# M. A. PSYCHOLOGY

## SEMESTER - II (CBCS)

## PSYCHOLOGY PAPER- COURSE VI

## (CORE COURSE)

# INTERVENTION SYSTEMS IN PSYCHOLOGY

## SUBJECT CODE : PAPSY202

**Prof. Suhas Pednekar**
Vice Chancellor
University of Mumbai, Mumbai.

**Prof. Ravindra D. Kulkarni**
Pro Vice-Chancellor,
University of Mumbai.

**Prof. Prakash Mahanwar**
Director
IDOL, University of Mumbai.

**Programe Co-ordinator** : **Prof. Anil R. Bankar**
Head, Faculty of Humanities and Social Sciences,
IDOL, University of Mumbai

**Course Co-ordinator** : **Dr. Naresh Tambe**
Assistant Professor (Psychology), IDOL,
University of Mumbai.

**Editor: Compiled SLM by** : **Dr. Archana Kamble**

**May 2022, Print I**

**Published by**
Director
Institute of Distance and Open Learning,
University of Mumbai,
Vidyanagari, Mumbai - 400 098.

DTP COMPOSED AND PRINTED BY
Mumbai University Press
Vidyanagari, Santacruz (E), Mumbai - 400098.

# CONTENTS



*****

**PSYCHOLOGY**

**MA Semester System (CBCS), Revised Course, 2022-23 Semester II: Course VI**

**Core Course: 4 credits, 60 hrs.**

**INTERVENTION SYSTEMS IN PSYCHOLOGY:PAPSY202**

**Objectives:**

1. To acquaint students with various systems of psychological intervention.
2. To orient students with eclectic, integrated and multicultural approaches to interventions

**Unit 1. Intervention systems emphasizing background**

a. Sigmund Freud- classic psychoanalysis
b. Alfred Adler-individual psychology
c. Carl Jung- analytical psychology

**Unit 2. Intervention systems emphasizing humanistic, cognitive and behavioural approaches.**

a. Carl Rogers- person centered therapy
b. Behaviour therapy
c. Aaron Beck- cognitive therapy

**Unit 3. Techniques in group.**

a. Fundamentals: influences, advantages of group therapy, organizing group, opening and later sessions, technical functions of group therapists.
b. Special problems during group therapy
c. Group therapy approaches: pre intake and post intake, special age groups, behavior therapy, experiential therapy, psychodrama and role play.

**Unit 4. Interventions emphasizing integration, eclectic systems, multicultural perspectives**

a. Integrated and eclectic interventions
b. Effective multicultural counseling
c. Psychoanalytical, Adlerian, person centered, behaviour therapy from multicultural perspective

**Books for study**


1. Corey, G. (2009). *Theory and Practice of Counseling and Psychotherapy* (8th ed.). CA: Thomson Brooks.
2. Seligman, L. & Reichenberg, L. W. (2010). *Theories of counseling and psychotherapy systems, strategies, and skills* (3rd ed.). Pearson education.
3. Flanagan, J.S. & Flanagan, R.S. (2004). *Counseling and Psychotherapy theories in context and practice: Skills Strategies and Techniques*. Hoboken, NJ: John Wiley & Sons, Inc
4. Wolberg, L. R. (2005). *The Technique of Psychotherapy Part I and II*. NJ: Jason Aronson Inc.


**Evaluation:**

**Internal evaluation:** 40 marks

**Semester end examination :** 60 marks

**Paper pattern:** 7 questions to be set of 15 marks each, out of which 4 are to be attempted. One of them could be short notes question, which could combine more than one unit.

*****

# 1

# INTERVENTION SYSTEMS EMPHASIZING BACKGROUND - I

**Unit Structure**



## 1.1 SIGMUND FREUD- CLASSIC PSYCHOANALYSIS

Sigmund Freud, an Austrian psychologist, is regarded as father of psychotherapy. He developed a traditional psychotherapy, which is also called as id Psychoanalysis, in early 1900. In this technique, the client would lie on a couch, and the therapist would seat on a chair, where the client could not see him. Client would say whatever that came to his mind and the therapy would continue. The term psychoanalysis was first used by Freud in 1896 paper. Classical psychoanalysis is grounded on id psychology; it believes that instincts and intrapsychic conflicts are the basic factors that shape development of personality.

**a) Structure of Personality :**

According to Freud, Personality has three systems: the id, the ego, and the superego. These separate structures of the personality work together as the internal forces that form one's personality.

**i) The id:**

Id is present at birth and it is largely unconscious, that is, out of awareness. The id is the biological component. It can be described as amoral, illogical, blind and demanding. It works on pleasure principle, avoiding pain and gaining pleasure. Id cannot stand tension, thus it aims at relieving the tension immediately. For gaining pleasure, Id uses two strategies- reflex actions and primary processes. Reflex actions consist of automatic processes that reduce tensions, such as tickle in throat. Sometimes, people form a mental image of something which is a solution to their problem- it is called as wish fulfillment. According to Freud, our dreams work on this function by providing a wish-fulfillment image.

Id includes inherited systems, called as Instincts. Drive theory or instinct theory is Freud's dynamic approach to human psychology. Sigmund Freud believed that humans are filled with a psychic/ mental energy. This energy comes from two sources- Life instinct (Eros) and death or destructive

instinct (Thanatos). Like good and evil, Thanatos and Eros are in opposition to each other.

Life instincts seek to avoid pain and gain pleasure. One important aspect of life instincts or Eros is Libido. Libido is present at birth. Initially, it was defined by Freud as sexual desire, but now it is also considered as a zest for life, energy, vitality. Wish for sexual fulfillment is still one of the important facets of life instinct. The death instinct (Thanatos) has its roots in aggression and other destructive forces. Freud wanted to explain about the human tendency toward destruction that overrides the pleasure principle through death instinct. According to Freud, both sexual and aggressive drives are powerful factors determining one's behaviour.

**ii) The Ego:**

The ego is not present at birth like Id, but it evolves later when a child realizes that it is separate, different from its mother. This ego works on reality principle. It regulates and organizes our personality by acting as a mediator within its structure. It tries to maintain a balance between Id and Superego, while still considering their needs. Ego takes decisions in a realistic and logical way.

**iii) The superego:**

It is an exact opposite of Id. The learning from our parents, teachers, society, traditions, and culture contribute to the development of superego. Superego is a strict conscience that internalizes standards, rules, guidelines, moral values etc. It strives for perfection and differentiates between good and bad, right or wrong choices, actions. Superego functions to control drives and impulses of id, but it is very controlling and represents ideal, and not real. When a child is growing up, self-control takes place of parental control when superego is forming. When one follows moral code of superego, it can make one feel proud; when one ignores directions of superego, it can lead to guilt, anxiety and shame. There are two parts of the superego: Conscience and Ego-ideal. The conscience develops as a result of prohibitions of parents. The ego-ideal is a positive desire to imitate adult standards of behaviour.

**b) Stages of Development:**

According to Freud, psychosexual stages are chronological phases of development. Stages in the first five years of life are very important as they determine development of personality in later life. Following are the five psychosexual stages:

**i) The oral stage (Birth to about one year of age):**

Oral stage is the first stage, which mouth is the most important zone for the baby to seek pleasure. It is because eating, sucking are important actions to sustain in life. In this period, biting is a way to show aggression. Mouth becomes child's first erotic zone. Problems in this stage could later

result in symptoms such as overeating, oral aggressiveness. It also deals with inability to trust oneself and others.

**ii) The anal stage (between the age of 18 to 36 months):**

This is the second stage, where the zone for gratification shifts from mouth. Child gets social pleasure by impressing the parents and the physical pleasure by emptying the bowels. In this stage, parents who try to do toilet training using punishment and restrictions are likely to promote compulsive, controlling characteristics in their children. Parents who use praise and rewards after appropriate behaviour are likely to promote creativity. This stage deals with the inability to recognize, express anger.

**iii) The phallic stage (between the age of 3 to 5 years):**

This is the third stage, of which Freud believed that it is complex and highly related to adult sexual relationship. Genitals become one's source of gratification and masturbation; sexual fantasies are developed. It deals with an inability to completely accept one's sexual feelings, sexuality and accept oneself as a man or woman. Self-esteem, self-image, need for love and approval, feelings toward authority figures and sense of initiative are evolved during this stage. At this stage, children develop unconscious sexual desires for a parent of the other gender. Children also have an unconscious wish to remove the parent of the same gender as it is seen as an obstacle in a child's first desire. For example, a boy having unconscious sexual desire about his mother, and wishing elimination of his own father. In boys, this is called as Oedipus complex. This name has come from Greek literature, where a boy unknowingly married his own mother.

The parallel situation in girls is called as Electra complex. This too has come from Greek literature where a woman had feelings of love towards her father. Freud believed that fear of retaliation or punishment from the father leads to boys developing castration anxiety. Castration anxiety lets a male child repress his feelings for his mother and identify with his father, which is an appropriate resolving of the feelings. Instead of castration anxiety, girls have penis envy; in which girls become resentful or jealous cause of not having a penis. Girls too, resolve this problem by identifying with their mother.

**iv) The latency stage (between the ages 5 to 11 years):**

This is fourth stage, which is considered as a comparatively quiet period in child's sexual development. Social interest increases and sexual drive becomes less important. Children engage in activities such as making friends, developing hobbies etc.

**v) The Genital stage:**

This is the final stage, which continues after latency stage through the life span from adolescence. One's personal identity is strengthened, feelings of

altruism, care are developed towards each other, positive and loving sexual relationships are developed.

During these developmental stages, if a child's needs are not sufficiently met, later in life that person may become fixated at that particular stage, and behave in psychologically immature ways. A fixation or complex can be defined as an unresolved unconscious conflict.

**c) Levels of Consciousness:**

Levels of consciousness and the concept of unconscious are considered as Freud's greatest contributions, which help us to understand human behaviour and personality. There are the following three levels of consciousness, according to Freud:

**i)** **The Conscious** is material in awareness, which is available to us all the time. The preconscious contains the information which may not be part of current awareness but which can be readily obtained. This information can be aversive (for example, the memory of painful treatment and hospitalization, after hearing siren of ambulance) or benign.

