages of different types of questions are depicted in Table 14.1.

Table 14.1: Advantages and disadvantages of different types of questions

Questions	Advantages	Disadvantages
Lineal	• It helps focus on a problem	• Answering lineal question brings no change. • Assessment interviews using lineal questions reinforce stuckness of problem. • It increases judgemental attitudes.
Circular	• It frees family from unhelpful blaming of self and others.	• It increased the area of exploration and may appear to clients to be far removed from immediate concerns.
Strategic	• It can be challenging and constructive when carefully worded.	• It can be controlling and leading.
Reflexive	• It opens up space for new options.	• It can foster confusion.

You will be learning more about circular questions as these are more useful in conducting family interviews.

14.5.3 Circular Questions

Circular questions are classified into three main areas of inquiry or intervention, which are as follows:

i) Problem definition questions,

ii) Sequence of interaction questions, and

iii) Comparision or classification questions.

Each of these are again sub-divided into questions asking about the time frame, that is :

i) Present

ii) Past, and

iii) Future.

These are further sub-divided in order to explore each of the aspects given below:

i) Difference,

ii) Agreement or disagreement (between family members), and

iii) Explanation or meaning.

Let us discuss these three types of circular questions in detail.

- **Circular Questions: Problem Definition**

Ask questions of each person about their perceptions of the problem(s) in the family now. Ask each one for his or her own explanation for the situation

[learn their hypotheses about why this is considered a problem or about why the problem exists (Penn, 1982)]. Children may prefer not to identify "problems" in the family; they may respond to a question about what types of changes they would like.

Examples of Problem Defining Questions:

Whenever possible, ask for a description of the specific behaviours which are perceived to be problematic (See Table 14.2).

Table 14.2 : Examples of problem defining question

Category	Examples of Questions
A. Present:	• What is the problem in the family now?
	• What concerns bring you here?
	• What problems do the other children have?
	• *For children:* What changes would you like in your family?
1. Difference	• How is this different than before?
	• Has this always been true?
2. Agreement or Disagreement	• Who agrees with you that this is the problem?
3. Meaning or explanation	• What is your explanation for this?
	• What does her or his behaviour mean?
B. Past:	• What was the problem in the family then?
1. Difference	• How is that different from now?
2. Agreement or disagreement	• Who agrees with Papa that this was the main problem?
3. Meaning or explanation	• What is your explanation for the difference between what was happening then and what is happening now?
	• What do you believe was the significance of her or his decision?
C. Future or hypothetical	• What would be the problem in the family if things were to continue as they are?
1.Difference	• How would that be different than it is now?
2. Agreement or disagreement	• Do you agree, Mother?
3. Meaning or explanation	• If change were to happen, how would you explain it?

- **Circular Questions: Sequence of Interaction**

Ask questions from each member about who does what, when (related to the problem, symptom, or to your hypothesis):

A. Ask for specific interactive behaviours:

1. Not in terms of personal character (for example, "When is he bad?", but rather, "When does he act badly?" or "When does he show you this behaviour?").

2. When members describe each other, have them elaborate with specific examples of behaviours (for example, "What do the children do when they are 'misbehaving'?" or, "Then what does uncle do that shows you he is angry?").

B. Ask about differences or changes:

1. In the past like, "How does what happens now differ from what used to occur?".

2. In the future like, "How does this differ from what will happen when she or he leaves home?".

3. In some hypothetical event such as, "What would happen if she or he did this instead of that?"

   This investigates the perceived consequences of change. Also use hypothetical event questions to take power away from an individual who uses threats of unwanted behaviours to manipulate the family like, "What would happen if she or he ran away?" or "What would Father or Mother do?"

C. Ask who agrees with whom about the sequence presented.

D. Ask for each member's explanation for certain member's behaviour (around the problem). Ask what certain behaviours, responses, symptoms, expressions, or suggestions mean to them and what they think these behaviours mean to others. These questions serve to investigate cognitions, values, rules, and myths about what is and what should be.

E. Attempt to discover the full cycle or sequence of behaviours between members, which may interact recursively with the symptom, thereby perpetuating it. An intervention may be designed to interrupt dysfunctional patterns in the nuclear family and the extended family, the school, friends, place of employment, the community, ethnic group, and so forth.

Examples of Sequence of Interaction Questions

These questions focus on interactional behaviours. A few examples of sequence of interaction questions are given in (Table 14.3).

Table 14.3 : Examples of sequences of interaction questions

Category	Examples of Questions
A. Present	• Who does what or when? • What happens next? • What does she or he do? • Ask Daughter: When Mummy tries to get Sister to eat (to solve or prevent the presenting problem) and she refuses, what does Dad do? Then what does Mom do? What does Brother do? And what does Sister do? Then what happens?

Category	Examples of Questions
	• Does *Abba* get involved in that fight or stay out of it? • When *Abba* doesn't get involved in their fights, what happens? How does your *Ammi* react when your dad doesn't get involved and fight with your brother?
1. Difference	• Has Sister always showed her dislike of eating?
2. Agreement or Disagreement	• Who agrees with you that Sister only behaves like this when she is angry?
3. Explanation or Meaning	• How do you explain Father's leaving home?
B. Past	
1. Difference:	• What solutions were tried? • What did the family do to try to stop it? Did it have any effect?
2. Agreement or Disagreement	• Who thinks that it was better when grandfather was alive? • When was it better?
3. Explanation or Meaning	• What does it mean to you that things have not changed in last three years?
C. Futuref or Hypothetical	
1. Difference	• If Father intervened would the fighting stop?
2. Agreement or Disagreement	• Who agrees that if Mummy started working, things would get worse?
3. Explanation or Meaning	• What do you think your Grandfather would believe if he were here?

• Circular Questions: Comparison or Classification

Ask questions from each member about the other family members – about their behaviours, beliefs, values, thoughts, traditions, habits, feelings, and relationships:

A. Have members compare, contrast, and rank similarities and differences; investigate inter-generational coalitions and alliances; watch for patterns. Such an exploration of the problem encourages members to gossip in the presence of the others (Penn, 1982; Palazzoli Selvini *et al.,* 1980). This is also called *triadic questioning* – when a third person is asked to comment on the behaviours and the relationship of two or more of the others (Palazzoli Selvini *et al.,* 1980; Tomm, 1984b).

B. Investigate differences or changes in coalitions over time. Explore how these changes may be related to the present dysfunction.

1. In the present and in the past; for example, "Has this always been true?"

2. In the future, for example. "Who will be closest to Mother when you have all grown up?".
3. In a hypothetical event; for example "Who would be closer to Mother if Sister gets married?".

C. Ask who agrees or disagrees with whom, as this also provides information about relationships (Penn, 1982; Palazzoli Selvini *et al.,* 1980).

D. Ask for their explanations of, or the meanings of, the coalitions and patterns of relating in the family.

Examples of Comparison or Classification Questions

Some examples of comparison or classification questions are listed below:

⇒ "Who is most convinced that something is wrong with his behaviour? Who next?"

⇒ "And who is least convinced that something is wrong?" (Rank order.)

⇒ "Classify the various members of the family in reference to their tendency to keep their rooms neat. Begin with whoever is the neatest (or the messiest)".

⇒ If Mother begins to cry during the session, you may state: "Mother seems unhappy. Who is most able to comfort her when she is sad – your dad, your grandmother, your sister, or you? (Then who?)".

Let us study some more examples of comparison or classification questions, refer to Table 14.4.

Table 14.4: Examples of comparison or classification questions

Category	Examples of Questions
A. Present	• Who feels most helpless when the problem occurs? • Who is most involved in this situation? • Then who? (Rank order.)
1. Difference	• Is your family as close as other families that you know?
2. Agreement or disagreement	• Which grandparents would agree that you are raising your children differently to your parents ?
3. Explanation or meaning	• Have you thought about why this occurs? • What is your idea about why your son does not like school?
B. Past	• Who was the most affected when this happened? • When the family went for therapy, who was most happy? • Who next? (rank)
1. Difference	• Has she always shown her sadness in this way?

2. Agreement or disagreement	• Who thinks that you were better off before you moved to the new house?
3. Explanation or meaning	• What do you think he meant when he said that he would never leave you again?
C. Future or Hypothetical	
	• If this happened, who would have to change?
	• Who would show the most surprise if she becomes a success in her business?
1. Difference	• How would their relationship be different if they had a baby?
2. Agreement or disagreement agree	• If your teacher were here, would she with you that your friends are not experimenting with drugs?
3. Explanation or meaning	• If father stopped drinking, would you begin to believe that he is more religious now?

Check Your Progress Exercise 3

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 two advantages of using circular questions rather than linear questions.

.....

.....

.....

2. Name the three main types of circular questions and give an example of each.

.....

.....

.....

14.6 INTERVIEWING AN INDIVIDUAL CLIENT

The session may comprise a single person for part of the duration of the therapy, or all of the sessions of the therapy. The systemic family therapy essentials remain the same; to question the person in a way that releases new information about relationships to the awareness of the person present in the session. The therapist asks the client about relationships with family, and other relevant persons, using circular questions based on hypothesis generated from information given by the client. The questions are formulated to help the client to reflexively think about the emerging new information on the

interconnectedness between different parts of the client's system. Reflexive thinking about one's role and activity and others', role and activity in that system becomes the mechanism for change.

14.6.1 Bringing in Multiple Perspectives

Instead of bringing in multiple viewpoints by questioning members of a family as in a family session, in an individual session family members and significant others are absent and different viewpoints are brought into the dyadic conversation between therapist and client by different ways. These are discussed below:

1. **Through circular questions:**
   - that bring in talk about people significant to the client, for example, "What opinion would your fiancé have on what you are saying now?" or "What advise would your sister give me about how to help you?"
   - that bring in the internal 'voice' or 'idea' or 'force'. For example, "When you felt like hitting him, but did not do so, whose internal voice told you not to do it?" or "In what situations does your internal voice prompt you to act destructive?".

The presentation of the 'third party' as an internal voice or idea that impacts on the client as a force for positivity or negativity is employed in family therapy. This technique is based on the building of a relational system between the therapist, the client and the 'internal voice' or the force of an idea or viewpoint. The therapist attempts to build a therapeutic alliance with the client and against any such 'voices, forces or ideas' considered responsible for the clients suffering or symptoms.

2. **Through role play** using empty chair technique, in which the client speaks directly to the significant other represented as seated in an empty chair. For example, "Suppose your father-in-law were sitting in that empty chair, what would you say to him?" or "if your habit of procrastination were sitting in that empty chair, what would it say to you?" The client can switch chairs, each chair representing a different voice or viewpoint. Also the therapist can enact a voice (internal or external) and the client can respond. All these ways enable the client to benefit from the experience of connecting with significant aspects of themselves or from seeing significant relations from another point of view. The role play ends with the therapist and client talking about their experience and ideas arising from this.

14.6.2 Clients Suitable for Individual Systemic Therapy

Individual systemic therapy is suitable for following clients:

- Adolescents or young adults who have terminated family or couple therapy and have resolved more or less the family conflicts but would benefit from one-to-one sessions to deal with problems outside the family, for example their identity and concerns about their future,
- Adolescents or young adults who refuse family therapy,

- Person who wants couples therapy but whose partner or spouse refuses to attend, and
- Where family members or significant others refuse to attend, or cannot attend due to physical or mental problems.

14.6.3 Therapist's Role in Working with Individual Clients: Using Circularity

The therapist must give priority to listening to the client and listening for all the client's external and internal 'voices' that the client has relationship with, while listening to their own professional and personal 'voices' in their head as they interact with the client.

When it is the therapist's turn to speak, the family therapist will *micro-reframe*, that is, the therapist offers a partial summary of what the client has said, which includes the therapist's observations. For example, "You were shocked to find out that your father too had failed once in school. You look puzzled and perhaps troubled as you say that. I wonder if you believe that there may be other things you may not know about your father?" The therapist carefully observes the effect of this summarizing and reframing comment which is asked like a question. The therapist can end the session with a longer commentary, a *macro-reframe* that summarizes the information emerging from the session and connects these elements so that it opens new perspectives for the client. For example, "Today we have talked about family history, particularly what is known and what is not and how these two aspects of your family, telling and concealing, impact you. The family rule appears to be to tell about success and to hide failure. You have followed the same rule without knowing it. But now your wife expects you to share both success and failure with her, for her it means emotional closeness. It's proving a challenge to your ideas of closeness".

14.7 FORMULATING AN END-OF-SESSION MESSAGE

As stated earlier, family therapists are continuously and simultaneously asking questions, getting feedback and using feedback to intervene to open up conversations to promote change during the session. At the end of each session, several areas need to be addressed.

A more formal feedback is asked for from the family by the therapist, "Did the session today connect you to possible ways to address your problems?" "Is there something I should have asked but have overlooked?", "Is there something else I should be looking at?" or "In today's meeting what surprised you the most? The least?".

The therapist formulates an ending message for the family. This could be a summary of the new information in the session focusing on closeness-distance, talking-not talking, problem clarification, finding solutions or anything else that is significant. It should always include an appreciation and acknowledgement of the family's efforts to build bridges and find solutions.

The end message can reframe symptoms of the identified person or of the problem so that the function of the symptom is seen as serving a useful

purpose for the family system. Pathologising, blaming and criticism should be reframed positively. Deficits can be reframed as strengths.

If working with a co-therapist or team, they are invited to offer their observations to the family for the family to accept or discard as they think. The observations are made in a supportive, tentative, nonjudgemental manner offering hope and encouragement.

Other end-of-session interventions that can be made are as follows:

14.7.1 Prescriptive Message

The therapist prescribes the dynamics of the family that have resulted in problems. This consists of a positive connotation of the family behaviour, with a prescriptive statement to continue their behaviour.

For example: In a conflict-avoidant couple, the members are told that they must 'continue to not fight at all, even if it results in not talking to each other or withdrawing from each other's company. They must pretend that all is well all the time. This will prevent any chance of a disagreement between them.

14.7.2 Homework Tasks

Tasks are prescribed for the family to target specific problems in a time frame. Tasks may be individual, reciprocal, or shared and can be conversation tasks or activity tasks.

For example: Father and adult divorced daughter (who has returned to stay with her parents after running her own home and career for 12 years) agreed to the task objective of increasing independence by being together less and respecting self-made decisions. The task called for actions such as not asking or telling who the daughter was going out with and what she was spending money on.

14.7.3 Prescribing a Therapeutic Ritual

Therapeutic ritual refers to a symbolic task used as an intervention. It has multiple meanings for the family on several themes; healing, identity, belief, celebration, membership, expression and negotiation. The family must determine the form and meaning of the ritual.

For example: A family that lost its father had not been permitted to attend his funeral. After discussing it the family decided that they would have their own farewell for him at home. They each would choose an object that most represented him and bring it to the garden where that would ensemble and share it with each other. They would finish by eating and drinking his favourite foods. This enabled them to acknowledge their grief at his loss, and to feel more connected to each other.

14.7.4 Therapeutic Paradox

Therapeutic paradox refers to another intervention in which the symptom is prescribed so as to create a benevolent context for positive change to take place. The idea is that if the system is resistant to change, then removing any expectation of change will neutralise the resistance. This is useful for families

where problems have become chronic and there are many risks and dilemmas involved in changing. Advising restraint, the therapist shows genuine respect and concern that the pace of change is decided by the family.

For example: A therapist tells a family that presents itself as chronically depressed, "What surprises me is that you are not more depressed than you are now. Things have been so disappointing for you all. In fact, you might be angry if you were not so depressed. But its possible that you are not ready to be angry yet. If you were not depressed you would have to deal with your extended family and your relationship with them. Since you are not ready for being angry or dealing with family relationships, I think its important to continue with your depression till such time that you can".

Check Your Progress Exercise 4

Note: a) Read the following question 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 in the statements below:

i) Different viewpoints are brought into the dyadic conversation between therapist and client by using _____ questions.

ii) Therapist must give priority to listening to the client and listening for all the client's external and internal '_____' that the client has relationship with.

iii) The end message from the therapist should always include an appreciation and acknowledgement of the family's _____ to build bridges and find solutions.

iv) Homework tasks may be individual, reciprocal, or shared and can be _____ tasks or activity tasks.

14.8 SPECIAL ISSUES IN CONDUCTING FAMILY THERAPY SESSIONS

14.8.1 Confidentiality Issues with Couples and Families

As in all therapy, information from family members and the families' identity must not be disclosed to anyone except to the supervisor. All notes, video or camera recordings must be kept in a secure place. If information is stored in a computer it must be accessible to authorized personnel only. If the therapist is using the work with the family in a publication or a presentation, the full facts must be disclosed to the family and their consent taken before proceeding. When consent is given, all efforts should be made to conceal the family identity by changing names, location, age and other revealing data.

When working with couples or other family constellations, at the outset, make an agreement with the clients about sharing or withholding of information if talking to one or more members with one or more being absent from the session. For example, if the husband attends a session alone, it is his responsibility to tell his wife what transpired in the session, not the therapist's.

In the next joint session, the therapist might start by asking if she has been brought up-to-date by her spouse about the session. If she says she has not been told, suggest that she ask her husband to tell her now, in the session. If a family member has been absent, ask who will tell the missing person about the session. This way the responsibility for communicating is the family's and the therapist can stay out of their way, letting them build their relationship.

If a member tries to talk alone in order to tell you something private, discuss the implications of this talking with the person and the family. It is better to meet with all the people involved together. It avoids the trap of being unwittingly being constrained by information about family secrets. Talking about discussion, the family process of information sharing and of information withholding should be discussed through circular questioning. This will reveal the meaning of secrets for the family and the need that the family has to be cautious, which can be dealt with safely.

14.8.2 Ethical Issues in Working with Children

It is unethical for the therapist to tell the family something that a family member has confided in confidence without seeking and being granted permission from that member. This is particularly tricky when dealing with children. Legally the parents or the guardians hold rights to confidential release of information such as school and doctor's records, so their permission should be sought when the children are under 18 years. So, if you need to speak to a child's teacher, ask the parents' permission before doing so. The family therapist should also discuss in the first session the appropriate 'ground rules' for confidentiality with the parents and child together. Adolescents often ask for more confidentiality and it may be helpful to agree to that when appropriate. Inappropriate promise of confidentiality would be in situation of life threatening situations or addictions or other situations that can be dangerous.

14.8.3 Creating a Safe and Respectful Environment for Talking

A safe environment for talking for all family members has to be created. By taking a stance of seeking to understand, the family therapist demonstrates respect of the family's struggles, acknowledging their efforts, expertise, and their ability to heal themselves. When families feel that they retain control of their family's process of problem solving and that no-one is judging or forcing them to change in therapist determined ways, they feel safe.

A child centered approach is advised for family work involving children. Sitting and talking is not what young children do naturally. Be ready that children will play in the session and conversation will be inter-spread with play. The pace will be different and challenging but very useful in the amount of family information that children possess. You should use language that children can understand.

Therapists need to respect the family's rules of addressing each other and being addressed. If two or more generations are in the session ask how they prefer to be called by you, would grandfather like to be called what his children call him, or by his first name or full name. Do the children like you to use their pet names or school names? Apologise if you have inadvertently caused offence by using the wrong form of address, particularly in working cross-culturally.

14.8.4 Representing of All Points of View

The silent member: The family therapist should hypothesise about the reason, meaning and consequence of a family member's silence during sessions. Using these hypothesis it maybe worthwhile to explore if the context of being in the therapy session is the reason for the reluctance to speak. The silence should be given a positive connotation (she or he wants to listen carefully) or reframed as a helpful contribution to the family discussion. The child who is prodded to speak by the parents feels judged and blamed. The therapist should try to make the situation feel less threatening by discussing with the young person how they could participate in the session if they wanted to, for example they could write something that someone could read out, or draw a drawing to show what their feeling was, or indicate with a gesture if they wanted to say something. The therapist could also ask another family member to guess what the silent member would say and then ask the silent member if they agreed or disagreed.

Too talkative member: The other extreme is the member who is too talkative, and this tendency can be explored in its effect on the talking of other members– "Who talks the most in your family?", "When father talks the most, are you glad to listen or do you start daydreaming?".

Absent member: Discuss with the members present about any member who is absent, for instance "What would she or he say about this viewpoint of yours, if she or he were here?". Ask the family which member will tell the absentee about the session. When the person rejoins the next session, ask if they know what transpired in the session and who was the information giver.

Reluctant members: Reluctant members are those that indicate their unwillingness to attend – "We only came because we were sent". This is worth exploring and will give information about whether the family is resistant to change or if some members are more cautious than others.

Advice seekers: Advice seekers are those that say, "We want you to tell us what to do" and may say that they recognize your expertise. Go slow with giving advice directly, until you understand the family patterns of change.

Check Your Progress Exercise 5

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

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

1. Answer 'true' or 'false' for the following statements:

i) It is okay for the therapist to tell the parents what the adolescent has confided in an individual session. _____

ii) There is no need to make any special effort to make children feel comfortable in a session. _____

iii) A family member who misses a session should be informed of what transpired, by a member agreed upon by discussion in the session _____.

14.9 RECORD KEEPING

It may be done in several ways, such as:

- Case notes during sessions may be made, though this is difficult because there is so much to observe that it is nearly impossible. Notes written post the session should contain process and content of the session, any new information gathered, which hypothesis were discarded, which were developed further, and which new ones will be used to create questions for further exploration. Which interventions were made and homework tasks prescribed should be noted. A section on therapist self reflexivity should include what meaning the session had for the therapist in personal and professional domains.

Sample of on-going session record sheet

Date:

Session number:

Family members attending:

Pre-session hypothesis:

Session process:

Session content:

New information, and feedback from family:

Closing formulation and homework tasks:

Therapist self-reflexivity:

- The co-therapist or reflecting team make notes of verbatim conversation between therapist and family members including pauses and nonverbal gestures or changing seats. This helps them to track interactional sequences.
- The session is audio or video taped with the family's consent. Playback is helpful for the family to become aware of its interactional patterns and to correct distortions in their communication. This technique is useful for training, supervision, for therapist self-monitoring and for treatment.

14.10 LET US SUM UP

In this Unit, we have learnt about the family interview and about interviewing methods. The main point is that systemic family therapy pays a great deal of attention to ways of introducing new information into the family system so that change can happen. This new information emerges in circular questioning when asking about past or present and future differences in problem definition, in agreements and disagreements, and in differences in meaning for each member. Through the use of examples we can formulate these questions based on hypothesis that are a result of information gathered, tried and discarded or further developed. Neutrality is the stance that the therapist takes in conducting the circular interview. At the end the therapist formulates

an ending message for the family to highlight similarities and differences and to encourage the system in its efforts to balance the forces of change and the forces of stability.

14.11 GLOSSARY

Alliance : A type of alignment in which two or more family members join together to co-operate on a task, often in opposition to another member.

Coalition : An alliance between specific members of a family, sometimes against one member or against a subsystem or across generations.

Dysfunctional pattern : A situation in which a family responds to stress with rigid, unyielding behaviour, rather than flexibility. It is often the reason that brings a family to therapy. For example, when a wife asks for her husband to express more affection and attention to her, he becomes more rigid, distancing himself and communicating that, 'If I give an inch, she will take a mile'.

Enmeshment : A way of relating in which there is too much closeness and a lack of differentiation. The boundaries between people are blurred, to the extent that there is no autonomy, only an exaggerated sense of belonging. A parent may be so enmeshed with a child, even an adult one, that the parent can speak for the child and vice-versa. This affects other relationships in a negative way.

Paradoxical intervention : A contradictory statement to the family that overtly conveys a message that it should not change; but is in fact made with the covert purpose of encouraging change. It does not arouse resistance in the system.

Recursive process : Description of a relationship in terms of other relationships. The word recursive can be substituted by reciprocal or circular. A husband yells at his wife who yells back. Each influences and is influenced by the other.

Reframing or positive connotation : Re-labeling or redefining something to give it a more constructive perspective. Social construction has made us aware of the process by which we label feelings, thoughts, behaviours and events and thus influence our perception of reality. We can, and do, construct our own reality, and thus can change it to heal.

Unbalancing : A technique used to change the rules (often unstated) that govern relationships in the family, particularly rules regarding hierarchy. Family members, especially the less powerful or the underdogs, are encouraged to take on new and expanded roles and functions. This provides new understanding to the family.

14.12 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. The major influence of post mordern ideas on family therapy is that there is no one truth, there are multi-versions, therefore all viewpoints are valid.
2. New information creates 'a difference that makes a difference', and thus brings about change.

Check Your Progress Exercise 2

1. i) questions
   ii) neutrality
   iii) concerns, hypothesis
   iv) feedback

Check Your Progress Exercise 3

1. Two advantages of using circular questions rather than linear questions are that they free the family from blaming themselves and others, and that they create more options for change.
2. The three main types of circular questions are problem definition questions, sequence of interaction questions and classification or comparision questions.

Check Your Progress Exercise 4

1. i) circular
   ii) voices
   iii) efforts
   iv) conversation

Check Your Progress Exercise 5

1. i) False
   ii) False
   iii) True

14.13 UNIT END QUESTIONS

1. What do you understand by family interviewing? How is this different from individual interviewing?
2. What are the necessary preparations for family interview session?
3. Explain different types of methods of interviewing.
4. Describe the important points one should consider while planning for end-of-session message.

14.14 FURTHER READINGS AND REFERENCES

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UNIT 15 CRISIS INTERVENTION

Structure

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15.1 INTRODUCTION

We all have gone through some part of our lives having experienced crisis. It is more serious than just having missed the bus, leaving the kitchen tap open with the water running or having forgotten to pay the electricity bill. A crisis is much more. The event is traumatic, immediate, typically unpredictable and overwhelming for the person. There may be a drastic change in the person's environment. At times, the event may involve threat to the very survival of the person. The usual methods of coping or tackling the problem may not work leading to a period of disorganization with no solution in sight. The person's state of being vulnerable and helpless in such a situation may be termed as a 'crisis'. Intervention by the counsellor or therapist or helper is to restore the person's equilibrium, and at the

same time, help the person perceive the world as a safe and secure place. Please note that the term 'helper' is used in throughout this unit to describe the one who 'helps' the person in a crisis situation.

Why do I want to do crisis work?

Whether we are trained professionals or volunteers, the need to help and care for others may be a motivation. Appropriate training is crucial and can determine how effective our intervention is to a person, family or community facing a crisis.

There are different types of crisis: 1) *developmental crises,* are events which occur in the normal course of time, for example birth of a child, change of job, graduation from college or retirement, 2) *situational crises,* are unpredictable, intense and sudden such as the loss of job, a sudden illness, death or loss of a loved person, divorce or separation, financial problems or motor accidents; natural disasters are included here (see Box 1), and 3) *an existential crisis* referring to inner conflict which may raise questions in the person, for example at the age of sixty, one may feel sad that one did not do much with life, or a bachelor of forty years may feel a sense of anxiety that it may be too late to marry. Each crisis situation is unique and different for each person. Box 1 given below reveals how people view crisis differently.

Box 1

Survivors of an earthquake may have faded memories of the event but may be faced with anxiety, panic or sleeplessness whenever there is noise or thunder in the distance. Persons with HIV may cope with a strong psychosocial support system but may abuse tobacco or alcohol whenever faced with depression as the illness progresses. Another woman facing physical battering by her spouse may be relieved to stay in a sheltered home but keeps worrying about facing the future due to no financial means – this may lead to her choosing to return to her abusive spouse.

Objectives:

After studying this Unit, you will be able to:

- Define and understand crisis;
- Learn how crisis develops and the role of precipitating factor;
- Understand steps in crisis management;
- Make an action plan for a person in crisis and evaluate the action; and
- Learn intervention strategies for crisis.

15.2 UNDERSTANDING CRISIS

In this section, you will learn about how crisis may be defined, understand crisis as both danger and opportunity and identify common features of crises.

Crisis has many definitions. Let us understand how the following different definitions broaden our understanding of crisis:

- Crisis results from impediments to life goals that persons believe they cannot overcome through usual choices and behaviours (Caplan cited in Gilliland and James, 1993).

- Crisis occurs because the individual knows no other response to deal with a situation (Carkhuff & Berenson, cited in Gilliland and James, 1993).

- Crises are personal difficulties or situations that immobilise people; it prevents them from consciously controlling their lives (Belkin, 1984 cited in Gilliland and James, 1993).

- The term '*crisis*' usually refers to a person's feeling of fear, shock and distress about the disruption; but not the disruption itself (Brammer, 1985 cited in Gilliland and James, 1993).

From the above definitions, we can understand that crisis is a perception of an event or situation as being intolerable and difficult; the person's resources and coping mechanisms are also inadequate.

The common features seen when a person is facing a crisis situation are summarised below:

- A triggering event perceived as threatening,
- Unexpected events,
- Person experiences discomfort causing fear, tension, confusion,
- Loss of daily routine,
- Failure of usual coping methods to reduce impact of stress,
- Uncertain future,
- Continuation of distress (about 2 to 6 weeks), and
- State of disequilibrium followed by rapid transition to an active state of crisis.

Crisis as Both Danger and Opportunity

It is important to keep in mind that there is an element of both danger and opportunity in a crisis situation. Danger, as serious pathology may result in the person. However, crisis is also an opportunity for self growth and empowerment if the person overcomes it using personal resources or seeks help. The symptoms of crisis are complicated as it affects a variety of areas for example workplace, family, etc. As the situation gets progressively worse, there is a high risk of disorganisation and psychological breakdown (see Box 2) which will be discussed later in this Unit.

Box 2

Vietnam veterans (USA) suffered from post traumatic stress disorder (PTSD) proving that when there is a crisis and coping methods fail, disorganisation occurs in the most tough individuals.

Anxiety, discomfort and abuse of substances like alcohol and tobacco are common. In many cases, intervention in the form of brief counselling is generally found to

be effective. Even though crisis and its after-effects on the person is time limited (of six to eight weeks), there may be recurrence of crisis due to a series of new problems which are unpredictable in nature. Long term therapeutic interventions may be required in such cases. Crisis may originate from different factors and people react differently to it.

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. How would you define crisis?

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2. What are the common features of crisis?

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15.3 UNDERSTANDING CRISIS

In this section you will study about the different origins of crisis, manifestations of crisis, natural and formal crisis management. You will also learn the key principles in crisis work.

The diagram (Fig 15.1) describes the interactional relationship between the origins of crisis, how it manifests, management and its outcomes (Hoff, 1989). In India, examples of crisis with origins situational in nature are the environmental disasters that caused disruption in the lives of many people, for example, the earthquake in Latur, Maharashtra or Tsunami in coastal Tamil Nadu etc. Pre-existing social or cultural values that surround the person also determine the extent of the crisis, for example origins on the basis of religion or faith led to riots in Ahmedabad in Gujarat and Mangalore in Karnataka. Examples of discrimination towards women have social origins, for example harassment for dowry and domestic violence.

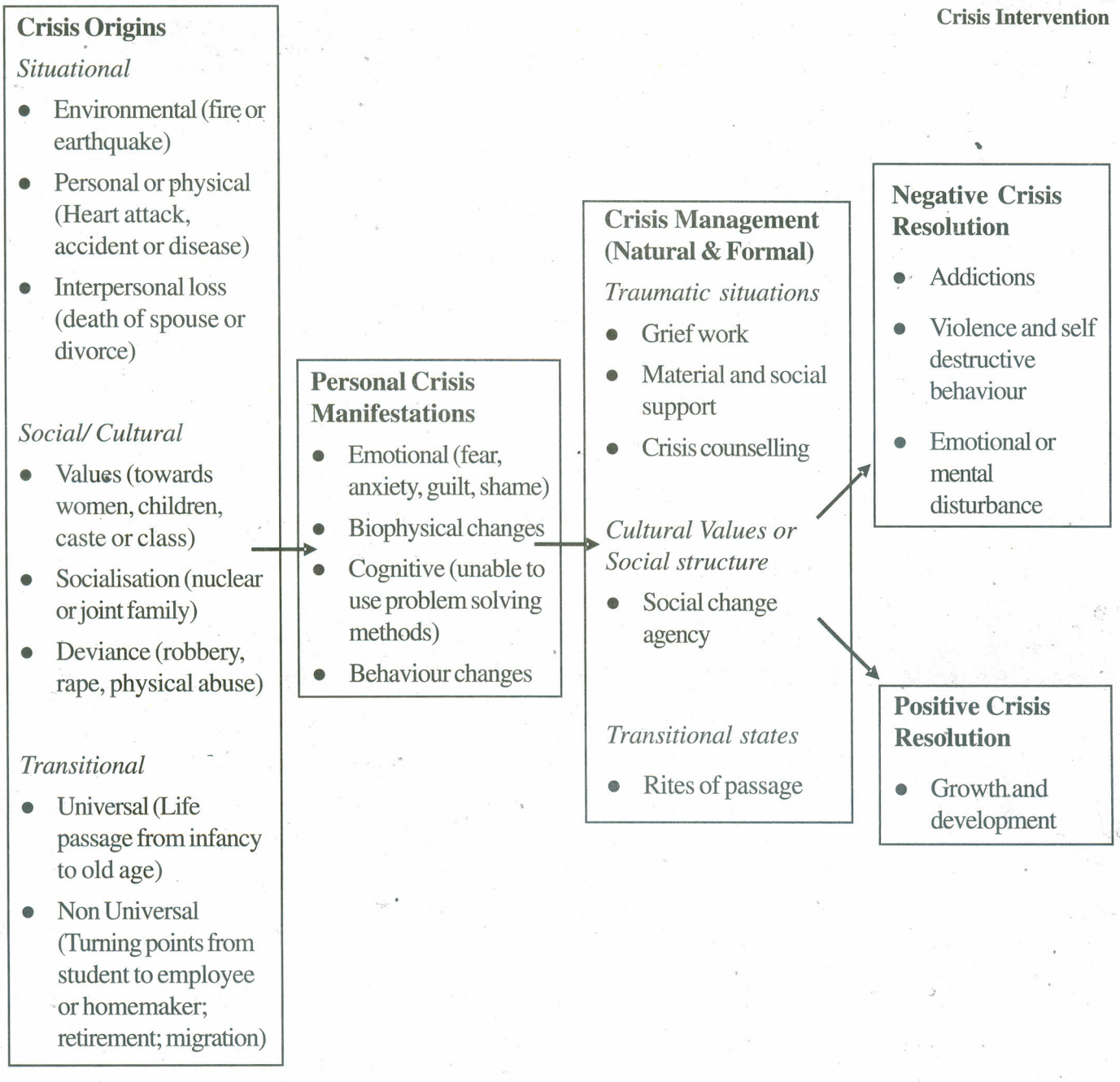


Fig.15.1: Crisis origins, manifestations, management, and negative and positive outcomes

Following the crisis, the person may develop problems that are emotional, cognitive and behavioural. There may also be physical problems, for example severe migraine, chest pains, sleeplessness and abdominal pains. The person's normal functioning in daily life is at threat.

Whatever the crisis may be, the person may manage the situation through the use of local supports and resources leading to a successful resolution (termed as *managing naturally*). This is possible for persons living in communities that have inbuilt supports which are a part of the socio-cultural system. Remember, that even if there are supports in the environment, the person in a crisis situation would use them (to resolve the crisis) only if she or he perceives or views them as being so.

In some instances, the person may receive formal help, that is, from doctors, mental health professionals, counsellors, health workers etc. Here, specific interventions such as grief work and listening skills are used. If the crisis situation persists, the person is at serious risk of developing emotional and mental health

during classes in college. We can see that there is greater stress for the family; but the crisis state is yet to occur. What will happen in Kumar's life next?

Phase 3 : The person's anxiety level and tension rises further. Every resource available is used to reduce the painful state of anxiety and solve the problem. Unresolved problems and increasing tension can result in depression.

Kumar's doctor counsels him and provides emotional support. He arranges for some nursing care at home. Rani decides to work to support the family and starts teaching at the local tutorial college. Sita's college teacher has been counselling her and advises her to apply for a scholarship to help paying of the college fees. A crisis has been prevented by using multiple resources.

Phase 4 : The active state of crisis occurs in this phase. Poor social supports and lack of inner strength could compound the problem causing more tension and anxiety. It can result in a psychological breakdown.

However, Kumar and Rani have been able to respond to his unexpected illness using available help. A full blown crisis has been avoided by taking various decisions and actions during the preceding phases.

Now, let us look at the same situation differently :

- Kumar may feel completely helpless after hearing about his illness;
- He has no support system or resources; he is unable to cope and use problem solving methods; and
- Tension and anxiety levels rise in Kumar and the family as a whole.
- A state of active crisis occurs.

The above case illustrates that despite the interplay of various difficult situations, the person including the family as a whole averts a crisis.

15.5.4 Outcome of Persons in a State of Crisis

Remember, a person cannot stay in a crisis state forever and indefinitely. As the process of being in this state is too painful, the person attempts to return to a level of stability that existed before the event. There are different outcomes after a crisis situation in a person's life. They are summarized below:

1. A person could return to her or his pre-crisis state and usual state of being. Various problem solving methods, inner values and external social supports play an important role in this. There may be no new insight or growth in the affected person.
2. Some can grow from the crisis experience and discover new resources and ways of solving problems. Using the resources is empowering for the person and family. There is personal growth.
3. There are others who may lapse into behaviour that is pathological and destructive (depression, psychosis, suspiciousness, and developing addictions). Committing suicide may also occur.

15.4.5 Crisis, Acute Stress Disorder and Post Traumatic Stress Disorder

Acute Stress Reactions (ASR) occur after traumatic events. If these reactions continue beyond a month, the person is diagnosed with Post Traumatic Stress Disorder (PTSD). These diagnostic categories appear in DSM IV and ICD 10 Classification of Mental and Behavioural Disorders (World Health Organisation, 1992). Remember, most crises can develop into traumas and most traumas begin as crisis. It is difficult to differentiate between these categories as the symptoms are similar. Let us understand the Acute Stress Disorder (ASD) and Post Traumatic Stress Disorder (PTSD).

Acute Stress Disorder (ASD)

The person can have acute stress disorder (ASD) when she or he has been exposed to a traumatic event in which both of the following were present:

1. The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others.

2. The person's responses involved intense fear, helplessness or horror.

Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:

1. A subjective sense of numbing, detachment or absence of emotional responsiveness;

2. A reduction in awareness of her or his surroundings;

3. Derealisation;

4. Depersonalisation; and

5. Dissociative amnesia (unable to recall aspects of trauma).

The traumatic event is persistently re-experienced in at least one of the following ways – recurrent images, thoughts, dreams, illusions, flashback episodes, a sense of reliving the experience or distress on exposure to reminders of the traumatic event. There is marked avoidance of stimuli that arouse recollections of the trauma (for example, thoughts, feelings, conversations, activities, places and people), and marked symptoms of anxiety or increased arousal (for example, difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, and motor restlessness). ASD leads to impairment in social, occupational or important areas of functioning or impairs the ability to pursue some necessary task or mobilise personal resources. Disturbance lasts for a minimum of two days to a maximum of four weeks and occurs within four weeks of the traumatic event. The disturbance is not due to the direct physiological effects of a substance (for example, a drug abuse, medication) or a general medical condition.