**ii)** **The unconscious level** contains memories that are highly charged. They include impulses, repressed drives. When these experiences are recalled, they may be so unacceptable, unpleasant that they are not allowed in preconscious or conscious level. Psychoanalysis can bring memories from unconscious to consciousness. According to Freud, unconscious contained a lot more memories than the preconscious or the conscious. There are certain ways in which we can access material from unconscious mind. First way is our dreams. Dreams are considered as symbolic representations of our unconscious needs, conflicts and desires. All dreams are considered important- the dreams try to satisfy impulses, desires that are not fulfilled while being aware. Second process where unconscious is revealed includes slips of tongue, errors, omissions, poorly performed tasks & forgetting, which have latent meaning. A misstatement that tells an unconscious desire or feeling is called as Freudian slip. There are some other ways too, such as information obtained from free association, projective techniques, posthypnotic suggestions & the symbolic information obtained from psychotic symptoms.

**iii)** **The preconscious level** refers to something that one is not currently aware of but could be brought into consciousness at any given moment.

**d) Anxiety and Defense Mechanisms:**

According to Freud, humans try to reduce tension and anxiety. Anxiety is important concept in the psychoanalytic approach. According to Freud, there are three kinds of anxiety that are as follows:

i) **Reality Anxiety**, which is a fear of danger from the external world around us is reality anxiety. The amount of reality anxiety is proportionate to the level of real threat.

ii) **Neurotic Anxiety,** which is a fear that instincts will be difficult to control and lead to punishment due to unacceptable behaviour.

iii) **Moral Anxiety** is a fear of one's own conscience.

Freud also gave the concept of signal anxiety, which can be defined as the anxiety resulting from a battle between internal wishes and limitations that stem from internalized prohibitions or external reality. Among the defenses used by humans, some are healthy, some are distorting.

Freud believed that signal anxiety would lead to automatic triggering of ego defense mechanisms. These ego defense mechanisms are developed to deal with anxiety, internal conflict, negative emotions etc. & to stop the ego from being overwhelmed. They work to repel unacceptable id impulses which are against superego or lead to problems in real life. The defenses used by an individual depend on his/her level of development and degree of anxiety.

**There are some characteristics of defense mechanisms:**

- They are automatic, i.e. Individual learns to spontaneously use a specific defense mechanism.
- They either deny reality or distort reality and operate on an unconscious level.
- They are categorized in several ways. For example, Primary vs. Secondary defense mechanisms, psychotic vs. neurotic defenses, immature vs. healthy defenses.

**Here are some defense mechanisms along with their examples:**

- **Denial:** It refers to not accepting threatening aspect of reality that is evident to others. For example, a person who has addiction of alcohol denying that drinking is not good for their health.
- **Reaction formation:** It refers to replacing unacceptable, threatening thoughts, emotions with active expression of their opposite, in order to overcompensate. For example, a person hates his boss, but behaves in an excessively nice, friendly manner with him.
- **Repression:** According to Freud, it is involuntary removal of something from consciousness. Thoughts and feelings that are painful, threatening are relegated to the unconscious, excluding them from awareness. For example, a person is sexually molested when she was 5 years old. There is behavioural evidence that it exists, but she genuinely cannot recall this event.

- **Projection**: It is projecting unacceptable thoughts, feelings, or impulses on another person. For example, a person hates his mother, but instead says that his mother is the one who hates him.

- **Displacement**: It is directing strong feelings from a threatening person/ object toward other person/object which is less threatening than the previous one. For example, a child is very angry with his mother, so he displaces these angry feelings toward his dog, by kicking it.

- **Rationalization** refers to using excessive explanations, to justify behaviour in self-serving but invalid ways. A person who is rejected by his date might say that he was not anyways attracted towards her.

- **Sublimation**is diverting potentially harmful emotions or impulses (sexual or aggressive energy) into other socially acceptable ways. For example, a person sublimating her aggressive impulses into athletic activities (playing football) where she finds a way to express these feelings.

- **Regression** refers to reverting to an earlier phase of development in thoughts, emotions, and behaviour when there were fewer demands. For example, a child who is traumatized may regress to earlier developmental stage and start thumb sucking behaviour.

### 1.1.1 Process of Therapy:

**Therapeutic Goals:**

Goals of Freudian psychoanalytic therapy include making the unconscious conscious and strengthening the ego.

**i) Making unconscious motives conscious**

It is one of the goals of psychoanalytic therapy because only then can person exercise choice. To bring out the unconscious material, therapeutic methods are used. Later, childhood experiences are discussed, reconstructed, interpreted and analyzed. This can result in behaviour which is based more on reality and less on instincts, irrational guilt; important modification in one's personality and character structure is also expected. Unconscious processes are considered as the root of all forms of neurotic behaviours, symptoms. According to this view, a "cure" for such symptoms & behaviours is built on revealing the meaning of symptoms, the causes of behaviour along with the repressed information which interferes with healthy functioning; intellectual insight alone cannot fix symptoms. The therapeutic process is not limited to problem solving and modification of behaviour, but it also considers exploring an individual's past to arrive at a self-understanding level which is needed for changes in character. It is important that the feelings and memories connected with this self-understanding are experienced.

### ii) Strengthening the ego

It is the second goal. Achieving equilibrium between id and superego is considered as a comprehensive goal of psychoanalysis. Individual must have a strong ego manage the demands of living, and to not get overwhelmed by guilt, shame, or nervous anxiety. Examples of certain treatment objectives are as follows- Reducing punitiveness, rigidity and perfectionism of the superego, promoting accurate assessment of reality, improving nature of defense mechanisms etc.

One of the main functions of analysis is to help clients gain the liberty to love, work, and play. Other functions involve helping clients to achieve self-awareness, honesty, and more effective personal relationship, to face anxiety in a realistic way; and to get control over impulsive, irrational behaviour.

### Therapeutic Alliance:

Generally, psychoanalysis is a long term and intensive process. Treatment continues for 3 to 5 years, where people are seen for 2 to 5 times a week. Freud recommended having the patient lying on the couch, whereas the therapist seating (behind the patients head) on the chair where he could not be seen. This was thought to relax the patient, reduce distractions for the patient and promote anonymity of the therapist. After lying on the couch, clients say whatever that comes to their mind; this content should not be censored by them. This is called free association. Generally, clients are the ones who talk the most in psychoanalysis. When clients are lying down on the couch, their ability to read facial reactions of the therapist is reduced and therapist also does not need to carefully observe client's facial expression. Therapist's role is to actively give direction to the sessions and encourage uncovering of the repressed information. The classical psychoanalyst stays outside of the relationship and comments on it taking an anonymous stance. This is called the "blank-screen" approach. Paying attention to underlying meanings, symbols, and omissions is done by the therapist.

Establishing a working relationship with a client, listening, interpreting is important. Specific attention is given to the client's resistance as well. Resistance is a fundamental concept in the practice of psychoanalysis. It is anything which works against the progress of therapy. It prevents the client from bringing the unconscious, repressed material to conscious. Resistance blocks the threatening material from entering awareness. Therapist then points it out and clients shall confront it, if they want to deal with conflicts realistically. Resistance can be a valuable tool in understanding the client if resistance is handled properly.

### Transference and countertransference:

Relationship between client and therapist is very important in psychoanalytic therapy. Client unconsciously shifting his feelings and fantasies which are reactions to important figures in his past, toward psychoanalyst is called as transference. It is characterized by its

inappropriateness. It involves (unconscious) repetition of past in the present and misperception of the therapist. Freud believed that the formation of transference is a key component for successful treatment. According to relational model of psychoanalysis, transference is an interactive process between the therapist and the client.

A client can have variety of feelings to a therapist, such as mixture of positive and negative. Transference can be positive, negative, or mixed. A client projecting feelings of anger and hostility on to a therapist which he originally had towards his father is an example of negative transference. For example, someone who had loving and caring mother may transfer the similar feelings toward the therapist, is an example of positive transference. A client who grew up with his seductive but caring grandmother may project those feelings on the therapist, is an example of mixed transference.

Psychoanalyst who is not observed by the client and who is neutral is more likely to elicit transference than one who is engaging in self-disclosure, is interactive. Working through transference is a lengthy process and it involves three stages. After the transference is developed, it is established and explored. This is done in order to evoke repressed material. Step by step, the original dysfunctional pattern is emerged again as transference towards the therapist. When positive and negative feelings toward the therapist become conscious, clients can recognize and resolve their unfinished business (unresolved issues) from these past relationships. At the end, the root of transference is understood, resolved and the client can relate with others in a healthier way.

Originally, Countertransference was called as the therapist's tendency to see the client in terms of his own relationships in the past. In classical psychoanalysis, countertransference is avoided. Countertransference is therapist's feelings about the client. Therapists are instructed not to respond to client's feelings about them. Clients can experience both positive and negative transference as a result of therapeutic process. The therapist shall understand the difference between client's transference and our own reactions to the client (which stem from therapist's unresolved issues). Therapists should carefully monitor all the strong reactions they have for the clients to check for the possibility of counter transference.

### 1.1.2 Therapeutic Techniques:

Some interventions that psychoanalysts use are questions, dream analysis, interpretations and free association.

### i) Free Association:

It is a primary technique in psychoanalytic therapy. It is used as an approach to get access to repressed material. Its process shows the most important rule of psychoanalysis. It is that the people should say whatever that comes into their mind, without judging or censoring the information no matter how painful, illogical, silly or irrelevant it may be. It is considered as a basic tool to get access to unconscious fantasies, wishes,

conflicts etc. Free association, in simple words, is automatic connecting of one thought to another. This was encouraged by Freud to facilitate patients recall of the information in past and release the intense emotions and feelings (catharsis). Blocks in the chain of free association can be viewed as a source to obtain repressed material. Free association plays an important role to maintain the analytic framework. Therapist's role during free association process is to acknowledge repressed material. Therapist then interprets the material to the client and helps them in increasing insight into the underlying problem. Hidden meaning underlying the surface content is understood. A slip of tongue, areas the client does not talk about are also significant.

**ii) Abreaction:**

Freud recognized the significance of emotions and believed that affect needs to go hand in hand with the recall of past material. The reason behind this is to fully understand and work through the importance that repressed material has for clients. Freud encouraged abreaction in his patients to promote the connection between recall of past material and emotions. Abreaction involves recalling a repressed painful experience, working through that painful experience and the conflicts created by it. For this process, one needs to relive the experience in memory, along with its associated emotions and analyze that experience. Finally, emotional release is achieved as the climax of this process.