Post Traumatic Stress Disorder (PTSD)

PTSD may occur in a person who has been exposed to trauma in which both of the following were present:

1. The person experienced, witnessed or was confronted with an event that involved actual or threatened death or serious injury or threat to physical integrity of self or others, and
2. The person's response involved intense fear, helplessness or horror.

The traumatic event is persistently re-experienced in one or more ways:

1. Recurrent and intrusive distressing recollections of the event including images, thoughts and perceptions;
2. Recurrent distressing dreams of the event;
3. Acting or feeling as if the traumatic event were recurring;
4. Intense psychological distress on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event; and
5. Physiological reactivity on exposure to internal or external cues that symbolise an aspect of the traumatic event.

There is persistent avoidance of stimuli associated with the trauma and the numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1. Efforts to avoid activities, places, people associated with the trauma;
2. Inability to recall an important aspect of the trauma;
3. Markedly diminished interest or participation in significant activities;
4. Feelings of detachment from others;
5. Restricted range of affect; and
6. Sense of foreshortened future.

One finds persistent symptoms of increased arousal (two or more of the following):

1. Difficulty in sleeping,
2. Irritability,
3. Difficulty in concentrating,
4. Hypervigilance, and
5. Exaggerated startle response.

Duration of PTSD is at least one month. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

What we need to keep in mind or what is most important to us as a helper is that, a crisis is distinguished from a stress reaction or trauma on the basis of how quickly it is resolved. The social and cultural background of the person, emotional support and type of crisis will dictate how soon the person can resolve the problem and return to normal life. Hence, intervention has to be immediate to prevent the person from developing more serious problems.

There are many ways of managing a crisis. The next section presents the steps to be considered when making an intervention plan and how we could prevent the situation from worsening.

Check Your Progress Exercise 3

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. What is a 'Precipitating factor'?

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2. Enumerate the phases of development of crisis.

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3. What are the outcomes for a person in crisis? List alteast three.

a. .....

b. .....

c. .....

15.5 BASIC STEPS OF CRISIS MANAGEMENT

In this section, we will learn about psychosocial assessment, making a plan, and evaluating the action plan. We will also discuss myths about the persons in crisis situations.

We have understood that crisis resolution by individuals occurs with or without the help of others in settings that are natural (in homes, communities) or institutional (hospitals, rehabilitation centres). People who go through crisis usually use available resources to avoid negative outcomes (termed *natural crisis management*). When help is received from professionals or institution, it is known as *formal crisis management,* for example, community health workers, doctors, nurses, teachers in the local school, police and mental health professionals. It is likely that most of us may neither have had previous experience nor training in this area and may have plans to do so in future. In such a case, it is important to consult with those who are trained and familiar with crisis work for guidance and supervision (that is, from experienced counsellors, mental health professionals including trained crisis workers).

The following sub sections present the basic steps of crisis management (Gilliland & James, 1993):

15.5.1 Psychosocial Assessment

Psychosocial assessment is done at two levels:

1. **At the first level**, you need to check if there is a threat to the life of the person in crisis; or for others. Suicidal thoughts or ideas can mean a risk to self,

whereas risks of assault and homicide mean a threat to others for example, children, spouse, other family members, neighbours or helpers.

Box 4: A case of attempted suicide

Sunita, aged 28 years is shocked to read her medical report stating that she is HIV positive. She is unable to accept the news and is also filled with shame and guilt. She starts thinking about ending her life. A few days later, she attempts suicide by taking an overdose of sleeping tablets. Her sister finds her lying unconscious and immediately rushes her to the local clinic. Sunita does not wish to speak to anyone at the clinic. The helper is requested to see her.

Guidelines During Assessment (Case of Risk of Suicide): Assess the person's reason for living or dying; what motivates her or him to die or what are the contributing social factors? What is the degree of planning involved? What is the method of ending her or his life, how lethal is it? Is the person safe once she or he is at home? Is she or he abusing any drugs or is she or he depressed? How long has she or he been having suicidal thoughts? Final acts in the form of leaving a note, making a will or distributing personal possessions to others are warning signs that the risk of suicide is high.

When there is a risk of suicide (as seen in the above case), or of assault and homicide, you need to consult a specialist (psychiatrist) and refer the person.

2. **At the second level**, check if the person functions in the usual role or is the person in danger of being excluded from her or his natural setting? For this, a more comprehensive assessment is done like:

- You need to identify the origin of crisis;
- To what extent has the crisis developed? Is it acute? Is the person in the early stage or in a transition state of turmoil?;
- How is the crisis manifested in the person? For this, we need to explore the emotional, cognitive and behaviour aspects in the person;
- How is the person coping with the situation? List local resources to help the person; for example, does the person have a family and others that offer support?; and
- Are there cultural factors in the environment that contribute to the crisis?

Assessment of the event or situation: Understanding the hazardous event including precipitating factors in the right context is important (see Box 5). Through questioning, identifying various events including failure of the usual coping methods that pushed the person to a state of crisis can be a challenge. Providing help and intervention in the early stages can help the person prevent the crisis situation from worsening.

Box 5

Ask a direct question like 'could you state what happened?' Remember, the person may be in a state of shock or too upset to answer your questions. Simple questions may be used, for example, "What time did it happen? What were you doing?". The way you question may help the person to put things in a sequence and can calm the individual; for example, many of them may say they are going crazy or their life is out of control.

Assessment of feelings: The person's subjective responses to questions in order to probe feelings show how vulnerable the person is (see Box 6). In a crisis situation, high levels of anxiety can lead to negative results. A sense of dread, fear of losing control and emptiness, threat of losing one's material possessions or social relationships, anger towards self or others, shame that one is unable to manage life, a sense of shock and lack of focus are commonly reported. Physical symptoms may accompany such feelings, for example, sweating, feeling like vomiting, increased heart beat, chest pain, headaches, stomach pain, skin rashes and sexual disinterest. The person may send distress signals to others when they experience crisis through use of unhealthy coping methods (like excessive drinking of alcohol or abuse of drugs, getting into law breaking activities and suicidal attempts).

Box 6

How do you feel about what happened?

Can you describe the feelings at the time of the event?

What are your feelings now?

I can see that you are very upset — would you like to talk about it?

Assessment of thoughts, perceptions and behaviour: The state of confusion faced in the person can affect normal decision making ability. The person may be unable to understand and make sense of the events happening around her or him. Where behaviour is concerned, a person may not be able to perform normal activities. Remember, such disturbances should not be considered as a mental illness as the person usually returns to normalcy once the crisis is tackled. Remember, what a crisis means for one person may not be so for another. Each person will react differently. An understanding of feelings will help us to make a specially tailored plan to decide the methods of intervention.

15.5.2 Making a Plan with the Person

Planning goals for a person facing a crisis comprise:

- Helping the person to return to a pre-crisis state,
- Strengthening the person with the use of problems solving skills, and
- Prevention of negative outcomes.

Let us study the excerpt of the case given below (in Box 7) to understand how the initial interview helps in making a plan.

Box 7

Ravi, about 52 years old, is seen by a helper volunteering at the local hospital. He has been seen by the duty doctor who cleaned his wounds. He had injuries caused by an accident while riding his motor cycle.

The Interview Session

Helper: Tell me what happened? *(Crisis assessment begins).*

Ravi: I had a motor cycle accident today.... (Angrily) Can't you see me with cuts and wounds? *(Person is distressed, crisis is to be identified).*

Helper: I can see that you are badly hurt. The doctor also said you were driving on the wrong side of the road. Can you tell me more? *(Probing questions).*

Ravi: Well, I was tired. So I lost my concentration while on the road and hit the road divider..... I have not been sleeping well recently *(Active crisis state— person is very anxious and has physical symptoms).*

Helper: Uh huh..*(Helper encouraging Ravi using non verbal methods).*

Ravi: I have also been having severe chest pain in the past *(Physical illness identified).* ... I heard last month that I may lose my job as my friend Ashok told me about this. After all, I have been working for 20 years in the same company. Today, I go to work and I get a letter from my boss confirming it *(Precipitating factor is hearing about loss of job).*

Helper: I see...*(she leans forward showing more interest).*

Ravi: My wife does not know about this. I have not told her yet. All these thoughts made me lose my concentration when I was riding my bike to return home. I lost control *(Vulnerable state – feels loss of external support, unable to communicate with wife and use her support; hazardous event is the accident).*

Helper: The sudden news of you losing your job has greatly disturbed you. It has caused you a lot of worry, tiredness, poor sleep and now chest pain. It distracted you and made you lose control of your bike on the road. Am I right? *(Helper checking if she has understood the problem correctly).*

Ravi: Yes. I don't know what I am going to do. I cannot face my family. What will I do for an income? I have two children studying in college *(Active crisis state: Person is vulnerable, feels he has not lived up to his role as main breadwinner).*

Helper: You feel helpless and desperate about the situation. How long have you been feeling this way?

Ravi: Since past 2 or 3 weeks, when I heard rumours about the job loss at office *(Precipitating factor is evident for current crisis situation).*

Helper: Have you talked to anyone about this?

Ravi: There was no one I could talk to. I sometimes thought of going to my family doctor to get some pain killers for my chest pain. But then no one can help me out of this situation *(inability to use outside resources; feeling helpless, alone, confused).*

Helper: You felt there was no one who could help you. Is that right?

Ravi: Yes.

Helper: Ravi, if you like to discuss some ways to deal with your job loss we could meet at the counselling centre *(Helper is checking if Ravi would like to take help for the problem).*

Ravi: I don't know what to do. I really feel my life is hopeless. But I can listen to what you have to offer *(Ravi acknowledges his state of hopelessness and expresses willingness to take help).*

Helper: Ok. There are several things we can discuss.

What does the above interview between the Helper and Ravi illustrate to us?

- Helper asks direct, simple questions during assessment of the crisis,
- Helper is understanding; acknowledges Ravi's feelings (sense of helplessness, hopelessness, anxiety),
- Ravi's health problems are associated with the precipitating event (poor concentration, sleeplessness following news of job loss),
- The precipitating factor leads to the hazardous event (accident),
- Resources available but unused by Ravi (for example, wife, doctor, friend),
- Lack of effective coping by Ravi during the crisis,
- Helper offers some concrete help (counselling intervention), and
- Ravi feels that the helper is concerned and is willing to consider her help.

Once the person is identified as being in a state of crisis, the planning process begins. A good plan made by helper contains arrangements for immediate help to restore the person to normalcy. This is the same for persons in an emergency situation (due to a suicide attempt or death of a loved one). Remember, the distressed person should feel that she or he is heard or understood. For example, the helper has used statements that are reflective of his feelings such as "You seem helpless". When the helper is not sure if she has understood Ravi, she clarifies – "Is that right?" Or "Could you tell me what happened?".

Ravi could also be asked to rate the problems he considers as most urgent, for example, "Which problem seems most important to you that you would like to work on?"; What do you think troubles you the most now?" or "Whom would you like to be involved to help you tackle this problem?". This way, Ravi is actively involved in decision making.

Note: A good understanding about listening skills will help you to work effectively in crisis management.

Following are some questions for a more detailed assessment in the later sessions:

- How much has the crisis disrupted Ravi's normal life?
- How has the crisis disrupted life in other family members?
- Is the person feeling suicidal or depressed? How high is the tension and anxiety felt by Ravi? How severe are his health related problems?
- Does Ravi have a support system (family, friends, and community)? What are the available resources and how can they be used?
- Will Ravi be able to find a new job?
- To what extent can the helper offer support to Ravi?

The next stage is about putting the plan into action.

15.5.3 Putting the Action Plan to Work

A plan is arrived at mutually, that is, after both helper and person in crisis have worked on together. We should keep in mind that even though a person is in crisis, she or he is able to make decisions and is essentially still in charge of her

or his own life. The active involvement can be empowering for her or him. The helper together with the person in crisis needs to discuss options that are reasonable and appropriate to the client's life situation. Goals and expectations are clearly discussed and prioritised.

Remember to keep in mind the local cultural context when working on the action plan. We may unknowingly impose our values and customs on a person who may be from a different background, for example. religion, ethnic group, urban or rural area. Coping with death, mourning, physical illness, marriages etc. may vary across cultures.

The plan includes significant others in the person's surrounding environment, that is the person's closest family members and friends should be included. Remember, the person may be unable to recognize them as being supportive and there could be loss of contact with them. In many cases, the person's closest contact may be hostile and contribute to the crisis. We have to consider as to whether the family is part of the problem or the solution. Finding newer ways of helping the person would be the next step.

Some common myths that need to be considered at the time of planning are presented below (in Box 8):

Box 8: Some myths about persons in a crisis state

Myth: Persons in a crisis state are helpless.

Fact: Persons may be denied the opportunity to help themselves in a crisis state. This may be due to the saviour tactics or rescuing tendencies by helpers – it can result in burnout for them and be damaging for others. The need to recognise each person's self determination, capability to grow and sense of control is important.

Myth: People in crisis suffer from a form of mental illness.

Fact: It is important to distinguish between the crisis state a person is in and various forms of mental illness. People in crisis are basically normal. Some who are acutely upset or in a crisis may have had emotional or mental disturbances before the crisis; or the unsuccessful attempts to tackle the problem may have resulted in a breakdown leading to a state of high tension and anxiety. Remember, for some persons, hospitalisation itself can be a hazardous event: I could not stand the hospital's smell.

Myth: Only psychiatrists or highly trained therapists can help those in a crisis.

Fact: Plenty of work has been effectively done by volunteers, police officers, nurses, teachers, clergy or priests, community workers etc. They often work in crisis intervention in the absence of mental health professionals.

Myth: Crisis intervention is a mere 'band aid' or temporary fix.

Fact: More and more mental health professionals recognise the effectiveness and economy of crisis intervention in helping distressed people. It is not considered as trivial or an ineffective practice.

15.5.4 Evaluating the Action Plan for Crisis Resolution

A good action plan should have both follow up and evaluation. While evaluating the action plan, check if the following points are included in the action plan:

- **Overall plan is mutually developed:** If the goals in the plan have been made by the helper alone, they may not be of much value for the person in crisis. Remember, the process of decision making recognises growth and development in the person and fits into the person's culture.

- **The plan should be flexible:** The ongoing changes in the person's life need to be considered, that is, the original plan should be uniquely tailored to suit each individual. Keep in mind possible changes from previously set goals.

- **Focus on the immediate issue:** For example, the precipitating factor may be the loss of job. Hence, the plan should address issues surrounding the job loss and not the individual's underlying personality factors (this could be a long term goal).

- **Concrete time and use of resources:** Specific time and days to meet should be stated. For example, "You have agreed to meet me for our sessions at the Centre on Wednesdays and Saturdays at 5pm". This would help the person gain confidence, reduce confusion and strengthen feelings that she or he is in control of her or his life again and that certain resources (like helper, centre or hospital) are available and dependable.

- **Anticipated end in the plan:** For example, action A is planned for week one, action B for second week and so on. This could be reassuring and a change from the chaos and crisis experience. An evaluation of the plan and outcome at different points of time could be done.

- **When the helper takes an active role in planning:** Often, the person in crisis is unable to take independent decisions and may face a temporary loss of functioning (excessive anxiety or depression). In such a case, the helper can step in to put a plan together till the acute crisis phase is over. This occurs after careful assessment of the person's capabilities. Remember, the helper's role is to inspire confidence and restore independence in the person in crisis. Hence, the helper encourages a healthy state of interdependence; not dependence on the helper or on others. The helper also knows when to terminate so that the person is once again in charge of her or his life.

- **Finally, a good plan has a follow-up**: If follow-up is excluded in the plan, it may be difficult to monitor the changes (positive and negative). The helper would not be able to evaluate and sustain the work achieved by the person in crisis.Hence, dates, time of meeting, place etc. have to be fixed in advance. The next section is about interventions that are relevant in crisis work.

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. How can one do the psychosocial assessment?

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2. What are the steps of helping a person manage a crisis?

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3. State at least 2 myths about persons in a crisis.

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15.6 INTERVENTION STRATEGIES

This section will acquant you with the knowledge of working through loss and grief, and stages of reactions to loss. Effective listening and verbal and non verbal skills of listening are two important techniques in crisis intervention. We will study these techniques in this section. Specific interventions go hand in hand with the action plan. Effective listening skills help individuals experiencing intense emotional reactions at the time of crisis.

15.6.1 Working through Loss and Grief

The crisis intervention process includes grief work for a person in whom loss is the central issue. Humans are attached to other human beings and have relationships in various areas, that is friends, family, pets, place where they live, country, status in the family or society, homes, loss of job, freedom, good health etc.

Loss of any of the above causes grief and emotional pain and the tendency is to avoid coming to terms with the situation. Hence, *grief* is a process of suffering when the bereaved person has to face a new life without the person, object or lost status. Before recovery, the person can experience symptoms that are both psychological and physical (crying, short of breath, intense anger, chest pain and sleeplessness).

The stages of reactions to loss are given below:

- Denial and avoidance of the memory of the lost object,
- Reactions such as anxiety, sleeplessness, sadness, preoccupation with thoughts about loss obstructs normal activity,
- Anger towards loss and others,
- Guilt due to perceived neglect by self or others on object of loss (person may feel guilty about having survived — termed 'death guilt'), and
- Attempting to recreate the lost object (for example, building lost homes).

The goals for the person going through grief would be as follows: acceptance of pain and loss; understanding that intense feelings are normal and part of loss; allowing open expression (feelings of sadness, guilt, anger as per rituals and customs) and enabling new patterns of living using local supports. In certain societies, care of the person going through grief is seen as a collective responsibility (commonly seen in many communities in the Indian context). Remember, in the

absence of any support systems, the above reactions may be excessive, prolonged and may lead to more serious problems. Assisting the person from preventing and developing pathological outcomes due to grief is important in crisis work.

15.6.2 Effective Listening

Effective listening assists the helper to build trust and establish rapport with the person. The person may be anxious, too afraid to talk or may feel that the problem is too small to be upset about. The person may also have bottled up feelings such as anger, hurt, hopelessness or sadness. When the person speaks, attention is paid by using verbal and non verbal methods (head nodding, comments such as 'go on', 'hmmm' etc). Use of listening skills can release pent-up emotions in the person (see Box 9 for listening skills).

Box 9 : Listening skills

Eye contact, body posture, tone of voice, warmth, empathy and genuineness are important during the counselling session. Use of open and closed questions, reflection of feelings, clarifying and summarising are skills used with the person in crisis.

The listening process helps the person to reflect and gain a better understanding of the entire situation, for example, there may be self blame by the person like "Why was our house attacked by the mob?"; or "Why did I get cancer when I am so health conscious?". Thoughtful reflection by the helper can help the person to change negative perception of themselves (for example, self- pity or anger) and accept reality. Some may feel that they are 'victims' or 'survivors'. Channeling negative emotions through action can bring about change.

The act of listening can bring back previous problem solving methods that may have been given up or simply disrupted by the person. The helper enables the person to re-use personal resources, learn healthier coping and newer responses. Social networks and supportive cultural rituals can be restored.

Remember, effective listening can save time and prevent further escalation of the problem. Lengthy hospitalisation, medicines and rehabilitation can also be avoided. The action plan should (as far as possible) be set in the person's natural setting or community.

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. What are stages of reaction to loss?

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2. List some of the listening skills.

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15.7 FAMILIES AND COMMUNITIES IN CRISIS

We will study about families and communities in crisis in this section.

15.7.1 Families in a Crisis Situation

Like individuals, there can also be families as a unit facing crisis. Some families may be very good at coping and using problem solving methods; others may be less successful due to fewer or even absence of resources or the poor use of them. Hospitalisation of a family member (due to illness or accident), death, marital problems, financial and job loss, suicide (besides what has been mentioned in this unit as contributing to crisis in an individual) can affect the family as a whole. Today, nuclear families in urban areas may be able to get more support from friends (referred to as 'New age' families). This is unlike traditional nuclear families where the support system may have been from a smaller group (parents, children, relatives). Remember, the family can play a dual role, that is, it may be the origin of a crisis or it may be a support to those in crisis.