**iii) Interpretation and Analysis:**

They are the most fundamental techniques in Freudian psychotherapy which promote awareness and insight. The tools of analysis and interpretation allowed Freud to bring unconscious material into consciousness.

- Ø The process of thoroughly exploring, understanding the unconscious representations in the material presented by people in treatment, is called as analysis. For example, in the process if analyzing a dream, Freud would examine the meaning of every item in the dream with the client. The person then would be motivated to free-associate to the dream and talk about the emotions reflected in the dream and emotions experienced after waking up and recalling the dream along with events which might have triggered the dream would be discussed. Suggestions of repressed, unacceptable urges and wish fulfillment acted by the dream would be emphasized.

- Ø The process of explaining the unconscious meaning of the symbols in presented material and of connecting these new insights to client's present concerns, blocks is called as Interpretation. Analysts point out, explain, and teach the meanings of behaviour to the client. Working through the material from unconscious on cognitive and emotional level allows people to understand the effect the past has had on them. It also allows people to use the mature defenses and strategies of ego for making better choices that are free from the negative effect of unconscious material. Interpretation is done to

accelerate the process of uncovering material which is unconscious. Any gaps, inconsistencies in client's story, inferring the meaning of reported dreams and free associations are paid attention to. Client is taught the meaning of these processes, through interpretation. This can result in clients achieving insight into their problems, increase awareness about ways to change, and gain more control over their lives.

**iv) Dream Analysis:**

According to Freud, dreams are "royal road to the unconscious". When we sleep, our defenses are lowered; repressed feelings come up to surface. There are some wishes, motivations that are not at all acceptable to the person, and thus they are expressed in symbolic form instead of being revealed directly. There are two levels of content in our dreams: latent content and manifest content. Latent content includes symbolic, unconscious and hidden motives, wishes, and fears. As they are painful and threatening for the client, the unconscious sexual, aggressive impulses that create latent content are transformed into the more acceptable manifest content, which is the dream that actually appears to the dreamer. There is a process by which the latent content is transformed into the more acceptable, less threatening manifest content. It is called as dream work. Therapist tries to study the symbols in manifest content of the dream to reveal the disguised meanings. Along with serving as a way to repressed material, dreams provide an understanding of clients' functioning in the present.

### 1.1.3 Strengths and Weaknesses:

One of the significant contributions of Freud is the great impact his thoughts had on our understanding of personality development. Even if some of us do not agree with the psychoanalytic model of treatment or an emphasis on infantile sexuality, Freud's contributions to our understanding of psychological development and knowledge of psychotherapy are undeniable. His views still influence contemporary practice.

- Many basic concepts given by Freud are part of foundation on which other theorists built and developed their theories. Psychotherapy was given a new horizon, new look & he developed the first therapeutic procedures to understand, modify the structure of one's basic character. Freud's Psychoanalytic theory is a benchmark theory against which many other theories are measured.

- Classical Freudian psychoanalysis has received much criticism from empirical researchers from years. In the practical application of classical psychoanalysis, one of the limitations is that many highly disturbed clients lack the level of ego strength which is needed for this treatment.

- A potential drawback of the psychoanalytic approach is the anonymous role of the psychotherapist. This approach by the therapist can be justified on theoretical grounds, but in therapies other than classical psychoanalysis, this approach is excessively restrictive. This classical approach of nondisclosure can be put to wrong use in short-term therapy and assessment. If applied in such situations, a therapist may actually be keeping himself hidden as an individual by "being professional."

- Classical psychoanalytic approach is costly. It is generally considered as being based on upper- and middle-class values. There can be some clients who do not share these values and cannot afford this treatment. It is a lengthy procedure as this approach is not designed to help people with urgent concern. Psychoanalytic therapy focuses on long-term personality reconstruction more than short-term problem solving. Because of the lengthy, intense nature of the treatment, each therapist can work only with limited number of people and each treatment is unique. Thus, research proving the value of classic psychoanalysis is limited.

- Multicultural dimensions may not be attended adequately and it talks a little about developing a healthy adult. It fails to adequately address the social, cultural, and political factors leading to person's problems. Clients may be held responsible for their situation, if there is no balance between the external and internal outlook.

- Freud had some incorrect and harmful ideas about women. He blamed mothers as they are children's primary caregivers. Freud seemed to look at men as emotionally healthier than women, as he viewed women as suffering from greater levels of narcissism, masochism, envy & shame. According to Freud's theory on female sexuality, women are considered as "essentially castrated men".

## 1.3 REFERENCES

1. Corey, G. (2009). Theory and practice of counseling and psychotherapy (8th ed.). CA: Thomson Brooks.

2. Seligman, L. & Reichenberg, L. W. (2014). Theories of counseling and psychotherapy: Systems, strategies, and skills (4th ed.). Pearson education.

3. Flanagan, J.S. & Flanagan, R.S. (2004). Counseling and psychotherapy theories in context and practice: Skills strategies and techniques. Hoboken, NJ: John Wiley & Sons, Inc.

*****

# 2

# INTERVENTION SYSTEMS EMPHASIZING BACKGROUND - II

**Unit Structure**



## 2.1 ALFRED ADLER-INDIVIDUAL PSYCHOLOGY

Alfred Adler was a settler of a holistic, social, systemic approach. He was also the first systemic therapist. He believed that it is necessary to understand individuals within the systems in which they live. Adler's theory of human development is called as individual psychology. It reflects the unique beliefs and skills that every individual advances from early childhood, which acts as a reference for their attitudes, behaviours, along with the private view of self, others, society.

Adler initially worked with Freud, but later he moved forward with his own ideas. Adler believed that Freud's focus on biological and instinctual determination was very narrow. The concept of the sexual drive and the libido was replaced with the drive to gain power, superiority, becoming a fully functioning adult. Adler looked at humans as the creators of their life and also as the creations of their own lives. This means that individuals create a unique style for living that is a way toward and an expression of their selected goals. Here, the focus is more on interpersonal relationships instead of individual's internal psychodynamics.

### 2.1.1 Basic Concepts of Individual Psychology

**a) The Whole Person and Patterns of Human Personality:**

Adler focused on the unity and indivisibility of the person. According to him, human behaviour is not merely decided by heredity and environment. Individual has the capacity to interpret, influence, and create events. The whole person makes the decisions for which he or she is totally responsible. Adler highlighted unity of thinking, feeling, acting, attitudes, values, the conscious mind, the unconscious mind etc. instead of breaking the individual into different functional parts. Adler emphasized the

understanding the whole person – how all the aspects of an individual are interconnected and unified by his/ her movement toward a life goal. Adler did not believe in id-ego-superego approach given by Freud. Comprehending and helping the unique individual is the goal of Adler's Individual Psychology. Client is considered as an integral part of a social system as an implication of this holistic view of personality.

According to individual Psychology, all human behaviours have a purpose. Human beings set goals for themselves, and behaviour becomes unified to achieve their goals. Humans can be fully understood considering their purposes and goals toward which we are striving. Adler's theory focuses on future without minimizing the significance of past influences.

According to individual psychology, human behaviour is considered as a function of a combination of many influences or contributing factors. Generally, no single, direct causal factor leads to a single behaviour. Adler believed that each person is responsible for his/her behaviour as they have the freedom to select from a variety of behavioural options. It shall be noted that though this approach says that an individual is responsible for his/her behaviour, it does not blame them for their wrong deeds.

**b) Private Logic:**

Being one of the major construct given by Adler, private logic means our beliefs about ourselves, our place in the world which is subjective and based on lifestyle. Private logic provides a life pattern and it begins in childhood, providing a compass by which to live. Individuals develop their own set of rules to overcome feelings of inferiority as they must learn to interact with that system. This Private logic is unique to every individual but it is not always logical. Feelings of superiority, fear of inferiority are meaningful only to the individual.

**c) Concept of Inferiority and Striving For Superiority:**

Adler looked at inferiority feelings as a normal condition of all individuals and as a source of all human striving. Instead of looking at inferiority feelings as a sign of weakness or abnormality, inferiority feelings can be thought of as the wellspring of creativity, as they inspire us to strive for mastery, completion, success or superiority. Individuals are driven to overcome their sense of inferiority and to strive for increasingly higher levels of development. Adler believed that the moment one experiences inferiority he/she is pulled by the striving for superiority. The goal of success pushes people toward mastery and enables them to deal with hurdles. Superiority does not necessarily mean being superior to others but it means moving from a perceived lower place to a perceived higher place. Human beings produce their own internalized goals and then they strive to achieve success. An individual deals with feelings of helplessness by trying hard for competence, mastery, and perfection.

The feelings of inferiority during the early childhood years have a significant impact on development. Most children experience these

feelings and they perceive themselves as small, powerless as compared to their parents, older siblings. Treatment given to young children and how they manage their feelings of inferiority play important role in shaping them. One achieves a sense of accomplishment by mastering an issue. According to Adler, pampered children generally grow up expecting others to care for them and thus they do not develop their own resources. Neglected children may become discouraged and hopeless if their attempts to manage an inferior role are ignored or rejected.

**d) Striving With Purpose:**

Humans actively shape themselves and their environment is one of the main concepts of individual psychology. Individual is not solely passive recipients of his/her biological traits or reactor to his/her external environment. Beyond biology and the environment there is a third element which influences and governs human behaviour. Adler called this third force as "attitude toward life". Attitude toward life consists of individual human choice, individual sense of purpose.

**e) Goals:**

According to Adler, a healthy & well-functioning adult is an individual who is independent, emotionally as well as physically self-reliant, useful, productive, and one who is able to cooperate with others for personal and social benefit. By using psychotherapy and education, Adler wanted to help people realize that feelings of pain, inadequacy are caused due to their own faulty logic and not by others. Therapist can help people deal their feelings of inferiority, dependency, and fears of failure by enabling them to become aware about their faulty logic & to establish healthy, realistic, rewarding goals, to align their lifestyles, thinking, and behavior with these goals.