15.7.2 Communities Affected by Crisis

Crisis can affect communities living in small villages and large cities. Social and economic problems where basic needs are unmet (religious conflicts, caste, lack of housing, slums, poverty, poor access to water, education, health care); and natural disasters (floods, tsunamis, droughts, earthquakes) can be sources of crisis. Disruption of normal functioning due to any of these can create tension and fear. Lack of resources can lead to poor coping by the community. Traumatic events can also mobilise and strengthen communities. Management of crisis would be similar to the methods used for individuals.

In conclusion, we can see that crisis are universal and usually brief. Intervention strategies should be structured, brief and capable of bringing small changes sufficient to solve problems. In most cases, the helper may have a single session with the person. The tapping of the person's strengths and abilities are central to a positive result. Seeing the person resume control after their lives have been shattered, can be a satisfying experience for helper.

Check Your Progress Exercise 6

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. What are the reasons of crises in family?

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2. What are the crisis the communites can face?

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15.8 LET US SUM UP

In this Unit, we have learnt about the crisis and how does it develop. We learnt that crisis is both danger as well opportunity. Further, we studied about the different origins of crisis and its manifestations. The Unit explained the natural and formal methods of crisis managment. It also discussed, the key principles in crisis work. Period of impact, a period of recoil, and a post traumatic period are the different stages of development of crisis. We have also studied the role of precipitating factors. The Unit aquainted you with the knowledge on acute stress disorder (ASD) and post traumatic stress disorder (PTSD). Pychosocial assessment, making a plan, putting action plan to work, and evaluating the action plan are four steps of managing a crisis. Making and evaluating of action plan includes several points, that are, overall plan should be mutually developed, the plan should be flexible, focus on the immediate issues, concrete time and use of resources, anticipated end in the plan, when the helper takes active role in planning, and a follow-up. We have also studied myths related to persons in crisis, in this Unit. We have learnt about the intervention strategies that are working through loss and grief, effective listening, and verbal and non-verbal skills of listening. In the end of the Unit, we have studied about the families and communities in crisis.

15.9 GLOSSARY

ASD	:	Acute stress disorder.
Crisis	:	A perception of an event or situation as being intolerable and difficult, and person's resources and coping mechanisms are also inadequate.
Formal crisis management	:	Help is recieved from professionals or institutions.
Natural crisis management	:	Using available resources to avoid negative outcomes.
PTSD	:	Post traumatic stress disorder

15.10 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. Crisis can be defined as a perception of an event or situation as heing intolerable and difficult in which the person's resources and coping mechanisms are also inadequate.

2. Following are the common features of crisis:

   i) A triggering event perceived as threatening,

   ii) Unexpected events,

   iii) Person experiences discomfort causing fear, tension, and confusion,

   iv) Loss of daily routine,

v) Failure of usual coping methods to reduce impact of stress,

vi) Uncertain future,

vii) Continuation of distress (about 2 to 6 weeks), and

viii) State of disequilibrium followed by rapid transition to an active state of crisis.

Check Your Progress Exercise 2

1. i) situational, social.

   ii) emotional, physical, behavioural

   iii) listening skills, grief work plan

   iv) suicide attempts, abuse of alcohol/drugs and severe depression.

Check Your Progress Exercise 3

1. Precipitating factor can be described as a minor accident that may turn into crisis depending upon the person's coping and problem solving methods.
2. The phases of development of crisis are given below:

   i) A period of impact,

   ii) A period of recoil, and

   iii) A post traumatic period.

3. Three outcomes for a person in crisis are listed below:

   i) The person returns to pre crisis state but there is no personal growth,

   ii) The person discovers new resources and problem solving methods, there is personal growth, and

   iii) The person lapses into behaviour that is pathological and destructive.

Check Your Progress Exercise 4

1. Psychosocial assessment is done at two levels:

   i) Assess for threat to the person in crisis; or for others. Suicidal thoughts or ideas can mean a risk to self; risks of assault and homicide mean threat to others for example, children, spouse, other family members, neighbours or helpers.

   ii) Check if the person functions in the usual role or is the person in danger of being excluded from her or his natural settings.

2. The four steps of helping a person manage a crisis are as follows:

   i) Psychosocial assessment,

   ii) Making a plan with the person,

   iii) Putting action plan to work, and

   iv) Evaluating the action plan for crisis resolution.

3. Following are two myths about persons in a crisis:

   i) Persons in a crisis state are helpless, and

   ii) People in crisis suffer from a form of mental illness.

Check Your Progress Exercise 5

1. Following are the stages of reaction to loss:

   i) Denial and avoidance of the memory of the lost object,

   ii) Reactions such as anxiety, sleeplessness, sadness, preoccupation with thoughts about loss obstructs normal activity,

   iii) Anger towards loss and others,

   iv) Guilt due to perceived neglect by self or others on object of loss (person may feel guilty about having survived — termed 'death guilt'), and

   v) Attempting to recreate the lost object (for example, building lost homes).

2. Some of the listening skills include:

   i) Eye contact,

   ii) Body posture,

   iii) Tone of voice,

   iv) Use of open and closed questions,

   v) Reflection of feelings, and

   vi) Clarifying and summarising.

Check Your Progress Exercise 6

1. Families can face crisis due to following reasons :

   i) Hospitalization of a family member (due to illness, accident),

   ii) Death,

   iii) Marital problems,

   iv) Financial and job loss,

   v) Suicide.

2. Communities can face crises due to:

   i) Religious conflicts,

   ii) Caste,

   iii) Lack of housing, slums,

   iv) Poverty,

   v) Poor access to water, education, health care, and

   vi) Natural disasters like floods, tsunamis, droughts, earthquakes.

15.11 UNIT END QUESTIONS

1. What are the origins of crisis?
2. State the difference between formal and natural crisis management.
3. How does a precipitating factor play a role in crisis?
4. Describe the four phases in the development of crisis.
5. Discuss as to how crisis affects a person's normal functioning.
6. How does culture play a role when we make an action plan?
7. State some of the supports a person in crisis may have.
8. Discuss the necessary skills for a helper working in the area of crisis.

15.12 FURTHER READINGS AND REFERENCES

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UNIT 16 SUPPORTIVE COUNSELLING

Structure

16.1 Introduction

16.2 Definition of Supportive Counselling

16.3 Aims of Supportive Counselling

16.4 The Counsellor-Client Relationship

16.5 Characteristics of Counsellor

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- 16.6.1 Maximise Adaptive Coping Mechanisms
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- 16.6.6 Interpreting Defenses
- 16.6.7 Catharsis

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16.12 Unit End Questions

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16.1 INTRODUCTION

The term "supportive counselling" has many different meanings. Supportive counselling often takes place after the initial stressful situation has subsided and the client perceives a need for additional emotional support. It is a form of psychological treatment given to clients with chronic and disabling psychiatric conditions for whom fundamental change is not a realistic goal. These people are often severely handicapped, with a limited range of interest and activities, and less interaction with the social world. They are often isolated and have conflicting relationships. Their ability to cope with the everyday challenges of life is limited and they have few social and other resources to assist them. The counselling is given by trained mental health professional but is also applied by, among others, general practitioners and social workers.

Objectives

After studying this Unit, you will be able to:

- Understand supportive counselling;
- Learn aims of supportive counselling;
- Explain counsellor-client relationship in a typical counselling session;
- Describe characteristics of the counsellor and techniques of counselling; and
- Discuss the problems in supportive counselling.

16.2 DEFINITION OF SUPPORTIVE COUNSELLING

Supportive counselling can be defined as a form of psychological treatment provided to a patient over an extended period, often years, in order to sustain her or him psychologically, because she or he is unable to manage her or his life adequately without this long term help. An alternative definition states it as a form of long term counselling that aims to optimise patients' functioning, promote their autonomy, enhance their self-esteem and lessen their anxiety and distress.

Supportive counselling should be "trauma specific". This means that the counselling should only address the immediate problem and any consequences and issues that arise in the aftermath of that trauma. Keeping the counselling relationship focused on the trauma helps ensure that the client – with support — confronts the crisis reaction she or he experienced and begins the process of reconstructing their life. This is not to say that pre-existing life problems will be ignored. Rather, once the trauma-specific support has been initiated, the counsellor will be better able to assist the client to resolve other problems in a descending order of priority. For example, a domestic violence victim should be provided emotional support to help cope with current violent incident(s). Then, when the immediate crisis situation has been alleviated somewhat, the counsellor can begin to explore with the victim other concerns she may have.

16.3 AIMS OF SUPPORTIVE COUNSELLING

The aims of supportive counselling can be summarised as follows:

1. To promote the client's best possible psychological and social adaptation by restoring and reinforcing her or his abilities to cope with the challenges of life,
2. To bolster client's self esteem and self confidence as much as possible by highlighting assets and achievements,
3. To make client aware of the reality of her or his life situation; for example, of her or his own limitations and those of treatment—of what can and cannot be achieved,

4. To enable the client to require only that degree of professional support which will result in her or his best possible adaptation, and so prevent undue dependency, and

5. To transfer the source of support (not necessarily all of it) from professionals to relatives or friends, provided the latter are available and in a position, psychologically and materially, to assume the role of caregiver.

Check Your Progress Exercise 1

Note: a) Read the following question 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) Supportive counselling enhances _____ .

ii) Supportive counselling should be _____ .

16.4 THE COUNSELLOR-CLIENT RELATIONSHIP

The typical client for whom supportive counselling is indicated experiences difficulty in maintaining relationships with others, both intimate and general. Thus, the relationship between client and counsellor in supportive counselling is of particular kind, that is the counsellor assumes a helping role, attends sensitively to the client's needs through various strategies but promotes only a modest level of closeness (Crown, 1988).

Apart from the issue of closeness, the other feature that typifies the counsellor-client relationship is the directive role the counsellor plays. He assumes a measure of responsibility—not seen in other forms of psychotherapy, because the client is chronically impaired and vulnerable, unable to live autonomously. To an extent the bond resembles that between parent and child, that is, the counsellor or therapist creates and maintains a link through which she or he offers the security and care the client needs (Winnicott 1965; Meyer 1993).

16.5 CHARACTERISTICS OF COUNSELLOR

Counselling is a process whereby a qualified person purposefully assists another person to better handle her or his problems. Counselling is not just giving advice. It's mutual trust and understanding. Counselling is a skill gained through knowledge and practice of time-tested fundamentals or traits. A competent counsellor should display sincerity, good listening skills, and integrity to successfully assist people in gaining a better understanding of themselves and their problems. A good counsellor will have a number of key characteristics as mentioned below:

- **Holding and Containment**

The ability of the counsellor to be there for the person provides a point of stability and security in her or his otherwise chaotic world. The comfort

clients will have in knowing that counsellor is there for them can soothe them when they are under stress. Often in counselling, the best intervention is to listen and do nothing rather than to do something that is ineffective or even destructive. On the other hand, it is important to recognise when a dysfunctional, though stable situation has changed and requires active intervention.



- **Genuineness**

The role of the counsellor in supportive counselling is to be a model for the client. Some minimal self-disclosure may be appropriate instead of discussing specific aspects of her or his life or personal problems. For example, counsellor can share a joke and tell patient that her or his life is not as perfect and ideal as she or he assumes.

- **Reassurance**

Reassurance is another key characteristic of a good counsellor. It is used more frequently in supportive counselling than in most other forms of therapy. The counsellor reassures clients in at least two ways, that is, by removing doubts and misconceptions, and by pointing to their assets. Clients commonly have thoughts or sentiments about themselves which are ill founded and lead to considerable distress. Reassurance can be used to relieve fears in the client that she or he is crazy or becoming so, that she or he has a serious physical illness, or that her or his symptoms are unique to her or him alone etc.



- **Explanation**

An ability to explain to the person and the family about her or his illness is an essential characteristic of a counsellor. People with severe disorders may have distorted perceptions of reality that adversely affect their judgement and behaviour. Clarification and explanation of the reality of a situation will help them meet challenges in more adaptive ways. For example a woman with depression and her family members are explained about the illness, its symptoms, causes, treatment and prognosis.

- **Advice**

Advice is given more frequently in supportive counselling because of the person's limited coping skills than in other forms of therapies. Advice is given about treatment of the illness and when and how to seek help; about every day problems such as budgeting, diet, good sleep habit and general self-care; and on social and interpersonal skills, for example, being assertive or how to behave on social occasions.

- **Suggestion**

A good counsellor must posses the ability to give right suggestion to her or his client. Similar to guidance, the person is offered less choice in considering whether to comply. The counsellor aims to induce change by influencing her or him implicitly or explicitly. An example of implicit influence is the counsellor manifesting approval of desirable behaviour like, "The way you stood up for yourself was terrific", with the obvious implication that the person ought to replicate the behaviour.

- **Encouragement**

By making encouraging statements about a person's actions, a good counsellor can enhance a person's self esteem, reduce her or his sense of ineffectiveness and promote further positive actions. Like reassurance, encouragement must be genuine and realistic if it is to be beneficial. It is important to stay alert to the possibility of change and progress. Clients must be encouraged to take small steps so that the chance of negotiating them successfully is increased. Each mastery experience then promotes self-confidence and serves as a source of encouragement for subsequent initiatives.

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. What are two key characteristics of a good counsellor?

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2. List the two ways by which counsellor can reassure clients.

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16.6 TECHNIQUES OF SUPPORTIVE COUNSELLING

A number of techniques are employed in supportive counselling. Basic interview skills are required, which include history taking, listening, clarifying, allowing the expression of feelings, asking directive psychological questions, using an empathetic style and responding to verbal and nonverbal cues. Most important is the ability to listen to the client, to clarify what she or he says, and to be alert to any significant change, whether for better or for worse. The following techniques are used as a part of supportive counselling:

16.6.1 Maximise Adaptive Coping Mechanisms

An important technique is to increase a person's coping skills and use of adaptive defense mechanisms. Adaptive defense mechanisms include intellectualisation, rationalisation, humor, anticipation, altruism, and sublimation. In contrast, the more maladaptive defense mechanisms include denial, splitting, projection and acting out. The supportive counsellor's goal is not only to increase the use of the former but also to decrease use of the latter. Whether one uses the term coping mechanisms or defense mechanisms, the process involved is one of healthy adjustment by the client to current stressors. Examples might include going for a walk, calling a friend, immersing oneself in work, applying relaxation techniques, speaking with a counsellor and so forth.

The supportive counsellor can enhance a person's coping skills through educating about problem, and repeated practice of specific mechanisms for dealing with stressful situations.

16.6.2 Focus on the Here and Now

Here and now issues should be the primary focus of supportive counselling. How is the client feeling? How is the client getting along at work, with family, with friends? Is the person able to pay the rent? Does she or he have difficulty finding transportation to and from work? Is the person having any medication? It is through these everyday details that the counsellor has sufficient data to judge how the client is doing and what should be the focus of their work together. Once current mood and symptoms as well as logistical issues concerning rent, transportation, medication and the like have been satisfactorily reviewed or addressed, the here and now focus should concentrate on a crucial area for most psychologically impaired persons, like, interpersonal relations and social skills. The more the counsellor can help a client to increase her or his interpersonal skills; awareness and reality testing as well as develop appropriate social skills, the better the person will function in everyday existence.

16.6.3 Provide a Role Model for Identification

The supportive counsellor as role model cannot and more importantly should not present herself or himself as a perfect human being. Not only is the counsellor far from perfect, but there is much the client can learn from the counsellor's mistakes and failures as well as from successes. Indeed, it is often of great benefit to the client to learn (either through counsellor's self-disclosure of past events or through direct observation of the counsellor in

the office) how the counsellor handles anger, irritation, confusion, disappointment, embarrassment, and failure — the vicissitudes of life that confront everyone, whether mentally ill or psychologically healthy.

16.6.4 Raise Self-Esteem

Many different approaches (for example, self-talk correction of cognitive distortions or unraveling of unconscious guilt) may be taken in order to accomplish this goal. Nevertheless, perhaps the most direct and often the most robust means of raising self-esteem is by fostering an individual's competency in real skills. Indeed, there is nothing more effective in helping a client feel better about her or him than the actual demonstration to self and others that she or he is truly competent.

A number of tactics are useful in promoting an individual's competence or mastery. Perhaps the most important are taking one step at a time and working to set a patient up for success rather than failure. In other words, the counsellor guides the client through individual steps and manipulates the variables to increase the likelihood of success at each step. For example, a female patient has been unable to obtain a job for several years. Rather than simply sending her on a job interview with the hope that she will be successful, the counsellor may engage in behavioural rehearsal with the client. Through role play, the client may alleviate some of her anxiety, and together she and the counsellor can solve the problem and potential difficulties. The client and counsellor may agree to engage in "practice interview" with family members where one of the active, confident members of the family may take the role of an employer and through role plays she or he can help the person to prepare for future interviews for desirable jobs.

16.6.5 Effecting Changes in the Client's Environment

Stressful factors need to be carefully assessed so that they can be suitably modified. Environmental changes of a more positive kind are as important as the removal of stress. Thus, encouraging the client to participate in social activities can be of considerable value. Social contact is enhanced but in a protective way. People who are close to client, like family members are included in the treatment. The supportive counsellor may attempt to maximise family support by working with key family members. The counsellor assisting relatives or friends can use many of the strategies we have already discussed including guidance, encouragement and reassurance.

Failure of supportive counselling of the chronically ill person may well be due to the counsellor's neglect of the family's needs. She or he may have overlooked or underestimated the marked positive effects on the client's welfare that can result when optimising the family's role as ally. The family's successful incorporation however requires that they be fully informed and counselled, and then instructed as to what to do and how to do it. In addition, family members need help in their own right to care for their relative as the process can be burdensome and frustrating.

16.6.6 Interpreting Defenses

Though the interpretation of defenses does not play a major role in supportive counselling, there are times when it is useful to clarify how a person feels, and to discuss maladaptive ways in which she or he responds to events. A useful technique is to ask a client to reflect back on how she or he reacted to a stressful event, after the event has passed and she or he is calm.

16.6.7 Catharsis

Within a trusting therapeutic relationship, a person may be able to reveal events in their lives that they have been unable to discuss with anyone else. The counsellor, by showing that she or he is a sympathetic, active listener who accepts the client unconditionally, grants her or him permission to share her or his secrets. Although sharing of emotionally charged material is not necessarily effective in itself (Yalon *et al.,* 1977), the process leads to a sense of relief and serves as a vehicle for other strategies.

Other methods usually used in supportive counselling are relaxation training, social skills training, attendance at a social club, and occupational therapy. Treating the person together with spouse or family may be indicated but the approach adopted is primarily supportive rather than dissecting the nature of intra-familial relationships. The counsellor uses the strategies discussed above to help the family cope more effectively as a group.

Check Your Progress Exercise 3

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. What is the primary focus of supportive counselling?

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2. What are the strategies used for enhancing a person's self-esteem?

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16.7 PRACTICE OF SUPPORTIVE COUNSELLING

Supportive counselling seeks to help the client establish a unique pathway to reconstruction or healing. Every client will find her or his own way in reconstructing a new life. Just as the problem is experienced in a common but unique fashion, so must the reconstruction process be unique but common.

During the counselling process, counsellor should be non-judgemental, supportive and open in their response to decisions. There are pathways that would generally be considered negative as clients try to reconstruct a future like substance abuse, suicide, destruction of relationships etc. Counsellors should be prepared to deal with ethical issues and to refer clients for appropriate mental health counselling when necessary.

One tool used in the counselling process is education. Education is invariably a large and important part of supportive counselling. Information on coping strategies for dealing with both problems and long term stress reactions is useful. Positive strategies, such as cultivating a support system of family and friends, relaxation exercises, or physical exercise should be stressed. Negative strategies, such as substance abuse, excessive sleep, or excessive activity, should be outlined so that choices may be made to avoid them.

Clients need practical education regarding their problems. Using understandable, non-technical language and employing sensitivity to what the client can and cannot tolerate hearing at a given time, the counsellor tries to help the person learn about her or his illness (for example, depression). The illness's symptoms, course, and prognosis are discussed. Armed with knowledge of participants and warning symptoms specific for a particular illness in her or his particular case, the client can take steps to prevent psychological breakdown. Throughout the continuing process of such education, it is important that supportive counsellor preserves hope in the client, balancing the reality of the client's circumstances with appropriate optimism for the future. There may be great benefit if client's family, significant others, key friends, or employer are educated. Such persons can serve, if they are willing and able, as additional "observing egos" for the client.

Timing of practical information is important. In immediate crisis situation, such information may be ignored. After a few days and through supportive counselling, most information will be welcomed. Problem solving exercises can be used in the session in order to enhance the expertise of the client. For example, give the client a scenario relating to the problem he or she is currently facing. Ask him or her to define the most critical issues facing individuals in that scenario. After they are defined, ask him or her to develop a strategy of action to deal with such issues, including a time-line for completing action tasks. She or he can report back on a regular basis the efforts made to accomplish the tasks and the problems confronted in reaching the goals.

Another tool of counsellor is encouraging clients to establish a healthy routine. This is easier said than done, since many clients don't care about their health, at least, not now. However, family members can be encouraged to take care of their diet as most client assistance providers know that a healthy regime will help anyone to cope better with life's stress.

It is crucial that the supportive counsellor help the client to become active, to "do" rather than simply "say" or "talk about". Whether in the office with the counsellor or in the everyday world, the client is encouraged to experiment with new ways of thinking, feeling and behaving. It is also helpful to have the client set concrete, achievable behavioural goals. "I want to be happy" or "I want to be a better person" are legitimate goals, but they are so broad as to be difficult to operationalise. In addition, such general goals make

assessment of progress difficult, often resulting in the client experiencing a sense of "going nowhere". Thus, "I want to be a better person" might be concretised into specific behavioural objectives as follows: "I want to apologise to my family when I become unreasonably angry with them, and I want to return telephone calls from friends within 24 hours."

Family members can play an important role in providing support to the client for fulfilling her or his goals. Specific concrete behavioural goals may be set by family members. For instance, they can help client through all steps involved in the process of obtaining a job; selecting the right job, constructing a resume, choosing the right clothes, practice appropriate manners, coherently describing occupational goals, responding to difficult questions and following up on the interview.

Another tool for the supportive counsellor is to help clients overcome their sense of estrangement and isolation from the world through some type of social integration. One factor in reconstructing social integration may be a reconnection with family members. Family members and friends may be involved in the counselling process and help can be sought for improving social relationship. Thus, family as a support system can be extremely valuable. Another factor in developing social integration is the potential of support in the work place or at school. Workplace support can be as useful as family support. More time is spent by many individuals with fellow employees or other students than it is in the family circle. But pre-existing tensions of the workplace may exacerbate the problem, and the demands of the workplace may also mean that stress is expressed and normal work is emphasised.

An option for the counsellor in generating social support is to offer clients an opportunity to participate in peer support groups. They provide people in similar circumstances with an opportunity to describe their experiences with the emotional aftermath of stress and effective coping strategies. The focus in the groups is on the confrontation and acknowledgement of grief, crisis and trauma for support for efforts to reconstruct new lives.

In a counselling session, the essence of supportive counselling is to help clients learn to cope through awareness, acceptance and understanding of their reactions. Clients may not be able to define those reactions so the supportive counsellor can help provide options of names and words that will help describe the sensations. Helping the client revisit the trauma or event is a part of supportive counselling.

Often, one of the most powerful supports a counsellor can give to client is to provide them materials and ideas that will help them construct a new sense of meaning in the world. That meaning may be found in a new relationship with God. It may be found in a love for humanity. The search for meaning, for some, is inextricably connected with trying to change things, so that the tragedy cannot be repeated in the future. Activism is often an antidote to depression and a constructive way of expressing anger.

16.8 PROBLEMS IN SUPPORTIVE COUNSELLING

There are certain limitations in the application of supportive counselling. How actively to intervene; when and how much to self disclose; deciding

whether or not a reassuring statement is true; how comprehensive an explanation should be; whether to ignore or confront a person's denial; when to give advice; what is appropriate encouragement; how actively to embark on a plan of rehabilitation; deciding the appropriate goals of rehabilitation, when it is useful to promote an emotional catharsis *versus* when to move on; and deciding whether an intervention is for the sake of the client or to satisfy an impulse of your own are issues that a counsellor constantly needs to grapple with. It is difficult to strike the right balance between providing support to the person while not promoting excessive dependence. The main limitations of supportive counselling are:

- Some degree of dependency is inevitable. On the other hand, excessive reliance on counsellor's guidance may cause the person to regress and act in less adaptive ways. An excessively directive approach may reinforce a person's feelings of helplessness and further compromise her or his ability to act autonomously.
- Since the people who are offered supportive counselling often have great difficulty in personal relationships, maintaining a therapeutic alliance with these people is often difficult.
- Moreover, the limited gains made over long periods of time can be demoralising and frustrating for the counsellor. It is essential to monitor counter transference to prevent acting out in the counselling.
- Counsellor in supportive counselling reveals more of herself or himself to the client, at times even providing some minimal self disclosure. It is a constant challenge deciding what, when and how much to self-disclose. Counsellor should be more careful not to blur the professional boundaries between counsellor and client. A failure to clarify the boundaries will confuse the person and may lead her or him to make excessive demands.

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. Describe any three techniques used in supportive counselling.

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2. What are the disadvantages of supportive counselling?

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16.9 LET US SUM UP

In this Unit, we have learnt about supportive counselling, its goals, strategies used and how to use it in practice. In supportive counselling, the counsellor simply aims to be a good listener and provide emotional support. Supportive counselling aims not to change, but rather to strengthen client's coping mechanism. The overall aim is to optimise the client's adaptation to living. Specific aims are to optimise their social and occupational functioning, to help them deal as adaptively as possible with life challenges, to acknowledge and cope with their losses, to boost their self-esteem, to improve their reality testing, to monitor their mental states and prevent relapse of their illnesses, to support their families and other carers, to provide a source of comfort and security, to promote their autonomy and eventually to transfer support from counselling on to the individual's family and other people in their social milieu.

The techniques used in supportive counselling are maximising coping skills, raising self esteem, focussing on here and now, interpreting defenses, improving social support and catharsis.

16.10 GLOSSARY

Catharsis : A term that refers to "venting an emotion" or "getting it out of one's system". It may sometimes be useful in lessening aggression, fear, or anxiety.

Defense Mechanisms : Unconscious strategies used to avoid anxiety, resolve conflict, and enhance self esteem.

Empathy : The ability to put one's self in another's place to understand the other person's views and feelings.

Frustration : Blocking of goal directed behaviour.

Perception : A general term referring to the awareness of objects, qualities, or events, stimulating the sense organs; refers to a person's immediate experience of the world.

Prognosis : Prediction about the course and outcome of a disease process or a psychological disorder

Reinforcement : A stimulus or event which, when its onset is made contingent on a particular response, increases the likelihood of that response.

Stress : An internal state which can be caused by physical demands on the body or by environmental and social situations which are evaluated as potentially harmful, uncontrollable, or exceeding the individual's resources for coping.

Transference : Transference permits the patient to express towards the counsellor attitudes and feelings she or he has held toward other people.

16.11 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. i) self esteem

   ii) traumâ specific

Check Your Progress Exercise 2

1. Two key characteristics of a good counsellor are — being genuine and having an ability to give advice.

2. The two ways by which counsellor can reassure clients are removing doubts and misconceptions, and pointing to their assets.

Check Your Progress Exercise 3

1. The primary focus of supportive counselling is on here and now issues.

2. Many different approaches like self-talk, correction of cognitive distortions, unraveling of unconscious guilt and breaking down the task into smaller parts are used for enhancing a person's self-esteem.

Check Your Progress Exercise 4

1. Following are three of the techniques used in supportive counselling:

   i) Maximizing adaptive coping mechanisms,

   ii) Focussing on the here and now, and

   iii) Providing a role model for identification.

2. Disadvantages of supportive counselling are given below:

   i) Dependency on counsellor,

   ii) Difficulty in maintaining a therapeutic alliance, and

   iii) Limited gains over longer period of time.

16.12 UNIT END QUESTIONS

1. What do you understand by supportive counselling?

2. Explain the characteristics of counsellor and importance of client-counsellor relationship in supportive counselling.

3. What are the techniques used in supportive counselling?

4. How will you practise supportive counselling for a person with mood disorders?

16.13 FURTHER READINGS AND REFERENCES

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UNIT 17 PSYCHOEDUCATION

Structure

17.1 Introduction

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17.8.7 Specific Effective Factors of Psychoeducation: Key Information and Emotional Topics

17.8.8 Psychotherapeutic Techniques within Psychoeducation

17.9 Let Us Sum Up

17.10 Glossary

17.11 Answers to Check Your Progress Exercises

17.12 Unit End Questions

17.13 Further Readings and References

17.1 INTRODUCTION

Psychoeducation is considered to be an inherent part of treatment regime in the modern era. Understanding the lack of awareness in patients and their families about the various disorders, it is important that well trained professionals educate them in a structured manner. This information would enable the suffering families to deal with the disorder effectively. According to Swaminathan *et al.* (2009), today's patients and caregivers want to completely understand the illness and, therefore, desire to know everything about it and its treatment. Writers of the modern times believe that intentional suppression of crucial information violates a patient's rights and is against the ethics of the treating physician. Patient education is imperative to improve compliance and outcome. After appropriate education one expects the patients

and their families to develop a fundamental understanding of the therapy and be prepared and committed for long-term involvement with the treatment process. Psychoeducation is an important tool that aims to empower the patient with information with a solid scientific basis, improves their confidence in themselves and in the treatment they are undergoing. It, thus, promotes the development of trust in their clinician.

Objectives

After studying this Unit, you will be able to:

- Define the concept of psychoeducation;
- Elaborate on the goal psychoeducation;
- Describe the history of psychoeducation;
- Understand the structure of psychoeducational sessions;
- Elaborate on the broad areas addressed in any psychoeducational programme; and
- Discuss family psychoeducation.

17.2.1 Defining Psychoeducation

Psychoeducation is defined as "systematic, structured, didactic information on the illness and its treatment which includes integrating emotional aspects in order to enable the participants — patients as well as family members — to cope with the illness" (Bäuml *et. al.*, 2003).

When considered from the perspective of psychotherapy, psychoeducation refers to the components of treatment where active communication of information, exchange of information among those afflicted, and treatment of general aspects of the illness is the primary aim.

17.2.2 What is Not Considered to be Psychoeducation?

Having understood the above definition, one must be in a position to exclude several interventions which might have been mistaken for psychoeducation. For example: "Pure psychotherapeutic groups are not considered psychoeducation; similarly inpatient groups where everyday routine activities are discussed, concentration groups, muscle relaxation groups or newspaper groups are not considered psychoeducation; routine information dialogues between patients or family members and the treating physician or psychologist are also not considered psychoeducation" (Bäuml *et al.*, 2003).

17.2.3 Goal of psychoeducation

The most important goal of all therapeutic interventions lies in empowering the individuals affected as well as their families. For the patients to be able to tackle their illness as best as possible, it is crucial that they develop a basic understanding of the disorder they are afflicted with, its background and the treatment options which are currently available. Without the differential understanding of the illness, there may not be requisite insight, compliance and improvement in coping, long-term and successful cooperation with professionals taking care of them and their families.

Preliminary briefing must, in every case, be carried out by a cautious and empathic therapist, in order to do away with the dysfunctional beliefs and attitudes of the patients and their families as also to help them understand

that sufficient research has been carried out on the subject and help is readily available to them. This would help them feel secure and remain hopeful.

Brochures, books, and videos can be introduced in a supportive function when it comes to providing evidence for the professional's assertions about the disorder and also for future reference. The employment of various forms of media can provide further support and facilitate understanding.

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. What are the key components in the definition of psychoeducation?

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2. What do we not consider as psychoeducation?

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3. What is the most important goal of psychoeducation?

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17.3 HOW DID PSYCHOEDUCATION COME ABOUT?

The term "psychoeducation" was first employed by Anderson et al. and was used to describe a behavioural therapeutic concept consisting of four elements; that are, briefing the patients about their illness, problem solving training, communication training, and self-assertiveness training, whereby relatives were also included.

Within the Anglo-American realm, psychoeducation was viewed as a combination of several therapeutic elements contained within a complex psychosocial intervention than an independent, self-contained therapeutic method. Thus, psychoeducation was originally conceived as a composite of numerous therapeutic elements within a complex family therapy intervention. Patients and their relatives were, by means of preliminary briefing concerning the illness, supposed to develop a fundamental understanding of the therapy and further be convinced to commit to more long-term involvement. Since the mid 1980s, psychoeducation has evolved into an independent therapeutic programme with a focus on the didactically skillful communication of key

information within the framework of a cognitive-behavioural approach. Through this, patients and their relatives should be empowered to understand and accept the illness and cope with it in a successful manner. The underlying aim was to create a well-defined, manualised, and curriculum-oriented therapeutic method, adapted to fit the needs of patients with schizophrenia. Since then it has been extended to create awareness about other mental illnesses as well.

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. What are the four essential elements of any psychoeducational programme?

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2. What was the aim of psychoeducationists till the mid 1980's?

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17.4 WHO DOES PSYCHOEDUCATION?

Most of the moderators of psychoeducational groups are psychologists, psychiatrists, physicians, counsellors, and family therapists. "Additional staff" for the initiation of psychoeducational groups is considered necessary in those institutions which do not offer psychoeducation. It, therefore, appears necessary to integrate more moderators into psychoeducation than there are today. On the one hand, this can be done by integrating the entire psychiatric team, that is, psychiatrists, psychologists, and especially the nursing staff and social workers, into psychoeducation (Kissling et al, 2003; Liberman et al 2001; Corrigan, et. al., 2001). For greater effectiveness, in fact, one needs trained cadres of counsellors and family therapists. Apart from the aforesaid, individuals from educational backgrounds such as Child Development, Human Development, Human Development and Family Studies, who have chosen to specialise as counsellors and / or family therapists, are suitable for performing the role of psychoeducation. Another approach to improving the availability of moderators for psychoeducation is the "*peer-to-peer concept*", in which recovered patients who are personally experienced with schizophrenia or their family members are trained to become group moderators themselves.

17.5 STRUCTURE OF PSYCHOEDUCATIONAL SESSIONS

Most institutions conduct psychoeducation according to the published recommendations, for example, regarding informational and emotional contents, moderators, participants, duration, or frequency of sessions. These

include: patient psychoeducation, that is, up to 10 participants meet once a week for 50 to 60 minutes for 8 to 12 sessions, moderated by two moderators; family psychoeducation is conducted every two weeks for 6 to 15 participants for duration of 90 minutes with a mean number of 7 sessions per group.

17.5.1 Broad Areas Addressed in Any Psychoeducational Programme

The main informational topics addressed, for example, while dealing with psychiatric disorders are warning signs, course and duration of illness, causation, vulnerability-stress model, contingency plan, pharmacotherapy, psychotherapy, relapse prevention, role of family and education in treatment, impact of illness, and resources available. Emotional topics frequently dealt with are stigmatisation, isolation, feelings of guilt and shame, monetary as in financial burden, familial in terms of impact on relationships etc.

Psychoeducation is used as a method to increase awareness based on scientific evidence in a number of disorders which include schizophrenia, depression, ADHD, behavioural problems in children, stress and related disorders etc.

For better comprehension of a psychoeducational programme an outline of psychoeducational sessions is given in Table 17.1.

Table 17.1: Outline of psychoeducational sessions (Adapted from Wai Tong Chien, 2008)

Persons present in a Session	Goals	Content
1. Family and caregivers only.	To orient to the programme and to establish trusting relationship between	· Orientation to the programme and introduction of group leaders and members to participants and one another. instructors. · Negotiation of goals, roles and responsibilities. · Ensuring confidentiality. · An overview of the topics and their relevance to group members.
2. Family, caregivers and patients	To understand, for example, schizophrenia, its symptoms and short -term and long-term effects to patients and families.	· Presentation of a video of one family caring for a person with, say, schizophrenia, with descriptions of symptoms and illness behaviour of patient. · Discussion of the importance of knowledgeable involvement by family members to patient and the whole family. · Initial discussion of the mental illness and its effects on family.

3. Family, caregivers, family members and patients	To understand the theoretical concepts, etiology and the course of illness, for example, schizophrenia.	· An overview of theories of, for example, schizophrenia from a bio-psychosocial perspective. · Discussion of the psychiatric conceptualisation of schizophrenia, a review of etiology, symptoms, diagnosis, and treatment.
4-5. Family, and caregivers only	To recall and share about illness symptoms and their effects on family life.	· Information sharing about symptoms and illness behaviour; discussion about their effects on family lives. · Sharing of intense emotions toward patient and suggestion on how to deal with negative emotions to patient. · An overview of treatments and rehabilitation programmes.
6. Family, caregivers and patients	To realize the effects of medications and its compliance	· Explanation of positive and negative effects of medications for schizophrenia. · Explanation of the importance of drug compliance and maintenance. · Discussion of the specific problems related to the side-effects.
7-8. Family and caregivers only	To openly share and understand more about individual concerns and cultural issues.	· Discussion about culture of family and mental illness. · Sharing of intense emotions and feelings about patient care provision and family interactions. · More information sharing about schizophrenia and its related illness behaviour. · Discussion about the ways to deal with negative emotions to patient.
9-10. Family and caregivers only	To improve the family environment and social support	· Introduction of the role of environmental stress as a risk factor for acute exacerbations of schizophrenia. · Discussion of the significance of family as a source of social support and its role and

		responsibility within the social environment of patient. · Presentation of family stress and expressed emotion and improvement of family relationships and emotional environment.
11-13. Family and caregivers only	To manage psychosocial needs for themselves, patient and family	· Discussion about each member's psychosocial needs. · Information about medications, managing illness, and available mental health services. · Effective communication skills with patient and seeking social support from others. · Exploration of home management strategies e.g. finance and budget, environment and hygiene.
14-16. Family and caregivers only	To adopt new roles and challenges and skills of coping and patient management	· Sharing of coping skills and mutual support. · Enhancing problem solving skills by working on some individual patient management situations. · Conducting behavioural rehearsals of interaction with patient and other family members within group. · Practising coping skills learned during the sessions to real family life (in-between group sessions) and evaluating the results.
17-18. Family caregivers and patients	To review the previous learning and to prepare for group termination	· A review and summary of the materials covered in previous sessions. · Preparation and discussion on termination issues e.g. separation anxiety, independent living and use of coping skills learned. · Evaluation of learning experiences and goals achievement. · Explanation of post-intervention assessment and follow-up taken in the following months.

Check Your Progress Exercise 3

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. Can everyone carry out psychoeducational sessions?

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2. Over how many sessions is structured patient psychoeducation expected to continue?

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3. Briefly outline what one needs to discuss in a typical psychoeducational programme?

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17.6 FAMILY PSYCHOEDUCATION

Family psychoeducation has become a strongly supported evidence-based practice in the treatment of schizophrenia (McFarlane et al, 2003; Murray-Swank Ab et al, 2004; Pitschel-Walz et al, 2001). Involving families in the treatment process ensures continued therapeutic support to the individual with the disorder even at times when professional help may not be available. It is with adequate understanding of the disorder by the family that most of the goals of treatment in psychiatric disorders are achieved as a number of factors in the family, vis-a-vis, the individual may be contributing to or maintaining the illness.