**f) Social Interest:**

Social interest and community feeling are important and distinctive concepts given by Adler. An action line of one's community feeling, which involves his/ her positive attitude toward other people in the world is called as social interest. The capacity to cooperate and contribute is social interest, which requires sufficient contact with the present to take a step toward a meaningful future, that one is willing to give and take, and that one develops his/her capacity for donation to the welfare of others.

As human beings are born into an interpersonal context, their personality development is shaped by interpersonal factors. The interpersonal nature of humans leads to community feeling. When a person experiences a strong sense of connection to others, an awareness of being a member of the human community then he or she is experiencing community feeling. Social interest is a community feeling in action. The development of social interest, sense of social responsibility is a goal of therapy for many clients. Adler thought of social interest as innate but he also believed that it must be taught, learned, and used. People with social interest guide the striving toward the healthy, socially useful side of life. As social interest develops,

feelings of inferiority and alienation reduce. Social interest is expressed by shared activity and mutual respect. Individual Psychology believes that that our happiness and success are greatly related to this social connectedness; Humans are primarily motivated by a desire to belong.

Community feeling incorporates the feeling of being connected to all of humanity and to being engaged in making the world a better place. People who lack community feeling get discouraged and end up on the useless side of their life. If one's sense of belonging is not fulfilled, it leads to anxiety. When one feels united with others, only then he is able to act with courage in dealing with problems. Adler maintained that we must successfully adept three universal life tasks. They are building friendships (social task), establishing intimacy (love–marriage task), and contributing to society (occupational task). Regardless of their age, gender, time in history, culture, or nationality, all people need to address these three tasks. Each of these tasks needs the development of psychological capacities for friendship and belonging, for contribution and self-worth, and for cooperation. These basic life tasks are fundamental to human living. Dysfunction in any one of them is generally an indicator of a psychological disorder.

**g) Phenomenology:**

The concept of phenomenology is main assumption of individual psychology. Viewing the world from the client's subjective frame of reference is described as phenomenological orientation. Adler emphasized on an individual's perception of reality and not what actually is or what others perceive. The internal and subjective were more significant than the external and objective for Adler. He paid attention on the way an individual perceived the world, his/her inner reality. Adler looked at each person as a unique individual. He believed that only by understanding that individual's perceptions of the world, private logic, lifestyle, and goals one can understand and know that person. This can be called as an essence of Adler's Individual Psychology.

Lifestyle is one of the important concepts in Adler's theory. The individual map everyone uses to navigate through life is created in childhood. This map is called as lifestyle. This is also called as "plan of life," "style of life," "strategy for living," or "road map of life." It gives us an idea about ourselves, others, and the working of the world. When we acknowledge the patterns, continuity of our lives, we can modify our faulty assumptions and make basic changes needed. Childhood experiences can be reframed and new style of life can be consciously created using therapeutic, educational experiences. Lifestyle comprises of four elements. They are 1) the person's subjective worldview (beliefs about the self and others, values, inner narratives, expectations, and attitudes), 2) goals, 3) behavioural strategies that an individual uses to achieve goals and negotiate the journey of life and 4) the outcomes of those behaviours.

Everybody has an image, often unconscious, of what life will be like when goals are met. Adler called this as fictional finalism. He believed that this aim is strongly established between the ages of 6 and 8. It remains constant throughout our life. Some people have beliefs about the self, world, and others that lead to emotional pain and distress. These beliefs are called as basic mistakes. Adler was hopeful, optimistic about helping people to change their cognitive maps as change is also possible.

**h) Birth Order and Family Constellation:**

Adler pointed out that it is not correct to assume that children born in the same family are formed in the same environment. Siblings do share some aspects in the family constellation but the psychological position of each child is different from other children because of birth order. Birth order is an aspect of families which has a profound impact on development of a child.

Adler identified five psychological positions (vantage points) from which children are likely to view life. The five positions are as follows- oldest, second of only two, middle, youngest, and only. Birth order increases an individual's likelihood of having a specific set of experiences. A persons interpretation of his/her place in the family is important than the actual birth order. Individuals learn a specific style of relating to others during their childhood, forming a picture of themselves which they carry into their adult relationships.

Adler believed that we can understand people's lifestyle by examination of the family constellation. An individual's family constellation involves the composition of the family, role of every person, along with the reciprocal transactions that a person has during his/her the early formative years, with his/her siblings, parents. Children do influence how their parents and siblings respond to them. Children are influenced by both their similarities and differences from their families. Exploring birth order and its influence on the development of an individual's personality can help understand that person.

**1. The oldest child:**

It is likely to be the most intelligent and achieving among the five groups. The firstborns are generally dependable, well organized, and responsible, and having strong verbal skills. Often, they are well behaved, cooperative, fairly traditional conforming to societal expectations. Due to their strengths they often attend leadership positions. Till the time firstborns are only child in the family, they are the centre of attention and often spoiled. After birth of their sibling, they might feel dethroned, threatened, angry, fearful, and jealous as a reaction to not being only child. If firstborns deal successfully with the birth of their sibling, it can help them to be self-confident and affiliative.

**2. The second child**:

The second child of the only two children is in a different position. The second child tends to feel pressurized to catch up, compete with the oldest child. As second-born child often realizes that he/she cannot outdo the successes the firstborn child has already obtained, they are inclined toward things in which their older sibling is unskilled or uninterested. A common pattern for a firstborn is to excel in a traditional area (English or mathematics) and for the second-born to excel in more creative area (singing or drawing). Second-born children are likely to be caring, friendly, and expressive than their older siblings. The second-born is generally opposite to the firstborn.

**3. The middle child:**

The middle child generally feels squeezed between older children and younger children, cheated and may get convinced of the unfairness of life. They sometimes have a problem searching a way to become special. They can also view themselves as unloved and neglected, accepting "poor me" attitude. This child may become a problem child. But in some families characterized by conflict, this middle child can become the peacemaker and an individual who holds things together. In case there are four children in a family, the second child will generally feel like a middle child. The third will be more easy going, social, aligning with the third born. Middle children generally become well adjusted, friendly, creative, and ambitious, value their individual strengths due to encouragement and positive parenting.

**4. The youngest child:**

The youngest child is generally the most pampered one and spoiled. It is the baby of the family. They often tend to go their own way where no others in their family have thought about. They may feel the need to keep up with their older siblings, and then may get discouraged about competition. Other pitfall is that others may take decisions for them, lack of taking responsibility for themselves or others may exist. These children may experience strong feelings of inferiority. These children can also get power and thrive on the attention received by their family. They generally become adventurous, sociable, innovative, and pursue their own interests in order to avoid competition with their siblings.

**5. The only child:**

These children have some things common with firstborn and last born children. i.e. achievement like the initial and attention like the later one. The only child may not learn to cooperate with other children and has problem of their own. As the only child is pampered, he/she may become dependent on one or both parents. Although as the other family members are adults, they deal with adults well and mature early. If parents are insecure, the children often adopt worries and insecurities of their parents.

**2.1.2 Treatment Using Individual Psychology:**

**a) Therapeutic Alliance:**

Adler's ideas about client-clinician relationship are different than Freud. Adler highlighted cooperative interaction which includes establishment of shared goals, mutual trust and respect. Therapists play role of role models, educators, teaching people how to modify their lifestyles, behaviours, and goals, fostering social interest. They recognize faulty logic and assumptions, explore & interpret the meaning and impact of clients' birth order, dreams, early recollections, and drives.

**b) Techniques:**

Adler's Individual Psychology has a lot of creative and useful interventions. They are as follows:

- **Spitting in the Client's Soup:** Clients often try to avoid demands and responsibilities considering the basic life tasks. Spitting in the client's soup is used as a metaphor for spoiling the client's use of a specific strategy for avoidance or a neurotic strategy.
- **Catching Oneself:** This technique is designed to help clients become aware about their maladaptive goals and behaviour patterns. The therapist teaches the client about how to catch himself/herself when he or she slips back into old and unhelpful behaviours. It encourages people to be more conscious of their repetitive faulty goals and thoughts. This approach lets the client monitor themselves without being critical toward themselves.
- **Pushing the Button:** Rather than allowing their emotions to control them, this technique makes clients aware about the control they can have over their emotions. Clients are encouraged to imagine pleasant and unpleasant experiences one by one, observing emotions accompanying each image. Then they realize that they can decide which button to push.

**c) Phases of Treatment:**

There are four treatment phases in Adler's model which generally merge and overlap. They are as follows:

**Phase 1) Establishment of the therapeutic relationship and setting goals**

Therapist and clients build a collaborative, democratic, and trusting relationship where they can work together to create a clear statement of the problem and meaningful, realistic goals. They can discuss about the structure of the treatment. Initial questions are asked to explore clients' expectations from treatment and their views about problems etc. Encouragement is necessary in this initial phase of treatment as it is used throughout treatment to deal with clients' discouragement. There are some appropriate ways to form partnerships with clients, which provide encouragement and support. For example, writing a note to the client who is in hospital, making a telephone call to them when they are in crisis etc.

**Phase 2) Assessment, analysis, understanding of the person and the problem:**

Adlerian therapy focuses on in-depth assessment. Initial interview and the lifestyle interview are taken. They provide thorough information about the client's current level of functioning and background which leads to current distress. The Life Style Interview is a semi structured process. It consists of 10 sections. The first 9 sections are called as the family constellation interview, which gives details from early childhood till adolescence. The 10th section collects early childhood recollections. Adler called initial interview as "the general diagnosis". Here the therapist conducts a general assessment of six main domains. They are identifying information, background, current level of functioning, presenting problem, expectations for treatment, and summary.

**Phase 3) Re-education, insight, and interpretation:**

As therapists need to be both encouraging and challenging, this phase can be difficult. Therapists provide support, as well as use interpretation and confrontation. They help clients to gain awareness of their lifestyles, acknowledge the covert reasons leading to their behaviours, realize the negative impact of such behaviours, and move toward positive change. Clinicians focus on present rather than the past. They are more concerned with results rather than with unconscious motivation. Their interpretations are introduced in ways that are acceptable by the client. Through these gentle interpretations, therapists try to educate clients, promote self-awareness, insight, and discussion. They try to help people weigh their options and take decisions. Beliefs, attitudes, and perceptions are emphasized because behavioural change will take place only by cognitive means and social interest.