Any successful psychoeducation programme involves family needs assessment, the encouragement of peer support between participants, and adequate staff training as well as on-going supervision. Gidron et al. indicated that educational and supportive group participation of families who are caring for a relative with severe mental illness enhances the knowledge of the illness, its treatment and mental health services as needed, and encourages the utilisation of the social resources available and the employment of more frequently active and interactive help-seeking coping strategies. Norton et al., on the other hand, found that family support groups provided guidance on how to establish better relationships with relatives with severe and enduring mental illness and how to negotiate more effectively with the mental health system. Overall, family education is known to lower relapse rates in people with schizophrenia

As we can see, literature supports the view that psychoeducation in families of patients with mental illness, say, schizophrenia can reduce the relapse rates of these patients (McFarlane et al., 1995; Hogarty et al., 1991), positively influence the course of the patient's illness (Corrigan, et al., 1990), and help the families and patients to better cope with the mental illness (Jungbauer et al., 2002; Sherman et al., 2003; Addington 2003; Nasser et al., 2005).

However, it is understood that there exists a gap between clinical realities and scientific understandings of any disorder (McFarlane et al, 2003; Murray-Swank et al, 2004; Pitschel-Walz et al, 2001; McFarlane et al, 1995; Hogarty et al, 1991). Families frequently find it difficult to implement the scientific understanding in their daily practice of managing these patients. This emphasises the need for structured information programmes tailormade for particular sets of individuals with specific backgrounds.

A number of different reasons might contribute to the current lack of family psychoeducation; for example, the timing at which it is being carried out for a group should be convenient to the participants, that is, it may be beneficial to carry out family groups in the evenings to allow working family members to participate. On the other hand, some family members are reluctant to take advantage of such offers (Montero, 1999; Pitschel-Walz, 2003; Angermeyer, 2005) not being sure of how these would benefit them.

In such cases, therapists have to motivate and invite all family members consistently to attend psychoeducational groups. The therapist should take into consideration that many family members hesitate to come in contact with psychiatric institutions. But integrating family members of patients with schizophrenia or other disorders into psychoeducational groups or family interventions reduces re-hospitalisation rates, facilitates support with coping strategies, and thus, empowers for competent decision making concerning relapse prevention with antipsychotic medication and thus, significant costs to the health system and substantial suffering of people with mental illness and their families could thereby be avoided.

Considering this possible reduction of costs and human suffering, it is important also that those conducting psychoeducation need to be adequately paid for. Health insurance companies and hospitals need to find ways for coverage of the costs of these interventions.

17.7 HOW CAN ONE REACH MORE PATIENTS WITH PSYCHOEDUCATION?

As explained in Section 17.4 one way to reach more clients is to employ as many more trained personnel in the process of psychoeducation. Another way of reaching more patients with psychoeducation might be an adjustment of the frequency of the sessions. Most institutions offer one psychoeducational session per week for patients, but because the time that patients with schizophrenia spend in the hospital is constantly decreasing, conducting 2 sessions per week might allow more patients to participate and also limit the number of dropouts due to discharge.

Further, it is important that the trained professionals individual in psycho-education are paid adequately so that they remain motivated to reach out to more and more people.

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. How is family psychoeducation different from patient psychoeducation?

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2. In what ways can one cater to a larger segment of people using psychoeducation?

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17.8 CARRYING OUT PSYCHOEDUCATION IN SCHIZOPHRENIA

Schizophrenia is a disruptive, distressing and burdensome illness, for the people affected and their family members. A number of people with schizophrenia, worldwide, live with their families, and they often depend on a family member's assistance and involvement in providing care at home. However, these family members are often inadequately prepared to be the main caregiver for the ill relative. Studies have indicated that there is a severe burden imposed upon the whole family when caring for a member with schizophrenia, because of unpredictable and bizarre behaviour, external stressors of stigma and isolation, family conflict, emotional frustration and burnout.

Family intervention, using a diverse range of modalities and a group format, could satisfy the informational needs of families, and develop a variety of coping strategies ensuring effective care is provided for a relative with schizophrenia.

In any psychoeducational programme, the primary caregiver of the patient is generally recruited as the study participant and is suggested to attend all the sessions and complete the relevant questionnaires that help assess current problems faced as well as level of understanding of the subject over time; other family members and patients may or may not be invited to attend only parts of the programme.

Each session begins with a didactic presentation using a PowerPoint presentation or slides, followed by a group discussion that emphasises the significance and relevance of information obtained for their family lives. Caregiving situations and incidents are presented by the caregivers and alternative ways of coping and resolving their difficulties of care provision are discussed among the caregivers.

A trained psychiatrist or psychologist then summarises the major findings of their group discussion and provides recommendations on techniques for patient management. Other mental health professionals such as social workers may be invited to be guest lecturers or speakers.

Also addressed are the high social stigma associated with mental illness and seeking mental health services, hierarchical but interdependent family structure, preference for indirect communication, difficulties in disclosure of feelings to strangers (at the first few sessions), and high tendency to expect immediate and practical help.

To work effectively for mutual support in the later sessions, the group instructor must continuously reinforce the principles of strengthening social support among the participants, including sharing personal data (ensuring confidentiality and disclosing information with trust), dialectical process (let members think about ideas and alternatives to solve problems), discussion of a taboo area (sharing of secret and internal psychological conflicts), commonality or a situation of 'all-in-the-same boat' (feeling in similar situation and working against a common plight), mutual help (reciprocal giving and receiving help and support among members), and individual problem solving (helping individual members to address unique troubles).

In-meeting and post-meeting rehearsals and practices in caring for their relative with mental illness at home are emphasised and evaluated in each of the later sessions. Supervision and progress monitoring of the psychoeducation group is important, and may comprise consistent reviews of the audiotape or minutes of each session by the trained personnel and regular clarification of problems and issues arising from each group session.

17.8.1 Benefits of Psychoeducation in Schizophrenia

Psychoeducational interventions belong to a standard therapy programme in acute and postacute phases of patients with schizophrenia. Modern treatment guidelines recommend education about schizophrenia as part of the treatment (APA, 2004). Psychoeducation for patients with schizophrenia improves the understanding of mental illness, increases the quality of life, and can reduce relapse rates (Sibitz et al., 2006; Kilian et al., 2001; Pitschel-Walz et al., 2006). In addition, such interventions are accompanied by a higher level of compliance, lower rate of relapse, and improved psychopathological status.

17.8.2 Areas Commonly Addressed in a Psychoeducational Programme on Schizophrenia

- Pharmacotherapy
- Vulnerability-stress model
- Contingency plan
- Relapse prevention
- Side effects
- Coping strategies
- Risk factors
- Positive and negative symptoms

- Socio-therapeutic therapies
- Diagnosis
- Impact of family and friends
- Neurotransmitter system
- Prodromal phase
- Prognosis
- Life events
- Psychotherapeutic offerings
- Course of illness
- Alcohol and other drugs
- Communication
- Post-psychotic depression
- Dopamine hypothesis
- Persisting symptoms
- Prevalence of illness
- Partnership and sexuality

Psychoeducation in schizophrenia, as in any other disorder, begins with the formulation of a functional concept of illness and the construction of a positive therapeutic alliance. The careful introduction of the diagnosis "schizophrenia" and the empathic processing of accompanying feelings of offense and insecurity can initially only take place in the cautious yet understanding context.

In the case of schizophrenic disorders, a number of generalisable facts that are commonly applicable to the majority of patients are conveniently passed on as quickly as possible within groups. This initiates the group solidarity and a shared fate, which cannot be achieved within the framework of one-to-one contacts. For this reason, psychoeducation is conceived as a tool for an optimal combination of the self-help potential of the afflicted and their relatives on the one hand and instances of professional help on the other hand. Thus, psychoeducation in schizophrenia serves to work on three different phases:

1. building relationship for therapeutic interaction,
2. understanding the "why" part of the illness (causes), and
3. building effective coping acumen.

The first phase helps in developing rapport and trust in the therapist and the therapeutic process which is essential for the process to go on smoothly. Here, the effective ingredient comprises a successful "process of interaction" between the therapist and patient; group interactions in the sense of a "shared fate" also constitute a component of this process. During the second phase, fundamental background information surrounding the disorder as well as its impact on the patient's behaviour must be successfully conveyed. Concerning building of effective coping acumen, the third phase, the acquisition of treatment knowledge and practical knowledge are of foremost importance.

These three fundamental phases of psychotherapeutic work represent the basis of psychoeducation. The quality of patient-therapist relationship when interacting with acute and postacute schizophrenic individuals is seen to be of primary importance. It is only when a bridge can be built to reach these patients, for the most part characterized through their illness by extreme mistrust and an attitude of skepticism in view of interpersonal relationships that the other variables — understanding causation and enhancement of coping competence — can come to bear.

First episodes of schizophrenic disorders, however, represent a fully new and incomprehensible experience. The emerging symptoms, including hearing voices, tactile hallucinations, delusional perception, thought insertion, disorganised thinking, etc., are all completely unfamiliar. Accordingly, most patients and relatives react with helplessness and in an uncoordinated manner. The symptoms which are specific to a schizophrenic disorder are generally so strange and so obscure to the normal citizen that even the individual who has previously proved successful and thrived in life inevitably develops the feeling that they just cannot believe what is happening.

In order that patients and their relatives are empowered from an early stage onwards in assuming the most constructive role possible in managing the illness, a "basic competency" with regards to comprehension and handling of schizophrenia is indispensable. To this end, psychoeducation entails teaching those affected the "ABC" of schizophrenic disorders and their treatment.

17.8.3 Indications for Participating in a Psychoeducational Programme

Indications for participating in such a psychoeducational group are wide ranging. There are only few mandatory contraindications, including massive formal thought disorders, manic elevated mood, hearing imperative voices, or acute suicidality with generally reduced stress resilience. Patients can be integrated within the treatment as soon as they are capable of taking part in a group for a period of 60 minutes. Ideally only patients suffering from schizophrenic psychoses should participate in the group, in order not to evoke unnecessary confusion in other patients through the schizophrenia-specific informational content.

17.8.4 Structure of Sessions

Group sittings last approximately one hour, take place once to twice a week, and consist of between 4 and 16 sessions. Group leaders are in most cases doctors, psychiatrists or psychologists; co-leaders can be recruited from all relevant and complementary groups.

17.8.5 The Goal

The superordinate goal can be seen in patients and their relatives acquiring basic competency in order that they may reach well-informed and self-competent decisions as to which of the modern therapeutic options such as, medical, psychotherapeutic, and psychosocial, are recommendable and suitable in their own case.

The formulation of an efficient crisis management plan directed at suicide prevention is of particular importance when dealing with schizophrenia. Depressive thoughts of resignation or giving up culminating in suicidal consideration are to be explained as a sign of post-psychotic depression and on no account made taboo. Additional administration of mood stabilizers, antidepressants, and tranquilizers together with the parallel involvement of the social environment are displayed as being normal. Patients are instructed regularly to take preprescribed emergency medication in the case of early warning signs and are equipped with crisis telephone numbers for dealing with emergencies.

There are certain non specific and specific factors involved in psychoeducation in schizophrenia. Let us now consider these.

17.8.6 Non-specific Effective Factors of Psychoeducation

Some of the non-specific effective factors of psychoeducation are given below:

- Development of a good therapeutic relationship,
- Unconditional appreciation,
- Empathic response to participants,
- Respectful attention to subjectively deviant opinions,
- Need and resource-orientated procedures,
- Stimulation of hope and reassurance,
- Encouragement of personal exchange of experiences, and
- Facilitation of "shared fate".

Only when a certain level of trust is established, are patients with schizophrenia prepared to be integrated into a group aiming to form a functional concept of the illness. After all, psychoeducation is of course a voluntary act requiring patients to partake of their own free will. Nevertheless, the commitment and expertise of professionals are crucial in motivating patients and their relatives to voluntarily cooperate.

17.8.7 Specific Effective Factors of Psychoeducation: Key Information and Emotional Topics

Key Information Relating to the Illness and Treatment Measures:

Information with respect to the following needs to be elaborated upon:

- Term "schizophrenia"
- Symptoms (positive and negative symptoms)
- Origin of symptoms: dopamine excess with disturbance in information processing
- Vulnerability-stress-coping model
- Medication and side effects
- Psychotherapeutic interventions and suicide prevention

- Psychosocial measures
- Early warning signs, crisis plan, and relapse prevention

In addition to these specific factors, emotional, illness-related topics are deliberately discussed. In addition to emotions with a positive overtone, such as pride in one's own role as an expert or the feeling of being particularly individual and original, more negatively emotional topics, such as being out of one's depth or struggling with one's fate, are also addressed.

Topics with positive and those with negative overtone are discussed. These may include:

Topics with a Positive Overtone

- Feeling of being ingenious and special,
- Sensitivity as a sign of particular individuality,
- Pride in own role as an "expert" of psychosis,
- Expansion of coping competency through psychoeducation,
- Psychosis as an object of fascination,
- Acceptance of "being as I am",
- Looking for meaning by coping with illness,
- Solidarity of group with "shared fate", and
- Support from social network.

Topics with a Negative Overtone

- Insecurity,
- Being out of one's depth,
- Alleged rareness and singleness of own fate,
- Anger and grief,
- Resignation,
- Struggling with own fate, and
- Isolation.

Thus, the take-home-message of psychoeducational programmes for schizophrenia must be as follows: schizophrenic psychoses are induced by biological factors in combination with psychosocial stress; therefore, they must be treated with both medication and psychotherapeutic interventions. Empowerment of patients can only be successfully developed on the basis of sufficient medication and long-term elements of psychosocial treatment.

17.8.8 Psychotherapeutic Techniques within Psychoeducation

The primary goal of psychoeducational interventions consists in finding a common thread between the objective, textbook medical knowledge with regards to background information of the disorder and treatment measures, and the subjective viewpoint of the afflicted individual. Carrying out this procedure is often not so simple. Important psychotherapeutic elements, as

discussed briefly above, within psychoeducation that may be used for the purpose may include the following:

1. **Building Relationship**

   - Simultaneous respect and esteem for subjective individual opinions of afflicted,
   - Modeling and imitation of therapists,
   - Modeling and imitation of patients who are successful in handling their illness,
   - Experience of solidarity in group of patients with shared fate, and
   - Exchanging experiences with others.

2. **Understanding Causation**

   - Conveyance of basic competence regarding knowledge of schizophrenia,
   - Professional simplification of complex facts,
   - Interpretation of complicated scientific information,
   - Visualisation of key information,
   - Interactive style of providing information,
   - Presentation of "missing links",
   - Induction of insight into illness and its requisite treatment measures,
   - Structure and organisation into individual therapeutic measures,
   - Two-way conveyance of information, and
   - Transmission of understanding and experiences of "enlightenment".

3. **Building Coping Acumen**

   - Focus on resources and not on deficits,
   - Optimised utilisation of psychopharmacalogy,
   - Optimised crisis management behaviour,
   - Adequate processing of grief,
   - Modification of life plan,
   - Transformation of patients into "experts" of their illness (knowledge is power),
   - Strengthening the protective potential of the family, and
   - Enabling relatives to develop into 'co-therapists'.

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. What does one need to focus on while using psychoeducation in schizophrenia?

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2. Can patients with severe symptoms also form part of the psychoeducational process? Give reasons.

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3. What are the three psychotherapeutic techniques that one needs to keep in mind while carrying out psychoeducation?

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17.9 LET US SUM UP

In this Unit, we have learnt that a number of key points must be kept in mind while doing psychoeducation. Psychoeducation has to be a highly structured curriculum-based module. It should contain informational contents that are interactively compiled. It must help patients to gain access to information concerning appropriate mental health behaviour. Any psychoeducational programme must begin with the individualised experienced-based knowledge of the participants, which when combined with a basic medical textbook knowledge of schizophrenic disorders helps the therapist develop appropriate treatment strategies. While individual opinions are appreciated and respected, great value is placed on clearly and comprehensibly presenting current scientifically founded expert knowledge in the form of direct information and advice giving.

It is important to construct a comprehensible concept of the illness and its treatment (causal and control attribution); for example, enabling lay persons to more fully understand why mental problems can be successfully treated by "chemical" interventions, is of great significance for increasing functionality. In this capacity, psychoeducation can be seen to serve an "interpreter" function, pursuing the aim of translating complicated "technical jargon" into common and everyday language, which can be understood by patients and their relatives and helps them to become experts of the illness.

In effect psychoeducation should aim at helping the participant's progress to a higher stage with treatment of each informational unit and further leave each session feeling encouraged and full of hope.

Psychoeducation is primarily a form of therapy conveying reassurance and hope, with the aim of optimally integrating empowerment of those affected with professional therapeutic techniques in a working and therapeutic alliance. The formulation of realistic and coherent therapeutic goals is of particular importance for all involved; patients, relatives, and professional auxiliaries. Goals which are too high and indeed unattainable must be deleted at the outset.

The very strength of psychoeducation lies in the deliberate focus upon patients and their relatives attaining basic competence in the area of schizophrenic psychosis. In light of the feelings of helplessness and overload with which many patients and their families are confronted, especially at the onset of the illness, this particular element is in no way of secondary importance. On the contrary, it is only when a basic understanding of the illness and its requisite therapeutic measures have been established that more continual and specific therapeutic elements can be employed. Too many elements of communication training, problem solving, training of social competence, etc, should not be integrated into short-term psychoeducational programmes.

Similarly, not all types of patients and relatives can be helped with psychoeducation. One may have to exclude those patients who are particularly severely ill. For patients suffering from a less severe schizophrenic clinical course, these basic orientation sessions may, together with information about relapse prevention, be adequate in providing stability. In the case of more seriously impaired patients, these groups can be successful in motivating and convincing individuals to opt for involvement in long term and more differential therapy. Chronic patients can, through recurrent integration in this group concept, be sent a sign of hope insofar as they have not been abandoned to their fate despite multiple relapses. Patients thus sense that others believe that they are able to recover in the face of repeated relapses.

Psychoeducation when combined with sustained medical intervention and long term psychosocial management proves to be more effective.

17.10 GLOSSARY

Communication training : Training the individual to learn the necessary skills to be effective in communication required for various roles for example, listening skills, assertiveness skills, negotiation, facilitation, public speaking etc.

Coping : The process of managing difficult circumstances, expending effort to solve personal and interpersonal problems, and seeking to master, minimise, reduce or tolerate stress or conflict.

Crisis management : The process by which one deals with major unpredictable event that threatens to harm her or him. This could involve seeking the help of a trained professional.

Motivation : Activation or energisation of goal oriented behaviour.

Problem solving training : Training the clients in moving from a given state to a desired goal state through modulation and control of more fundamental skills.

Self-assertiveness training : Training clients in a specific communication skill involving dealing with personal boundaries, their own and those of other people as distinguished from aggression and passivity.

Trust : Having faith in the therapist and believing him or her.

17.11 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. The key components in the definition of psychoeducation are structured sessions, active communication, treating general aspects of illness, focus on emotional aspects, facilitating effective coping.

2. Pure psychotherapeutic groups, inpatient groups where everyday routine activities are discussed, concentration groups, muscle relaxation groups or newspaper groups, routine information dialogues between patients or family members and the treating physician or psychologist are not considered psychoeducation

3. The most important goal of psychoeducation is empowerment of individuals affected as well as their families.

Check Your Progress Exercise 2

1. The four essential elements of any psychoeducational programme are; briefing the patients about their illness, problem solving training, communication training, and self-assertiveness training.