**Phase 4) Reorientation, reinforcement, termination and follow-up:**

After the clients have gained some insight and modified their distorted beliefs, they become ready for reorientation and initiation of new ideas, patterns of behaviors. Clients can make more rewarding choices and look at their lives from different perspective. Clinicians help people to become full participants in their social system, shift their roles and interactions; take on rewarding challenges. In this phase, clinicians model and support optimism and flexibility. This final phase of treatment enables client to consolidate the gains they have made, and move ahead with their life. Primary role of therapists here is to reinforce positive changes. Together, client and therapist decide when the client is ready to complete treatment, agree on follow-up procedures. This is to make sure that clients continue their positive growth and move forward.

### 2.1.3 Evaluation of Individual Psychology:

Adler's theory is considered as an optimistic, growth oriented, and educational theory. According to Adler, people can change their goals and lifestyles to live happier, fulfilled lives. Adler's model of Individual Psychology is used for treatment of various groups such as children,

individuals, couples, families for various reasons such as career development, education, training, supervision, consultation etc. Adler's ideas have influenced many other approaches of treatment such as cognitive therapy, reality therapy. Individual Psychology can be effectively combined with other treatment approaches as well. But there are some limitations as well. Some of the Adler's concepts like fictional finalism and superiority are not well defined. Adlerian therapy fails to account for biological, genetic influences. Adler is also called as overly optimistic because of his statement that social interest is innate.

## 2.2 CARL JUNG- ANALYTICAL PSYCHOLOGY: BASIC THEORETICAL CONCEPTS

Carl Jung's theory is known as analytical psychology. He called his theory as well as therapy "analytical psychotherapy" to differentiate it from Freud's psychoanalysis. According to Jung, unconscious shall be approached with respect, hope and listening attitude. Jung's concept of psychotherapy helps people to make conscious and integrate aspects of psyche.

**a) Components of the Psyche:**

Jung's concept of the psyche is more complex than Freud's concept of psyche. The conscious mind, the collective unconscious, and the personal unconscious are three levels in psychic functioning. They are described below:

**i) The Conscious Mind:**

Conscious mind is only a small part of the psyche. It includes the ego, the persona, two attitudes, and four functions.

**The Ego:**

It is formed of perceptions, memories, thoughts, and feelings which are within one's awareness. Being the centre of the conscious mind, ego offers us our sense of world and reality. It affects our transactions with our environment, giving us a sense of identity. The development of ego lets us differentiate ourselves from others. Comparatively, ego is weaker than other parts of the psyche. Ego protects itself using process of repression, by assigning threatening material into personal unconscious. Like this, conscious and unconscious levels of personality are connected by ego.

**The Persona**:

It is the idealized side of ourselves which we present to the external world. It is the face of collective psyche. Although it is a mask or protective façade which hides our problems, sorrows, it allows us to function properly in society, deal with other individuals and continue with our daily activities. Our persona is affected by people around us and it can change in order to adapt with the social situations. Generally, our original thoughts

and emotions which are not socially acceptable, are not reflected in our persona.

**Attitudes and Functions:**

Extraversion and introversion are two attitudes, and thinking, feeling, sensation and intuition are four functions. Thinking is opposite to feeling and sensation is opposite to intuition. People interact with the world through one of these four functions. This function is called as primary or superior function. The opposite function of the primary function is least developed, inferior and it's the problematic. Opposites are in balance in the well-functioning person and they provide psychic energy. We will later look at each of the functions and attitudes in detail.

**ii) The Unconscious Mind:**

Jung's view of unconscious mind is complex and positive. It is considered as source of creativity, spiritual and emotional growth, along with confusion, symptoms. It contains forces, predispositions, motives and energy in our psyche which is unavailable to conscious mind. There are two levels of the unconscious mind – the personal unconscious and the collective unconscious.

**The Personal Unconscious:**

The personal unconscious is unique to every person reflecting his/ her history and it is material which was once conscious. It forms over one's lifetime and includes memories which are forgotten or repressed but which might be made conscious again. Memories from the personal unconscious can be triggered by daily stimuli and then they are recalled. Repressed material generally emerges from the personal unconscious via dreams or symbols. Dreams and fantasies represent the personal unconscious when they are of a personal nature. Archetypes and the shadow are also found in personal unconscious.

**Complexes:**

They are located in the personal unconscious, having an archetype at their core, containing related and emotional collection of one's feelings, thoughts, perceptions, memories. These dynamic structures of the personality can be thought of as challenging obstacles. They are not necessarily negative, but their impact might be. They might affect our daily life but as they are located in the unconscious, generally we are not aware about them. Jung thought of complexes as a pool where energy whirls and circles, due to unresolved areas in an individual's life. Complexes can be as diverse as human experiences.

**The Collective Unconscious:**

The collective unconscious can be described as storehouse of motives, urges, fears, and potentialities which we inherit by being human. It is shared by all humans in the world and contains myths, images and symbols. According to Jung, collective unconscious is far larger than

personal unconscious. When dreams and fantasies include impersonal material which is not related to our personal experiences, they come from the collective unconscious. Some examples of reactions originating from collective unconscious are fear of the dark, fear of snakes.

**Archetypes:**

The collective unconscious has patterns that are important elements of the common human experience. These patterns are called as archetypes. Archetypes are innate, unconscious energies which are universal and they predispose people to look at the world and organize their perceptions in specific ways. Archetypes are transmitted through cultures, generations, appearing in dreams and fantasies. They affect how people think, feel, and behave in their lives. There are some archetypes such as the warrior, the hero, the great mother, the innocent, and the trickster. Here are some of the archetypes described below:

**(i)** **The self:** It is a central, organizing archetype, which is regulating centre of the personality. It integrates and balances the needs, messages of the conscious, the personal unconscious, and the collective unconscious. It is primarily located in the collective unconscious, emerging from dreams, symbols, perceptions, and images. It generally emerges after the second half of our lives, reflecting from our spiritual, philosophical perspective. The self gives our personality unity, equilibrium, and stability. When the self within us is fully realized, it helps us to connect with the larger spiritual truth.

**(ii)** **Anima/animus:** These concepts have similarity with Chinese concept of yin and yang, which are the feminine and masculine principles that exist in every human. The anima is the psychological feminine element in a man and the animus is the psychological masculine element in a woman. These archetypes are evolved from generations of experience. Their functions are to be a part of self and project on others. Anima and animus affect how we feel, present our masculine and feminine sides, along with our relationships with the other gender. In men's dreams, the archetype of anima manifests as a female and in women's dreams, the animus manifests as a male.

**(iii)** **The shadow:** The archetype of shadow can be manifested in collective and the personal unconscious. It can be described as a dark side of an individual which he/ she does not wish to admit, and thus tries to hide it from self as well as others. This archetype consists of traits, instincts that are morally objectionable. It is in direct and reciprocal relationship with our persona. As nature of the shadow is not restrained but primitive, it is a wellspring of energy, creativity, vitality. In a way it is opposite to persona as persona tries to get social acceptance, while shadow contains the socially undesirable. People project their archetype of shadow on other individuals and then over react to that overblown projection. Some similarities are observed between Freud's concept of id and shadow.

**b) Concept of Human Development**:

According to Jung, people's lives are divided into two periods. In the first half of their life, they find our place and develop interests, values, find a partner, make career choice. In the second half, with established foundation, they move towards individuation. In search of individuation an individual becomes a psychological individual i.e. a whole. This is a lifelong process where the whole personality develops. Greater access is obtained to unconscious and latent abilities; movement is made towards a state of greater balance, harmony, equilibrium along with clarification of who we are in relation to others. In this second half of life, one's self evolves, persona is weakened, shadow becomes integrated and is better understood, empowering archetypes emerge. An individual's values are shifted from materialism, sexuality, procreation towards spiritual, social, and cultural values. Vision of purpose and meaning of life becomes clear. Jung's theory of human development is optimistic, focusing on growth.

**Balance and Polarities:**

Life has opposites or polarities. Their balance determines our psychological health and development. Extremes are harmful as they prevent the realization of the opposite construct, gaining satisfactory expression. The result of imbalance is the likelihood of an extreme emotion to turn into its opposite over time. There are inborn self-regulating systems within people which regulate energy flow and help to maintain balance. This self-regulation is facilitated by transcendent functions, allowing people to make the transition from one dimension of their personality to another. The self-regulating systems include the principle of equivalence and the principle of entropy. The principle of equivalence states that energy lost in one system reappears in another system, with the sum total of energy being constant. The principle of entropy states that the libido flows from a more intense to a less intense element in order to prevent the overload of energy in one area. Jung defined libido as total psychic energy.

**c) Dimensions of Personality:**

Individual differences in personality are assigned to two dimensions. First dimension is the typical ways in which people take in and understand internal and external stimuli (the four functions). Second dimension is the characteristic directions of people's libidos (the two attitudes).

**i) The Two Attitudes:** The direction of movement of libido or energy is the second determinant of personality. Energy of every person moves primarily in one of the two ways- Extraversion and introversion.

**Extraversion:** Those who have dominant extraversion attitude, direct their energy towards the world outside. They are likely to be outgoing and adapt smoothly to the external change. These people are energized by social, interpersonal situations than by solitude.

**Introversion-** Introversion is an opposite attitude of extraversion. Those who have dominant introversion attitude, are comfortable in directing their libido inward. They may have good social skills, but they prefer to be introspective and recharge themselves by being alone.

**ii) The Four Functions:** Thinking, feeling, sensation and intuition are the four functions which determine how we process internal and external stimuli. Thinking and feeling are known as rational functions and sensation and intuition are known as irrational functions. They are as follows:

**Thinking:** Those who have dominant thinking function reacts cognitively and intellectually, trying to interpret and understand a stimulus.

- **Feeling:** This function is opposite to the feeling function. Those with dominant feeling function react emotionally and focus on pleasure, dislike, anger, etc. emotions raised by a stimulus.
- **Sensation:** Sensation includes receiving, identifying physical stimuli through our senses and passing them on to the consciousness. Those who have dominant sensation function look at substance of a stimulus, facts and seek evidence of its meaning, value.
- **Intuition:** This function is opposite to the sensation function. Those with dominant intuition function depend on feelings about where a stimulus has come from, its direction and possibilities to determine their decisions and reactions about the stimulus.

Every individual has a dominant/ superior function. This superior function organizes experiences, perceptions and an inferior function that is closer to the unconscious. We have minimum control on our inferior function and it causes us discomfort. If one has balance or access to all four functions, then it allows him/ her to operate fully in various situations. Unconscious compensates for the dominance of an individual's superior function by encouraging the opposite tendencies.

The four functions can be paired with each of the two attitudes and makes eight possible personality types. They are thinking and introversion, thinking and extraversion, feeling and introversion, feeling and extraversion, sensation and introversion, sensation and extraversion, intuition and introversion, intuition and extraversion. The functions and attitudes form the basis for the Myers-Briggs Type Indicator (MBTI).

### 2.2.1 Treatment Using Jungian Analytical Psychology

According to Jungian analysts, treatment is a lengthy, intensive process where clients are generally seen at least twice a week.

**a) Goals of Psychotherapy:**

This approach focuses on emergence and understanding of material from personal and the collective unconscious. Painful, unacceptable aspects of the unconscious are made conscious, acceptable, and meaningful which

leads to resolution of inner conflicts, greater balance, integration in the person, individuation, growth in creativity, energy and spiritual feelings. The goal is not to bring people happiness but make clients able to cope with the inevitable pain and suffering of life. The ultimate goal of Jungian analysis is individuation (transcendence or self-actualization).

**Jungian treatment typically has four stages-**

- **First stage** is catharsis, and emotional cleansing, where strong emotions are discharged.
- **Second stage** is elucidation, where meaning of clients difficulties in life, symptoms, archetypes (anima and animus, shadow) and current situation is understood, clarified. Transference and countertransference are explored, analyzed which can inform and direct the treatment. People also work through their immature and unrealistic thoughts, fantasies.
- **Third stage** is education, where analyst is encouraging, supportive and helps people to take risks in order to improve their life. Many clients stop taking treatment at this point.
- **Fourth stage** is transformation, which takes place when clients achieve thorough access to the collective unconscious and the archetypes. After facilitation of an ego- self dialogue, balance is emerged which in turn promotes individuation and self-realization.

**b) Therapeutic Alliance:**

Jung's psychotherapy has a more relational view. He looked at psychotherapy as providing healing, guidance and comfort. Jungian analysts' play role of educators, collaborators and take active part in the process of treatment. They try to create awareness through interventions. Jung believed that both client and analyst have an unconscious impact on each other which can facilitate treatment. Jung considered therapy as a reciprocal process as each participant (client and analyst) experience healing, growth and benefit from the positive changes in the other participant.

**c) Interventions:**

In the beginning, Jungian psychotherapy focuses on the conscious, builds a therapeutic alliance, and provides foundation for safe, productive exploration of the unconscious. After this, various techniques are used to obtain access to the contents of the unconscious. When this content of the unconscious is brought into consciousness, it is explored, clarified, interpreted, and understood. This content can be later integrated into the overall psyche of the person.

**i) Use of Symbols:** Jung's work highlights the capacity to think symbolically and look at the underlying dynamics, patterns which drive clients' thoughts, feelings, and actions. These patterns may appear in symbolic, indirect way in client's dreams, symptoms,

fantasies etc. Analysts ability to understand this psychological subtext can be improved by knowing the symbols which seen in myths, fairy tales, art, literature, religions etc.

ii) **Dream Interpretation:** According to Jung, dreams provide easiest access to the unconscious, reflecting people's inner lives and their unconscious responses. Dreams represent wishes, fears, fantasies, memories, experiences, visions, truths, etc. Dream interpretation of this approach includes retelling the recalled dream, describing its effect on consciousness; searching for events that may have triggered that dream. After this, investigation of the dream's objective and subjective content is done for archetypal images and symbols of the unconscious. After understanding the dream, it is assimilated into consciousness.

iii) **Word Association Tests:** In these tests, the analyst reads single words one at a time to the client. Client's task is to reply with the first word that comes into his/her mind. Responses which are unusual, repeated and hesitations, flushing, visible tensions give clue to the presence of unconscious material and complexes. Associations are used for exploring the meaning of the dreams.

iv) **Rituals:** Jung occasionally incorporated rites, rituals into therapy which can enhance its process and strengthen its individual, cultural relevance and impact.

### 2.2.2 Evaluation of Jung's Analytical Psychology:

Jung's concepts are complex, ill-defined and the treatment is lengthy. His work is not empirically validated. Little attention is paid to immediate crisis and to practice Jungian analysis, extensive training and supervision is needed. There are some strengths as well. For example, Jung's ideas are later reflected in many theories in various fields. The Myers-Briggs Type Indicator, a personality inventory is based on his theory.

## 2.3 REFERENCES

1. Corey, G. (2009). *Theory and practice of counseling and psychotherapy (8th ed.).* CA: Thomson Brooks.

2. Seligman, L. & Reichenberg, L. W. (2014). *Theories of counseling and psychotherapy: Systems, strategies, and skills (4th ed.)*. Pearson education.

3. Flanagan, J.S. & Flanagan, R.S. (2004). *Counseling and psychotherapy theories in context and practice: Skills strategies and techniques.* Hoboken, NJ: John Wiley & Sons, Inc.

*****

# 3

# INTERVENTION SYSTEMS EMPHASIZING HUMANISTIC, COGNITIVE, BEHAVIOURAL APPROACHES

**Unit Structure**



## 3.1 INTRODUCTION

This chapter describes another set of three major therapies in counselling and psychotherapy. They are Person Centred Therapy by Carl Rogers, Behaviour Therapy, and Cognitive Therapy by Aaron T. Beck.

## 3.2 CARL ROGERS – PERSON CENTRED THERAPY

Carl Rogers (1902-1987) was a major spokesperson for humanistic psychology and is considered as the “father of psychotherapy research”. He introduced many phenomena in the field of counselling and psychotherapy for the first time, including analysis of the transcripts of actual therapy session to study the counselling process in depth, use of quantitative methods to conduct major studies on psychotherapy, and formulation of a comprehensive theory of personality and psychotherapy grounded in empirical research. He also contributed to developing a theory of psychotherapy that de-emphasized pathology and focused on the strengths and resources of individuals.

The Person-Centred Therapy by Carl Rogers shares many concepts and values with another psychotherapy called "Existential Therapy". The basic assumptions of the Person-Centred Therapy about people are as follows:

- People are essentially trustworthy and resourceful
- They are able to make constructive changes and live effective and productive lives
- They have a vast potential for understanding themselves and resolving their own problems without direct intervention on the therapist's part
- They are capable of self-directed growth if they are involved in a specific kind of therapeutic relationship.

According to Rogers, the attitudes and personal characteristics of the therapist and the quality of the client-therapist relationship are the major determinants of the outcome of the therapeutic process. Since Rogers did not present person-centred theory as a fixed and completed approach to therapy, his person-centred therapy is considered as the result of an evolutionary process as it continues to remain open to change and refinement (Cain, 2010; Cain & Seeman, 2002).

Rogers' approach developed in four periods with major turning points that finally led the development of person-centred therapy. These identified four periods with milestones/turning points are mentioned below in brief:

- **1940s:** During this first period, Rogers developed a counselling approach called "nondirective counselling". This approach provided a powerful and revolutionary alternative to the directive and interpretive approaches to therapy being practiced during that period. He also challenged the validity of commonly accepted therapeutic procedures, such as advice, suggestion, direction, persuasion, teaching, diagnosis, and interpretation in this period.
- **1950s:** In this second period, Rogers renamed his approach as client-centred therapy to reflect its emphasis on the client, rather than on nondirective methods. This period was mainly characterized by a shift from clarification of feelings to a focus on the phenomenological world of the client. Rogers assumed that how people behave can be understood best from their own internal frame of reference. He also focused on the actualizing tendency more explicitly as the basic motivational force that leads to client change.
- **Late 1950s to 1970s:** This period mainly addressed the necessary and sufficient conditions of therapy. Rogers' interest in how people best progress in psychotherapy led him to study the qualities of the client-therapist relationship as a catalyst leading to personality change. He also conducted extensive research with his associates on both the process and outcomes of psychotherapy.

- **During 1980s and the 1990s:** This period was marked by considerable expansion of counselling approach to education, couples and families, industry, groups, conflict resolutions, politics, and the search for world peace. Thus, Rogers' theory came to be known as person-centred approach due to his ever-widening scope of influence, including his interest in how people obtain, possess, share, or surrender power and control over others and themselves. Being mainly applied to individual and group counselling, person-centred approach was further applied to important areas including education, family life, leadership and administration, organizational development, health care, cross-cultural and interracial activity, and international relations.

Many of Carl Rogers' ideas, especially on the positive aspects of being human and the fully functioning person, are based on Abraham Maslow's (a pioneer in the development of humanistic psychology) basic philosophy. According to Rogers, there are three therapist attributes that create a growth-promoting climate. They are i) congruence (genuineness or realness), ii) unconditional positive regard (acceptance and caring), and iii) accurate empathic understanding (an ability to deeply grasp the subjective world of another person).

Rogers believed that in such a climate, individuals can move forward and become what they are capable of becoming. Also, such a therapeutic climate with this attitude of the therapists makes the one being helped to become less defensive and more open to themselves and their world. They will also behave in prosocial and constructive ways. Thus, the person-centred approach rejects the role of the therapists as the authority and of the passive clients merely following the beliefs of the therapists. Overall, person-centred therapy is rooted in the clients' capacity for awareness and self-directed change in attitudes and behaviour.

The emphasis in the person-centred approach is mainly on three things:

- how clients act in their world with others,
- how they can move forward in constructive directions, and
- how they can successfully deal with obstacles (both from within themselves and outside of themselves) that are blocking their growth.

### 3.2.1 The Therapeutic Process:

**Therapeutic Goals:**

The aim of the person-centred approach is to make the client achieve a greater degree of independence and integration. Hence, the focus in the therapy is on the person, and not on the person's presenting problem. Thus, the main goal of the therapy is to assist clients in their growth process, so that clients can better cope with problems as they identify them. People entering psychotherapy often ask such questions (Rogers, 1961) as follows:

- "How can I discover my real self?"
- "How can I become what I deeply wish to become?"
- "How can I get behind my facades and become myself?"