2. The aim of psychoeducationists till the mid 1980's was helping patients and their families develop a fundamental understanding of the therapy and commit to long-term involvement

Check Your Progress Exercise 3

1. No, only trained personnel can carry out psychoeducation.

2. Depending on the disorder, structured patient psychoeducation could vary from 6 to 15 sessions.

3. In a typical psychoeducational programme, one needs to discuss warning signs, course and duration of illness, causation, vulnerability-stress model, contingency plan, pharmacotherapy, psychotherapy, relapse prevention, role of family and education in treatment, impact of illness, and resources available.

Check Your Progress Exercise 4

1. Family psychoeducation is different from patient psychoeducation as aspects of illness that a patient may not have insight into are dealt with through educating the family about them.

2. One can cater to a larger segment of people using psychoeducation by employing many more trained personnel, adjusting the frequency of the sessions as per the need of the population to be catered to and paying the trained professionals adequately so that they remain motivated to reach out to more and more people.

Check Your Progress Exercise 5

1. One needs to focus on the following aspects while using psychoeducation in schizophrenia: meaning of the term "schizophrenia", symptoms (positive and negative symptoms), origin of symptoms, vulnerability-stress-coping model, medication and its side effects, psychotherapeutic interventions and suicide prevention, psychosocial measures, early warning signs, crisis plan and relapse prevention, resources available and stress management.

2. Patients with severe symptoms should not be included in a psychoeducational programme as their cognition may be clouded by their illness and they may not be able to participate in the group as per its requirement.

3. The three psychotherapeutic techniques that one needs to keep in mind while carrying out psychoeducation include building relationship, understanding causation and developing coping techniques.

17.12 UNIT END QUESTIONS

1. Why should a structured psychoeducational programme be devised for any illness?

2. What are the basic tenets of any psychoeducational programme?

3. How does effective psychoeducation help in building trusting relationship with the clients?

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UNIT 18 SOCIAL SKILLS THERAPY

Structure

18.1 Introduction

18.2 Social Skills Therapy: Introduction and Techniques

- 18.2.1 Relevance of Social Skills
- 18.2.2 Types of Social Skills
- 18.2.3 Social Skills Therapy: Some Techniques
- 18.2.4 Generalization of Social Skills

18.3 Social Skills Therapy in Different Disorders

- 18.3.1 Social Skills Therapy for Individuals with ADHD
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- 18.3.3 Social Skills Therapy for Children with Autism

18.4 Use of Social Skills Therapy along with other Therapies

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18.6 Let Us Sum Up

18.7 Glossary

18.8 Answers to Check Your Progress Exercises

18.9 Unit End Questions

18.10 Further Readings and References

18.1 INTRODUCTION

According to the Oxford dictionary, skills are, "the abilities to do something well". We require skills in performing everyday tasks. Some of these tasks are common to most of us, such as, getting up in the morning, eating food, drinking water and so forth. To do these tasks we require skills. Some of the skills which are required include,

- Fine and gross motor skills for movement,
- Time management skills to initiate and finish the activity in particular amount of time,
- Thinking skills and so forth.

However, we also perform certain tasks which may be unique to us, for instance, not everyone amongst us will know how to drive a car. In fact, reading this text also requires certain skills. Some of these skills include:

- Visual skills to see the text,
- Skills to read spellings, and
- Skills to understand the meanings of the words in English language, and so on.

Even when we say that we know how to do a certain task, there are various

skill levels at which we are able to accomplish the task. For instance, in a group of cricketers, all of them know the rules of the game and play cricket, we still judge them on their expertise and thus, comment on who is more skilful on certain parameters as compared to another. Thus, there are various levels of skills acquisition as well.

There is no one fixed way in which skills can be classified. However some of the clusters of skills include, life skills, social skills, and vocational skills. It may be noted that this is not a rigid classification of skills. Skills that are part of one cluster may be a part of another cluster also.

An important aspect about skills is that they can be learned. However, the expertise of the skill which can be acquired depends on a combination of many factors which include:

- Physical factors such as a blind person will not be able to drive a car since there is no vision. Thus, for certain skills to be acquired there are certain physical pre-requisites;
- Motivation of an individual to acquire a skill;
- Abilities of an individual; and
- Skill level of the model or the trainer from whom the individual is learning the skill.

In this Unit, we will be focussing on social skills therapy. *Social skills* are a set of skills through which we interact, relate and communicate with others. We will focus on various techniques through which social skills can be acquired.

Objectives

After studying this Unit, you will be able to:

- Explain what are social skills and their relevance in day-to-day life;
- Describe the importance of social skills therapy;
- Enumerate certain techniques of social skills therapy; and
- Describe certain ways through which social skills therapy can be provided to individuals with ADHD, autism and schizophrenia.

18.2 SOCIAL SKILLS THERAPY: INTRODUCTION AND TECHINQUES

Social skills therapy includes a set of standard behavioural techniques or learning activities that enable children, adolescents and adults to establish or restore practical skills in domains required to meet the interpersonal, self-care and coping demands of community living. In order to understand the techniques of imparting social skills therapy, it is very important to understand the concept of social skills and how they are acquired; and the need for social skills therapy. The following sub-sections focus on the acquisition and the relevance of social skills and types of social skills and thereafter, the focus will be on basic techniques of social skills therapy.

18.2.1 Relevance of Social Skills

Social skills are interpersonal behaviours which are learned or acquired by individuals and are important for establishing and maintaining socially rewarding relationships. We can say that an individual is socially competent when she or he is able to engage in socially appropriate behaviour with others and is aware of her or his actions in relation to self as well as others. However, the social norms for appropriate behaviour are determined by cultural and situational factors. For instance, in Japanese culture when people meet each other they greet them by bowing as compared to shaking hands for greeting which is followed in many other cultures. Nonetheless, social skills are an important aspect of interacting with others in every culture.

The foundation for learning social skills is laid during childhood, wherein the child starts learning them through the process of socialisation, observing others, getting feedback on his or her actions. However, it is difficult for certain individuals to acquire or maintain certain aspects of social skills. Some of these conditions in which social skills acquisition can be deficit include the following:

- Disorders such as ADHD, autism, schizophrenia, mental retardation;
- Child sexual abuse: A child who has grown up with physical or sexual abuse is prone to develop feelings of shame, guilt and may become isolated from others, unable to trust others and may find it difficult to establish social relationships with others; and
- Individuals with personality traits of shyness and introversion often find it difficult to initiate conversations with others in public situations and express themselves.

It is important to note that social skill deficit is not necessarily found in children or adults with disorders but it can be present in any individual on any particular aspect of social skills. Moreover, factors like motivation and lack of reinforcement also influence the individual for demonstrating social skills. Social skills are necessary since, individuals who lack certain social skills find it difficult to interact positively with others and thus, there are chances that their self-esteem may become low. Let's now look at a few domains of social skills.

18.2.2 Types of Social Skills

A very important component of social skills is interpersonal relationship skill. Therefore, communication is an important component of social skill. Communication includes both expressive and receptive domains. Some of the components of expressive communication include the speech content, pitch of voice, and rate of speaking. While expressing it is also important to perceive situations in which one is required to speak and in which one is not required to speak. For example, we all know that while writing an exam in the examination hall, we are not supposed to engage in conversation with our friend about a movie which we watched the other day. However, a child with Attention Deficit Hyperactivity Disorder (ADHD), because of her or his impulsivity, may blurt out things when not even asked or in situations where silence is expected. Additionally, non-verbal components of communication are very crucial while we are expressing ourselves which includes, looking in the eye of the other person, our body posture and so forth. Children with disorders such as autism, ADHD find it difficult to understand non-verbal aspects of communication.

Receptive aspect of communication is the ability to understand what the other person is communicating and to structure our responses in a relevant manner. A significant component of receptive communication is to understand the subtle cues in the conversation which include, to gauge when someone wants to change the topic of conversation etc. Some people with or without emotional disorders don't have adequately developed ability to read the subtle cues transacted in social interactions. These cues include both verbal and non-verbal cues. For example, a person with developed social skills is able to interpret in conversation when the other person is saying a joke or giving a sarcastic comment. However, for some children with learning disability, it is difficult to understand the jokes or sarcasm in conversation. Similarly, there are many other aspects of emotions which are reflected verbally and non-verbally in social interactions. It is to be noted that individuals with certain disorders have poor ability to recognise social and affective cues such as individuals with ADHD, schizophrenia and mental retardation. Therefore, in many instances their communication is impaired. Ability to understand social and affective cues and to communicate play an important role in establishing and maintaining social relationships such as friendships, marriages etc. Thus, individuals with social skills deficit in these areas have difficulty in establishing and maintaining these relationships. Some important social skills which help in developing and maintaining socially rewarding relationships include the following:

- Sharing and cooperating with others,
- Listening to others,
- Displaying respect to others,
- Being empathetic,
- Taking turns,
- Participating in activities,
- Communicating politely with others, and
- Being assertive.

Remember that skills such as ability to take care of one-self, performing the activities of daily living independently in accordance with the age have an impact on the social skills.

Social skills therapy aims at helping the individuals overcome their social skills deficit by using certain behavioural principles and strategies. The impact of social skills therapy is however, dependent on the severity of the disorder. For instance, a child with mild mental retardation can learn money transaction if taught using modelling or role-play. However, even if we use these methods with a child with severe mental retardation, she or he will not be able to learn money transaction.

Social skills therapy not only focuses on overcoming social skills deficit such as improving eye-contact and listening skills but also enables individuals with or without emotional disorders to learn how to deal in specific situations. Some of these situations in which social skills therapy is imparted include, conversation skills in specific situations, telephone conversation manners, interacting in job situations, doing shopping and so forth.

desired behaviour and undesired behaviours are demonstrated such that it is clear to the client that which behaviour gets rewarded and which does not. For learning to take place, the behaviour is presented many times and by several models.

Thus, modelling can be used effectively for learning behaviours such as listening to others, being empathetic, assertion skills and many more interpersonal skills.

2. Role-playing: Once effective modelling has taken place, it is recommended that role-play of the desired behaviour is done. Role-play is a simulated situation which demonstrates the social skill to be enhanced. Through role-play the client gets the opportunity to practise the modelled behaviour which contributes to effective learning. Role-play is also an effective tool for acquiring new desirable responses and unlearning the previous (undesirable) ones. Through role-play, the therapist is able to assess the ability of an individual before the therapy and train the individual in acquiring desired response. Then, the individual is made to rehearse the skills which are developed through subsequent role-plays. Role-plays can be conducted in group as well as in one-to-one situation. Feedback given after the role-play has an important role in maintaining the new behaviour. For example, for developing conversation skills, a role-play situation can be created to practise conversation skills in various situations. It is only through practise in many sessions that the skills get developed. Also, each skill has many components; therefore, for enhancing every component different role-plays are to be conducted. For children with ADHD, socially anxious children, autism, role-play method is an effective technique to develop desired social behaviour. Children with ADHD find it difficult to behave appropriately in social situations. Similarly children with autism, and asperger syndrome find it difficult to initiate conversation, and see others' view points. These can be developed through role-plays. Through role-play they can be taught desirable responses. However, one should remember that there will be a ceiling limit on the level of skills which can be acquired by child or adult with emotional difficulty because of the limitations imposed by the condition of the disorder. Other skills which can be developed through role-plays include, showing empathy, introducing one's self to others, being a good listener, money transaction etc. Role-play is an effective medium for transferring the learning from the clinic situation to the real-life situation. To ensure transfer of learning to real-life situation practice is a must.

As already mentioned giving feedback and reinforcement is essential for bringing, a long-lasting change in behaviour, and therefore, the demonstration of desirable behaviour during a role-play should be given feedback and reinforcement. Through feedback, suggestions on improving the behaviour on certain aspects need to be given. We will now look at reinforcements which have an important role to ensure that the behaviour learnt is maintained. We will also discuss a method of giving reinforcements which is 'contingency management'.

3. Reinforcement: *Reinforcement* is defined as a consequence which follows the display of behaviour and thereby attempts to increase the frequency of the occurrence of the behaviour. Reinforcement is provided through reinforcers. Reinforcers are stimuli which when given after the occurrence of behaviour increases the probability of the occurrence of that behaviour. Some examples of reinforcers include: food items, toy materials, praise and so forth.

Reinforcers can be positive or negative. *Positive reinforcer* is a stimulus/ consequence which when given after a behaviour increases the probability that

the behaviour will occur again. For example, if a child greets guests and the parents praises the child for the behaviour, the child is likely to repeat the behaviour of greeting guests in other situations as well, since the child received a positive response. However, *negative reinforcer* is a 'stimulus' whose termination is dependent on a behaviour, which increases the probability that the behaviour will occur again. It is important to note that negative implies that behaviour will cause the termination of an event or stimulus. For example, by completing school work (behaviour), the child wards off teachers' scolding (event), therefore, since completion of school work led to avoidance of teachers' scolding, the child will repeat the behaviour of completing the school work. A very important point to be noted here is that for each child the value of reinforcer will differ. Thus, the reinfocers are selected according to what motivates a particular child.

During the social skills therapy coaching sessions, the individual is given reinforcers on the display of desirable behaviour. Reinforcers help in the acquisition of behaviour and in the maintenance of the behaviour. Here, we are giving an example of using reinforcers in a systematic and consistent manner. *Contingency management* is a method which involves contingent presentation and withdrawal of rewards and punishments. Here the therapist also trains others such as parents and teachers to function as contingency managers. Lets' understand the method. First, a baseline assessment is done to establish the relative frequency or infrequency of the behaviour which has been identified to be changed. Thereafter, reinforcers are selected. Reinforcers could be primary, that is, tangible products such as favourite food, toy etc., or secondary that is, praise, tokens etc. Things or responses that act as reinforcers for one child may not do so for others. Reinforcers should be specified prior to actual initiation of treatment. A contingency plan is spelled out clearly in advance, for example the child is told that every time the child will greet guests when they come to her or his house, she or he will get the decided number of tokens. A personal token system is worked out, points are assigned to various activities, for instance, taking forward the example of greeting guests; every time the child greets guests, she or he gets 4 tokens. A reward, that is the reinforcement is decided for say 20 tokens. Remember, contingencies are clearly spelled out in advance, child and contingency manager make formal agreements about elements to be in effect. There is a clear specification of target behaviours and reinforcers that will be made contingent upon them. In case of behaviours not being demonstrated, withdrawal of reinforcer is usually planned in the contingency plan. Given below is an illustration of a star/token chart.

Table 18.1: Illustration of Star or Token Chart

Activity/ chores	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total no. of stars
Getting awake on time								
Wearing uniform by one self								

To get the child used to the star chart system you may give rewards for lower number of stars in the initial stages as well. The value of the reward may

correspond with the number of stars. This type of a record can help a child or adult see the number of tokens earned and thus how many tokens they need more to get the reward.

Here, another component of reinforcement which is self-reinforcement is important for the client to learn. Initially, external reinforcement is important to ensure that the behaviour is learnt by the client. At the same time, while the client is being given external reinforcement, the therapist makes aware the client of the self-reinforcement aspect as well. The client is taught to do self-praise after the desired behaviour is performed. The goal of reinforcement is to shift gradually from external reinforcement to internal reinforcement, since that ensures that the behaviour will be maintained for a longer period of time.

18.2.4 Generalisation of Social Skills

Therefore, using the above mentioned techniques different aspects of social skills therapy can be taught. A very important component of social skills therapy is ensuring that behaviour learnt in the clinic setting is transferred or generalized to other settings in the real world. Following are a guidelines which help to ensure that transfer of skills will take place:

1. The client should be explained the rationale, rules and strategies for using the skills.
2. Enough amount of time should be given for practice of new skills in correct manner.
3. While the client is under-going social skills therapy, the client should be given opportunities to practice new skills in varied interpersonal settings.
4. Reinforcements should be given to the client on practising appropriate behaviour.
5. Focus on developing internal reinforcement of the client, and
6. Give frequent home-works to the client which focus on practising the desired behaviour. The family members of the client can be involved for ensuring that certain situations are simulated at home for the desired behaviour to be practised. The client's progress report is maintained either by the client or by the adult in case the client is a child.

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.

Briefly describe the following:

1. Skills

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2. Social skills

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3. Social skills therapy

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4. Role-playing

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5. Modelling

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18.3 SOCIAL SKILLS THERAPY IN DIFFERENT DISORDERS

Let's now look at social skills therapy for different disorders:

18.3.1 Social Skills Therapy for Individuals with ADHD

As you all know individuals with ADHD exhibit symptoms of hyperactivity, impulsivity and inattention. Because of these symptoms, they experience various difficulties – social difficulties; difficulties in establishing interpersonal relationships and so on. Through social skills therapy, the child or adult with ADHD, can be trained to become less aggressive, become more attentive of her or his actions and others' expectations and overall behave in a more socially responsive way.

Before exploring some of the social skills therapy techniques for people with ADHD, let's briefly look at how people with ADHD miss out on developing social skills. We have already discussed that the foundation for social skills is laid during childhood, with most of the acquisition taking place from observing behaviours of others, practising the behaviour and getting feedback. Along with observation, children pick up social skills through indulging in various play

activities such as make-believe play, collaborative learning and engaging in other interactive activities during childhood. Thus, observation and feedback from others especially peers play an important role towards developing social skills. However children with ADHD, find it difficult to observe others in a systematic manner (due to inattention, hyperactivity or impulsivity) and thus, they miss out on details of social interaction. This is not to indicate that they don't pick up any social skills on their own. They may pick up some aspects of appropriate behaviour, but they don't have the understanding of social expectations in totality.

Another factor which has an impact on their acquisition of social skills derives from the fact that their inability to understand social skills leads to negative responses from others. These negative responses from others may be in the form of peer rejection which reduces the opportunities to learn social skills. Thus, they are caught in a vicious cycle. Some of the social difficulties which are faced by children or adults with ADHD include the following:

- Difficulty in establishing and maintaining friendships;
- Disturbances in peer relationships;
- Inadequate social behaviours (such as not knowing how to stand in a queue; sharing toys; asking for help and so forth);
- Difficulty in reading the emotional cues in conversations like difficulty in reading facial expressions, and tone of voice of others;
- Interrupting conversations to put forth their point; difficulty in responding to others; and
- Blurting out answer in the class without seeking permission.

Thus, social skills therapy for children with ADHD focuses on:

- Helping children acquire appropriate social skills;
- Make them aware of their behaviours, strengths and limitations;
- Enabling children to efficiently use the social skills in different settings.

To help the children acquire appropriate social skills, quite a few of the times, these skills are taught to the children in a group setting. A brief overview of the process which is usually followed to impart social skills to the children with ADHD is given below:

★ The first step before imparting social skills is to do an assessment of the current level of social skills which are present and the gaps in the skills. Then, identify one behaviour or skill to be enhanced at a time;

★ The selected behaviour is broken into smaller portions;

★ Various techniques are used to demonstrate the targeted behaviour. Some of these techniques include giving verbal instructions, modelling the targeted behaviour (demonstrations by the therapist), showing video of the targeted behaviour, coaching children to role-play the targeted behaviour. Positive feedback and reinforcement is given by the therapist for demonstrating appropriate behaviour; and

★ Once the social skills are acquired, the next step is to enable the child with ADHD to apply the acquired social behaviour appropriately in various social settings. For this, parents and teachers are coached to create positive and responsive environment at home and school. Through the parent or teacher therapy, adults learn to prompt and reinforce the child to use the newly acquired behaviour in appropriate situations. Moreover, they are also trained in several behavioural strategies which can be used with the child at home, and when the child is interacting with other family members. Parents or teachers are also taught through role-plays the behaviours which they need to demonstrate while dealing with the child in various situations. In an attempt to ensure that the skills have been acquired by parents or teachers they are also given home-works to monitor child's progress by undertaking certain defined activities with the child for a period of time. Another aspect which is a focus of many social skills therapy programmes for parents/teachers is the technique of giving commands to children with ADHD, and developing contingency management schedules for reinforcing positive behaviour.