In line with this set of questions, the underlying aim of person-centred therapy is to provide a climate conducive to helping the individual strive toward self-actualization. According to Rogers (1961), people who become increasingly actualized have the following characteristics:

- An openness to experience,
- A trust in themselves
- An internal source of evaluation, and
- A willingness to continue growing.

The basic goal of person-centred therapy is to encourage these characteristics.

**Therapist's Function and Role:**

The role of person-centred therapists is rooted in their ways of being and attitudes. It is the attitude of therapists that facilitate personality change in the clients, rather than therapists' knowledge, theories, or techniques (Rogers, 1961). Thus, basically therapists use themselves as an instrument of change. In short, their "role" is to be without roles, when they encounter the client on a person-to-person level. In other words, they do not get lost in their professional role. Thus, it is the therapist's attitude and belief in the inner resources of the client that creates the therapeutic climate for growth (Bozarth et al., 2002).

The therapist's function is to be present and accessible to clients and to focus on their immediate experience. First and foremost, the therapist must be willing to be real in the relationship with clients. Thus, the therapist is a catalyst for change by being congruent, accepting, and empathic. These attitudes of the therapists lead the clients to have the necessary freedom to explore areas of their life that were either denied to awareness or distorted.

**Client's Experience in Therapy:**

Clients have the opportunity to explore the full range of their experience, including their feelings, beliefs, behaviour, and worldview as result of a climate created by the counselor which is conducive to self-exploration. Thus, the therapeutic change depends on clients' perceptions both of their own experience in therapy and of the counselor's basic attitudes.

Clients basically seek therapy because they have a feeling of basic helplessness, powerlessness, and an inability to make decisions or effectively direct their own lives. However, in person-centred therapy, clients soon learn that they can be responsible for themselves in the

relationship and that they can learn to be more free by using the relationship to gain greater self-understanding.

The person-centred therapy relationship provides a supportive structure within which clients' self-healing capacities are activated, since it is grounded on the assumption that it is clients i) who heal themselves, ii) who create their own self-growth, and iii) who are active self-healers (Bohart & Tallman, 1999, 2010; Bohart & Watson, 2011). Clients value most, especially the following things:

- being understood and accepted which results in creating a safe place to explore feelings, thoughts, behaviours, and experiences;
- support for trying out new behaviours (Bohart & Tallman, 2010).

As a result of the progress in counselling, clients also have the following valuable experiences:

- They are able to explore a wider range of beliefs and feelings.
- They can express their fears, anxiety, guilt, shame, hatred, anger, and other emotions that they had deemed too negative to accept and incorporate into their self-structure.
- They distort less and move to a greater acceptance and integration of conflicting and confusing feelings.
- They increasingly discover aspects within themselves that had been kept hidden.
- They become less defensive and become more open to their experience, when they feel understood and accepted,
- they become more realistic, perceive others with greater accuracy, and become better able to understand and accept others, because they feel safer and are less vulnerable,
- They come to appreciate themselves more as they are, and their behaviour shows more flexibility and creativity
- They become less concerned about meeting others' expectations, and thus begin to behave in ways that are truer to themselves.
- They direct their own lives instead of looking outside of themselves for answers.
- They move in the direction of being more in contact with what they are experiencing at the present moment, less bound by the past, less determined, freer to make decisions, and increasingly trusting in themselves to manage their own lives.

**Relationship between Therapist and Client:**

Rogers' (1957) hypothesis of the "necessary and sufficient conditions for therapeutic personality change" was based on the quality of the relationship. His hypothesis stated, "If I can provide a certain type of relationship, the other person will discover within himself or herself the capacity to use that relationship for growth and change, and personal development will occur" (Rogers, 1961, p. 33). Rogers (1967) further hypothesized that "significant positive personality change does not occur except in a relationship" (p. 73). This hypothesis was formulated on the basis of many years of Rogers' professional experience, which remains basically unchanged to this day. For Rogers's, the client–therapist relationship is characterized by equality and the process of change in the client depends to a large degree on the quality of this equal relationship. Following are the core conditions, that are an integral part of the therapeutic relationship:

**1. Congruence, or genuineness:**

It implies that therapists are real; genuine, integrated, and authentic during the therapy hour. Their inner experience and outer expression of that experience match, and they can openly express feelings, thoughts, reactions, and attitudes that are present in the relationship with the client.

**2. Unconditional positive regard and acceptance:**

Deep and genuine caring for the client as a person, or a condition of unconditional positive regard can best be achieved through empathic identification with the clients (Farber & Doolin, 2011). Therapists should communicate through their behaviour that they value their clients as they are and that clients are free to have feelings and experiences. Thus, acceptance is the recognition of clients' rights to have their own beliefs and feelings. However, it is not the approval of all behaviour, and all overt behaviour need not be approved of or accepted.

**3. Accurate empathic understanding:**

Understanding clients' experience and feelings sensitively and accurately is one of the main tasks of the therapist because they are revealed in the moment-to-moment interaction during the therapy session. The therapist strives to sense clients' subjective experience, particularly in the here and now. The aim of this accurate empathic understanding is to encourage clients to get closer to themselves to feel more deeply and intensely, and to recognize and resolve the incongruity that exists within them. Thus, it is the cornerstone of the person-centred approach, and a necessary ingredient of any effective therapy (Cain, 2010). Accurate empathic understanding implies that the therapists will sense clients' feelings as if they were his or her own without becoming lost in those feelings.

**3.2.2 Application: Therapeutic Techniques And Procedures**

- **Early Emphasis on Reflection of Feelings**: Rogers's original emphasis was on grasping the world of the client and reflecting this understanding. Many followers of Rogers simply imitated his

reflective style. client-centred therapy has often been identified primarily with the technique of reflection.

- **Evolution of Person-Centred Methods:** Contemporary person-centred therapy is the result of an evolutionary process of more than 70 years, and it continues to remain open to change and refinement.

- **The Role of Assessment:** Assessment is frequently viewed as a prerequisite to the treatment process. In person-centred therapy, the client's self-assessment, not how the counselor assesses the client. Assessment seems to be gaining in importance in short-term treatments in most counselling agencies, and it is imperative that clients be involved in a collaborative process in making decisions that are central to their therapy.

**Application of the Philosophy of the Person-Centred Approach:**

The person-centred approach has been applied to working with individuals, groups, and families. It has been found effective in many such following cases:

- With a wide range of client problems including anxiety disorders, alcoholism, psychosomatic problems, agoraphobia, interpersonal difficulties, depression, cancer, and personality disorders (Bozrath, Zimring, and Tausch, 2002).

- In training both professionals and paraprofessionals who work with people in a variety of settings.

- In crisis intervention such as an unwanted pregnancy, an illness, a disastrous event, or the loss of a loved one. People in the helping professions (nursing, medicine, education, the ministry) are often first on the scene in a variety of crises, and they can do much if the basic attitudes

- In the group counselling, where the unique role of the group counselor as a facilitator rather than a leader. The primary function of the facilitator is to create a safe and healing climate—a place where the group members can interact in honest and meaningful ways.

- Several writers consider person-centred therapy as being ideally suited to clients in a diverse world.

- Motivational interviewing, which is based on the philosophy of person-centred therapy, is a culturally sensitive approach that can be effective across population domains, including gender, age, ethnicity, and sexual orientation (Levensky et al., 2008).

### 3.2.3 Evaluation of Person-Centred Therapy:

**Criticism/evaluation:**

- Person-centred therapy is based on a philosophy of human nature that postulates an innate striving for self-actualization.

- Rogers's view of human nature is phenomenological; that is, we structure ourselves according to our perceptions of reality. We are motivated to actualize ourselves in the reality that we perceive.

- Rogers's theory rests on the assumption that clients can understand the factorsin their lives that are causing them to be unhappy. They also have the capacity for self-direction and constructive personal change. Change will occur if a congruent therapist makes psychological contact with a client in a state of anxiety or incongruence. It is essential for the therapist to establish a relationship the client perceives as genuine, accepting, and understanding.

- The person-centred approach emphasizes personal relationship between client and therapist; the therapist's attitudes are more critical than are knowledge, theory, or techniques employed. In the context of this relationship, clients unleash their growth potential and become more of the person they are capable of becoming.

- This approach places primary responsibility for the direction of therapy on the client. In the therapeutic context, individuals have the opportunity to decide for themselves and come to terms with their own personal power. The underlying assumption is that no one knows the client better than the client.

**Contributions:**

- Rogers had, and his theory continues to have, a major impact on the field of counselling and psychotherapy.

- One of Rogers's contributions to the field of psychotherapy was his willingness to state his concepts as testable hypotheses and to submit them to research.

- His theories of therapy and personality change have had a tremendous heuristic effect, and though much controversy surrounds this approach, his work has challenged practitioners and theoreticians to examine their own therapeutic styles and beliefs.

- Among the major contributions of person-centred therapy are the implications of empathy for the practice of counselling.

- One of the strengths of the person-centred approach is "the development of innovative and sophisticated methods to work with an increasingly difficult, diverse, and complex range of individuals, couples, families, and groups" (Cain, 2002b, p. xxii).

- One of the developments associated with the person-centred approach is the emergence of emotion-focused therapy (EFT).

**Limitations:**

- This therapeutic modality emphasizes the role of techniques aimed at bringing about change in clients' behaviour.

- A potential limitation of the person-centred approach is that some students-in-training and practitioners with this orientation may have a tendency to be very supportive of clients without being challenging.

## 3.3 BEHAVIOUR THERAPY

**Introduction:**

Behaviour therapy is rooted mainly in the work of three pioneers in B. F. Skinner (1904-1990), Albert Bandura (b. 1925), and Arnold A. Lazarus (b. 1932). Behaviour therapy practitioners focus on directly observable behaviour, current determinants of behaviour, learning experiences that promote change, tailoring treatment strategies to individual clients, and rigorous assessment and evaluation. Behaviour therapy has been used to treat a wide range of psychological disorders with different client populations.

Anxiety disorders, depression, posttraumatic stress disorder, substance abuse, eating and weight disorders, sexual problems, pain management, and hypertension have all been successfully treated using this approach (Wilson, 2011). Behavioural procedures are used in the fields of developmental disabilities, mental illness, education and special education, community psychology, clinical psychology, rehabilitation, business, self-management, sports psychology, health-related behaviours, medicine, and gerontology (Miltenberger, 2012; Wilson, 2011).