It can be concluded that though children with ADHD have problems in developing and maintaining relationships with others which has an impact on their overall life, however, with socials skills therapy and a responsive environment at school, home etc, their skills can be improved. The impact will be higher when the social skills are taught to the child from a younger age. It is best when the child is trained in social skills through a professional along with the coaching of the parents. The therapy is most effective when there is enough practice and reinforcement at home and school. Remember, that as the child starts seeing the positive results of her or his appropriate behaviour, she or he gets reinforced to demonstrate those behaviours more often and thus this way the child is able to acquire the social skills. To emphasise again, the skills will only be learnt if they are practised sufficiently in different settings through the involvement of parents, teachers or counsellors.

18.3.2 Social Skills Therapy for Individuals with Schizophrenia

Social skills therapy for individuals with schizophrenia is useful along with pharmacological therapy. Some of the social skills deficit which individuals with schizophrenia demonstrate are listed below:

- Poor eye contact and odd facial expressions,
- Unrelated responses in the conversation, and
- Lack of perception of emotions in other people.

Social skills therapy is helpful for managing these social skills deficits. Social skills therapy programmes for schizophrenics aim at improving conversation skills, conflict management skills, assertiveness skills, performing activities of daily living, work and vocational skills. The social skills therapy has been shown to help the patients adjust better in the society after their treatment. Usually, when the patient is in the day-care centre, social skills therapy is imparted.

The therapy is imparted using similar principles as have mentioned for ADHD. Thus, a typical session may focus on one aspect of social interaction, which can be taught using several techniques including role-play, demonstrations and

feedback from the therapist. The important aspect of generalising the skill learnt to the real-world setting is also taken under consideration. In order to promote generalizations of the skills in real-world settings, the patients are trained in day-care centres; therapeutic communities; short-stay at the psychiatric ward and so forth. During the course of stay, activities for enhancing skills in various social domains are planned. And since the setting is a community based setting, opportunities for rehearing and generalizing the skills in the real world setting are many. Moreover, there is a scope for receiving feedback from the other patients as well. This acts as a reinforcement.

Some of the methods which are employed include role-playing, token economy/ contingency management. As we have already been discussing, each social skill has several components. Therefore, the individual components are taught one by one, using role-play, modelling etc. as procedures. Therapy is also provided in developing social perception skills which is the ability to interpret social and affective cues in conversation. There is a strong evidence to suggest that social skills therapy, when carefully designed and delivered, can increase patients' knowledge and skill levels, make them better adjusted members in the community and goes a long way in preventing relapses. However, for the results to be achieved and maintained the programme needs to be simple and yet at the same time specific enough to do justice to the individual case.

Let's look in detail at one of the set-ups in which social skills therapy is provided to people with schizophrenia. This set-up is called *Therapeutic Community (TC).* Therapeutic community is a set-up (mostly residential) which along with treating individuals with chronic disorders such as schizophrenia, or bipolar affective disorders, also promotes their rehabilitation through enhancing their social and vocational skills. It is a tertiary care set-up. Either TC has only one kind of patients or patients with schizophrenia, and bipolar affective disorders together. Patients, who are responding positively to the medicines and are recovering, can be referred to therapeutic communities. Through therapeutic community they are able to develop their selves, social and vocational skills. This set-up can be located in the hospital extension or exist independently.

A safe community environment is created, in which the patients are often called *residents of community*. The hierarchy with the doctors or nurses is relaxed here. However, there are clear rules and expectations which are set by the significant involvement of residents. Here, the doctors' role becomes more of a facilitator who acts as moderator when required. All these processes are facilitated by the doctors. The members contribute in running of the unit. The main aim of the unit is to help the patients become independent, responsible and empowered to enable their integration in the society. Therefore, TC is structured in a way which provides them with opportunities to take up responsibilities, share and care for each other. Moreover, it also helps towards reducing the dependency on the professionals.

The basic premise is that an individual is assisted to accept her or his past enactments. Along with this, the individual is also helped to learn social, creative and vocational skills. After a detailed psychological assessment of every individual, an individual plan is developed, which includes attending one to one therapy sessions, medication to be followed, skill therapy. In addition to the individual sessions, group sessions are also undertaken. Since it is based on the community model, there is an increased emphasis on group activities. Thus, group psychotherapy sessions, peer groups, community meetings, and group-

based social skills therapy are undertaken. Activities such as yoga, therapy, and teaching of various vocational skills etc. are also undertaken.

A typical day in a TC begins with a community meeting which is chaired usually by a resident. It is to be noted that the members of the TC undertake a contract with the community (once they are comfortable in the TC after their admission), that they will follow the rules of the community, use the resources effectively and be involved in helping each other to get well. In the community meeting, difficulties and experiences of the members are shared. It is usually seen in case of individuals with personality disorder that there are chances of splitting happening in the community.

(Splitting) This is a phenomenon often seen in patients with personality disorders: typically, one staff member is privy to the vulnerable side of the patient – made to feel special and drawn into a rescuing role – while the rest of the team feel irritated by the patient's destructive behaviour and are more in touch with the manipulative aspect of his or her personality. These splits often develop in teams, with both sides blaming the other for the patient's worsening state. An understanding that team members are holding different aspects of the patient's personality can potentially redeem the situation and inform psychological understanding. Therapeutic communities are therefore structured to discourage 'secrets' and 'special relationships' between individuals and subgroups. (Campling, 2001)

Thus, through the community meetings, open discussions are encouraged and members are given the space to freely express themselves and their feelings. After the community meetings, individual and group activities are undertaken in a routine manner. Structures such as *mentor group* (group formed along with the staff members with which the residents are comfortable; therefore, depending on the number of residents, there could be more than one mentor groups), *buddies* (forming pairs of members who are comfortable with each other) etc., are also functional in many therapeutic communities which encourage members to develop and maintain interpersonal relationships. Periodic review and evaluation is undertaken of each member's achievement of short-term goals. They are also assessed on the rating scales for their level of functioning. Based on the assessment and achievement of their various individual goals (skills they acquired), they leave the therapeutic community. There is a regular follow-up of the members even after they have left. Research has indicated that therapeutic communities are effective in social and vocational rehabilitation of patients with disorders, back in the society.

18.3.3 Social Skills Therapy for Children with Autism

You all have studied earlier in other Units that varying levels of difficulty in social interaction is one of the cardinal features which most children with autism face. Some of the key aspects of difficulty in social interaction include the followings:

1. Inability to develop eye to eye contact,
2. Failure to develop age appropriate peer relationships, and
3. Lack of social and emotional reciprocity.

Additionally, communication skills of children with autism are also impaired. Some of these impairments include (a child with autism may display one or more of the following impairments):

1. Lack of language development or delayed language development;
2. In spite of language development, marked impairment in the ability to initiate conversation with others; and
3. Stereotyped use of language.

Another difficulty which most of the children with autism face is the inability to read subtle cues in the conversation. We have already discussed the role of subtle cues in conversation at the beginning of this Unit. This difficulty at times can lead them to a tough situation wherein children with autism can at times, say inappropriate things, hurt others, also get into a situation where they are bullied, teased etc.

Social skills therapy focuses on helping children with autism manage these difficulties. It is important to note that depending on the severity of the impairment, the intensity of social skills therapy will differ. Also, depending on the child's impairment on the autism spectrum, there will be a limit to which the child will be able to acquire the skills.

It is to be noted that social skills therapy for children with autism is a specialised area and the therapists undergo special therapy to deal with children with autism. Here, we are giving a brief overview of the social skills therapy for children with autism. The exact methodology of social skills therapy for children with autism may undergo a change depending on the school of thought of therapy followed.

Social skills therapy for children with autism is conducted in both individual and group settings. For quite a few children with autism, they respond positively to therapy in one to one setting. Gradually, group activities focussing on the specific goals are also conducted with them. Some of the skills which are focussed are playing, initiating and responding to conversations, and developing peer relationships. As has been shared earlier, here also, target behaviour is selected, it is broken in to smaller portions, each portion is taught using various strategies such as role-plays, and video or live demonstration. Reinforcement is given for the demonstration of behaviour in the clinic setting. Once the skill is demonstrated in the clinic setting, then the task of generalising the skill to other settings is undertaken. In order to ensure that the acquired social skill is generalised to the social setting, the reinforcement for children with autism should be substantial, that is, when the child displays the acquired skill in the social setting, she or he should be reinforced substantially. Thereafter, the child should be reinforced by praise to enable the maintenance of the behaviour in social settings.

18.4 USE OF SOCIAL SKILLS THERAPY ALONG WITH OTHER THERAPIES

Social skills therapy is used with other therapies as well. For example, for treating social phobia, social skills therapy is used along with cognitive restructuring and coping skills therapy. For treating schizophrenia, social skills therapy is used along with pharmacological treatment and family therapy.

18.3.5 Precautions While Doing Social Skills Therapy

Some of important precautions are listed below, which a therapist should keep in mind while doing social skills therapy:

1. Before planning social skills therapy for any individual, objective assessment of the patient's actual difficulties while interacting or relating with others needs to be undertaken. Once an assessment of the difficulties is made, the severity of the disorder also needs to be assessed. The assessment of the severity of the disorder enables the therapist to project the individual's capacity to acquire the skill. This will help in objective goal-setting.

2. While undertaking social skills therapy with clients, the therapist should move at a pace which does not weigh down the client by focussing on changing too many behaviours at one time.

3. Also, while imparting therapy, the therapist should be cautious that patients don't feel inadequate for their present level of social skills.

4. The social skills therapy will be complete only when the skill learnt during the therapy setting is transferred to the real-life situations. This is called *generalization.* For generalization to take place, the therapy should have a clear focus. It is also dependent on the motivation of the client to learn the skill.

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.

Briefly describe the following:

1. Social skills deficit faced by individuals with ADHD.

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2. Social skills difficulty faced by individuals with schizophrenia.

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3. Role of therapeutic community in developing social skills.

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4. One precaution while conducting social skills therapy.

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18.4 LET US SUM UP

In this Unit, we learnt about social skills therapy. For understanding social skills therapy, we first explored the concept of social skills. Social skills are interpersonal behaviours which are learned or acquired by individuals and are important for establishing and maintaining socially rewarding relationships. Interpersonal skills are one of the components of social skills, thus communication skills form an important part of social skills. Some of the examples of social skills include cooperating with others, listening to others, displaying empathy and so forth. The foundation for social skills is laid during childhood. Due to certain disorders and personality related factors, children or adults can lack social skills. These social skills can be enhanced through social skills therapy. Next, we explored social skills therapy. Social skills therapy includes a set of standard behavioural techniques or learning activities that enable children, adolescents and adults to establish or restore practical skills in domains required to meet the interpersonal, self-care and coping demands of community living. Important aspects before undertaking social skills therapy were also discussed. Some of these include, undertaking a detailed assessment of the individual's current functioning in the social domain along with the nature of disorder which the individual is facing due to which social skills deficit is present. Broadly, some of the key methods used to impart social skills therapy such as modelling, reinforcement and role-playing were also discussed. Modelling is observational learning which is the first step to teach the client social skills. The client observes the social skill which is demonstrated by a live or a symbolic model. Certain aspects about selection of a model which need to be kept in mind were also discussed. The importance of practising the modelled behaviour through role-playing has been highlighted in the Unit. Role-play is a simulated situation in which the social skill to be enhanced is practised by the client along with the therapist or other people. It can be done in individual as well as in group settings. Other applications of role-play in the context of social skills therapy have also been discussed in the Unit. Finally, for ensuring that the behaviour is internalised and learnt, the importance of reinforcement and generalisation of the skills to real-settings has been highlighted in the Unit. Reinforcement is the consequence after the demonstration of behaviour. Both positive and negative reinforcement, as well as contingent management have been discussed. Thereafter, since for different disorders, the nature of social skills deficit differs, very briefly the nature of social skills deficit in ADHD, schizophrenia and autism were discussed. Consequently, very briefly a few strategies for social skills therapy for each of the disorder were also outlined. Some precautions which need to be followed while imparting social skills therapy, including setting up the expectations appropriately; and ensuring generalization of the behaviour learnt in the therapeutic setting.

18.5 GLOSSARY

Contingency management: A method which involves contingent presentation and withdrawal of rewards and punishments.

Modelling : Modelling, also known as observational learning is based on behavioural principles of learning. Usually, a model demonstrates a particular behaviour and the individual who wants to learn particular behaviour observes the model.

Reinforcement : The consequence which follows on the display of behaviour and thereby attempts to increase the frequency of the occurrence of the behaviour.

Reinforcer : Reinforcers are stimuli which when given after the occurrence of a behaviour increase the probability of the occurrence of the behaviour.

Role-playing : A method in which simulated situation is created in which the client is able to practise the social skill to be enhanced. It is also used for demonstrating the social skill to be enhanced.

Skills : The abilities to do something well. They are required to perform everyday tasks. Certain skills are innate and some of them are acquired.

Social skills : Skills which help in establishing and maintaining relationships with others. Most of these skills are acquired through social interactions, observing others and getting feedback from others.

Social skills : therapy Social skills therapy is given to those individuals (adults or children) who have social skills deficits in certain domains. Social skills therapy follows behavioural principles of learning, some of them being modelling, role-playing and so forth.

Therapeutic : community A set-up (mostly residential) which along with treating individuals with chronic disorders such as schizophrenia, bipolar affective disorders, also promotes their rehabilitation through enhancing their social, vocational skills.

18.6 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. Skills : Skills are the abilities to do something well. They are required to perform everyday tasks. Skills can be categorised in several ways, for example, fine motor and gross motor skills; skills to type and so forth. Certain skills are innate and some of them are acquired.

2. Social skills : Social skills are a kind of skills which help in establishing and maintaining relationships with others. We say that an individual is socially competent when she or he is able to engage in socially appropriate behaviour with others and is aware of her or his actions in relation to self as well as others. Certain prerequisite conditions are required for the development of social skills. Though social skills broadly aim at maintaining and establishing relationships, some of the behaviours depicting social skills differ from culture to culture.

3. Social skills therapy : Social skills therapy is given to those individuals (adults or children) who have social skill deficits in certain domains. The foundation for learning social skills is laid during childhood, wherein the child starts learning them through the process of socialization, observing others, getting feedback on her or his actions. However, it is difficult for certain individuals to acquire or maintain certain aspects of social skills such as those with certain disorders. Through social skills therapy some of the social skills deficit can be overcome. Social skills therapy follows behavioural principles of learning, for example modelling.

4. Role-playing : Role-play is a method in which a simulated situation is created in which the client is able to practise the social skill to be enhanced. Once effective modelling has taken place, it is recommended that role-play of the desired behaviour is done. Role-play not only provides opportunity to the client to practise the modelled behaviour but it is also an effective tool for acquiring new desirable responses and unlearning the previous (undesirable) ones. Also, through role-play, the therapist is able to assess the ability of an individual before the therapy and train the individual in acquiring desired response.

5. Modelling : Modelling, also known as observational learning, is based on behavioural principles of learning. It usually involves a model who demonstrates a particular behaviour and the individual who wants to learn the behaviour observes the model. Modelling can be done through using live or symbolic models. Through this technique, desirable behaviours, social skills/behaviours can be learnt; fears can be eliminated.

Check Your Progress Exercise 2

1. Some of the social skills deficits faced by individuals with ADHD include: difficulty to establish and maintain friendships; inadequate social behaviours (such as not knowing how to stand in a queue); difficulty to read the emotional cues in conversations; difficulty in reading facial expressions; tone of voice of others; blurting out answer in the class without seeking permission.

2. Individuals with schizophrenia exhibit poor face-eye contact, exhibit odd facial expressions; unrelated responses in the conversation; and lack of perception of emotions in other people.

3. Therapeutic community being a residential set-up, has members responsible for running the unit. It provides many opportunities for developing social and other skills. Through the setting of rules, assignment of responsibilities, skills such as team building are fostered. Moreover, it helps making the members independent, responsible and empowered. It also helps towards reducing the dependency on the professionals.

4. While undertaking social skills therapy with clients, the therapist should move at a pace which does not weigh down the client by focussing or changing too many behaviours at one time.

18.7 UNIT END QUESTIONS

1. Define skills.
2. What is your understanding of social skills and their relevance?
3. Define social skills therapy.
4. What are the pre-requisites before social skills therapy is planned?
5. Discuss modelling as a technique for social skills therapy.
6. How will you ensure that generalization of social skills is undertaken to real world setting from the therapeutic setting?
7. Briefly describe some of the techniques that can be used to enhance the social skills of a child with ADHD.
8. Outline the social skills deficit faced by children with autism.
9. How does 'therapeutic community' help in developing social skills in individuals with Schizophrenia?
10. What precautions are undertaken while conducting social skills therapy?

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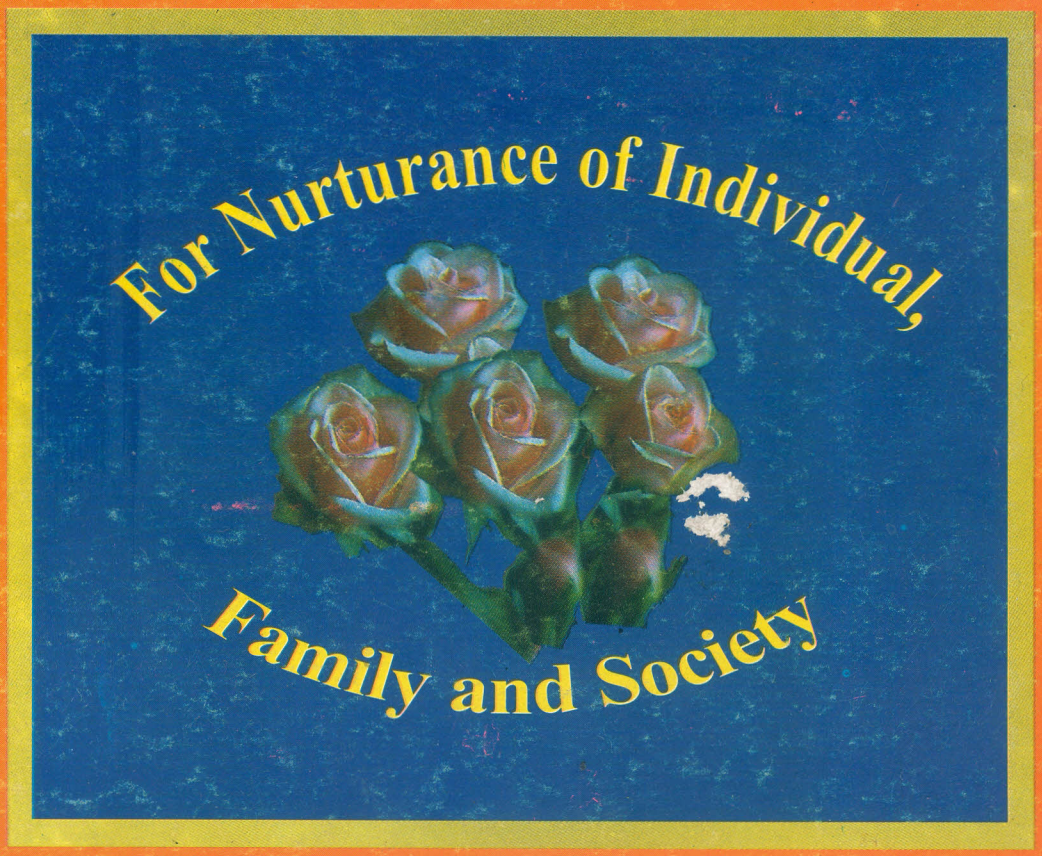
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