### 3.3.1 Historical Background:

The behavioural approach had its origin in the 1950s and early 1960s, and it was a radical departure from the dominant psychoanalytic perspective. The behaviour therapy movement differed from other therapeutic approaches in its application of principles of classical and operant conditioning to the treatment of a variety of problem behaviours. As behaviour therapy has evolved and developed, it has increasingly overlapped in some ways with other psychotherapeutic approaches (Wilson, 2011).

Traditional behaviour therapy arose simultaneously in the United States, South Africa, and Great Britain in the 1950s. In spite of harsh criticism and resistance from psychoanalytic psychotherapists, the approach has survived. Its focus was on demonstrating that behavioural conditioning techniques were effective and were a viable alternative to psychoanalytic therapy. In the 1960s Albert Bandura developed social learning theory, which combined classical and operant conditioning with observational learning. Bandura made cognition a legitimate focus for behaviour therapy.

During the 1960s a number of cognitive behavioural approaches sprang up, which focus on cognitive representations of the environment rather than on characteristics of the objective environment. Contemporary behaviour therapy emerged as a major force in psychology during the 1970s, and it had a significant impact on education, psychology,

psychotherapy, psychiatry, and social work. Behavioural techniques were expanded to provide solutions for business, industry, and child-rearing problems as well. Behaviour therapy techniques were viewed as the treatment of choice for many psychological problems.

Two of the most significant developments in the field were (1) the continued emergence of cognitive behaviour therapy as a major force and (2) the application of behavioural techniques to the prevention and treatment of health-related disorders.

**Four Areas of Development:**

Contemporary behaviour therapy can be understood by considering four major areas of development: (1) classical conditioning, (2) operant conditioning, (3) social cognitive theory, and (4) cognitive behaviour therapy.

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

**Operant conditioning** involves a type of learning in which behaviours are influenced mainly by the consequences that follow them. If the environmental changes brought about by the behaviour are reinforcing—that is, if they provide some reward to the organism or eliminate aversive stimuli—the chances are increased that the behaviour will occur again. If the environmental changes produce no reinforcement or produce aversive stimuli, the chances are lessened that the behaviour will recur. Positive and negative reinforcement, punishment, and extinction techniques. illustrate how operant conditioning in applied settings can be instrumental in developing prosocial and adaptive behaviours. Operant techniques are used by behavioural practitioners in parent education programs and with weight management programs.

The **social learning approach (or the social cognitive approach)** developed by Albert Bandura and Richard Walters (1963) is interactional, interdisciplinary, and multimodal (Bandura, 1977, 1982). Social cognitive theory involves a triadic reciprocal interaction among the environment, personal factors (beliefs, preferences, expectations, self-perceptions, and interpretations), and individual behaviour. In the social-cognitive approach the environmental events on behaviour are mainly determined by cognitive processes governing how environmental influences are perceived by an individual and how these events are interpreted (Wilson, 2011). A basic assumption is that people are capable of self directed

behaviour change and that the person is the agent of change. For Bandura (1982, 1997), self-efficacy is the individual's belief or expectation that he or she can master a situation and bring about desired change.

**Cognitive behaviour therapy (CBT)** represents the mainstream of contemporary behaviour therapy and is a popular theoretical orientation among psychologists. Cognitive behavioural therapy operates on the assumption that what people believe influences how they act and feel. Since the early 1970s, the behavioural movement has conceded a legitimate place to thinking, even to the extent of giving cognitive factors a central role in understanding and treating emotional and behavioural problems. By the mid-1970s cognitive behaviour therapy had replaced behaviour therapy as the accepted designation, and the field began emphasizing the interaction among affective, behavioural, and cognitive dimensions (Lazarus, 2008a; Wilson, 2011).

Contemporary behaviour therapy has much in common with cognitive behaviour therapy in which the mechanism of change is both cognitive (modifying thoughts to change behaviours) and behavioural (altering external factors that lead to behaviourchange) (Follette & Callaghan, 2011). Considered broadly, the term "behaviour therapy" refers to practices based primarily on social-cognitive theory and encompasses a range of cognitive principles and procedures (Wilson, 2011).

### 3.3.2 Key Concepts:

**View of Human Nature:**

Modern behaviour therapy is grounded on a scientific view of human behaviour that accommodates a systematic and structured approach to counselling. The current view is that the person is the producer and the product of his or her environment. Behaviour therapy aims to increase people's skills so that they have more options for responding. By overcoming debilitating behaviours that restrict choices, people are freer to select from possibilities that were not available to them earlier, which increases individual freedom. People have the capacity to choose how they will respond to external events in their environment, which makes it possible for therapists to use behavioural methods to attain humanistic ends (Kazdin, 1978, 2001).

**Basic Characteristics and Assumptions:**

Seven key characteristics of behaviour therapy are described below.

1. Behavior therapy is based on the principles and procedures of the scientific method.

2. Behaviour is not limited to overt actions a person engages in that we can observe; behaviour also includes internal processes such as cognitions, images, beliefs, and emotions. The key characteristic of a behaviour is that it is something that can be operationally defined.

3. Behaviour therapy deals with the client's current problems and the factors influencing them, as opposed to an analysis of possible historical determinants.

4. Clients involved in behaviour therapy are expected to assume an active role by engaging in specific actions to deal with their problems.

5. This approach assumes that change can take place without insight into underlying dynamics and without understanding the origins of a psychological problem.

6. Assessment is an ongoing process of observation and self-monitoring that focuses on the current determinants of behaviour, including identifying the problem and evaluating the change; assessment informs the treatment process.

7. Behavioural treatment interventions are individually tailored to specific problems experienced by the client.

### 3.3.3 The Therapeutic Process:

**Therapeutic Goals:**

Goals occupy a place of central importance in behaviour therapy. The general goals of behaviour therapy are to increase personal choice and to create new conditions for learning. The client, with the help of the therapist, defines specific treatment goals at the outset of the therapeutic process. Continual assessment throughout therapy determines the degree to which identified goals are being met. It is important to devise a way to measure progress toward goals based on empirical validation.

The therapist assists clients in formulating specific measurable goals. Goals must be clear, concrete, understood, and agreed on by the client and the counselor. The process of determining therapeutic goals entails a negotiation between client and counselor that results in a contract that guides the course of therapy. Behaviour therapists and clients alter goals throughout the therapeutic process as needed.

**Therapist's Function and Role:**

Behaviour therapists conduct a thorough functional assessment (or behavioural analysis) to identify the maintaining conditions by systematically gathering information about:

- Situational antecedents (A),
- The dimensions of the problem behaviour (B), and
- The consequences (C) of the problem.

This is known as the ABC model, and the goal of a functional assessment of a client's behaviour is to understand the ABC sequence. This model of behaviour suggests that behaviour (B) is influenced by some particular events that precede it, called antecedents (A), and by certain events that

follow it, called consequences (C). Antecedent events cue or elicit a certain behaviour. Consequences are events that maintain a behaviour in some way, either by increasing or decreasing it.

In doing a behavioural assessment interview, the therapist's task is to identify the particular antecedent and consequent events that influence, or are functionally related to, an individual's behaviour (Cormier, Nurius, & Osborn, 2013). Here are some of the functions of behaviourally oriented practitioners:

- They tend to be active and directive and to function as consultants and problem solvers.
- They rely heavily on empirical evidence about the efficacy of the techniques they apply to particular problems.
- They must possess intuitive skills and clinical judgment in selecting appropriate treatment methods and in determining when to implement specific techniques (Wilson, 2011).
- They pay close attention to the clues given by clients, and
- They are willing to follow their clinical hunches.
- They use some techniques common to other approaches, such as summarizing, reflection, clarification, and open-ended questioning.

Behavioural clinicians perform other functions as well (Miltenberger, 2012; Spiegler & Guevremont, 2010):

- The therapist formulates initial treatment goals and designs and implements a treatment plan to accomplish these goals.
- The behavioural clinician uses strategies that have research support for use with a particular kind of problem.
- The clinician evaluates the success of the change plan by measuring progress toward the goals throughout the duration of treatment.
- A key task of the therapist is to conduct follow-up assessments to see whether the changes are durable over time.

**Client's Experience in Therapy:**

Both therapist and client have clearly defined roles, and the importance of client awareness and participation in the therapeutic process is stressed. The client engages in behavioural rehearsal with feedback until skills are well learned and generally receives active homework assignments (such as self-monitoring of problem behaviours) to complete between therapy sessions. Behaviour clinicians emphasize that changes clients make in therapy need to be translated into their daily lives.

It is important for clients to be motivated to change, and they are expected to cooperate in carrying out therapeutic activities, both during therapy

sessions and in everyday life. If clients are not involved in this way, the chances are slim that therapy will be successful. Clients are encouraged to experiment for the purpose of enlarging their repertoire of adaptive behaviours. Clients are as aware as the therapist is regarding when the goals have been accomplished and when it is appropriate to terminate treatment. It is clear that clients are expected to do more than merely gather insights; they need to be willing to make changes and to continue implementing new behaviour once formal treatment has ended.

**Relationship between Therapist and Client:**

Behavioural practitioners have increasingly recognized the role of the therapeutic relationship and therapist behaviour as critical factors related to the process and outcome of treatment. Today, most behavioural practitioners stress behavioural practitioners have increasingly recognized the role of the therapeutic relationship and therapist behaviour as critical factors related to the process and outcome of treatment. Today, most behavioural practitioners stress the value of establishing a collaborative working relationship with their clients. The skilled behaviour therapist conceptualizes problems behaviourally and makes use of the client–therapist relationship in facilitating change.

### 3.3.4. Application: Therapeutic Techniques And Procedures:

A hallmark of the behavioural approaches is that the therapeutic techniques are empirically supported and evidence-based practice is highly valued. According to Lazarus (1989, 1992b, 1996b, 1997a, 2005, 2008a, 2008b), behavioural practitioners can incorporate into their treatment plans any technique that can be demonstrated to effectively change behaviour. Lazarus advocates the use of diverse techniques, regardless of their theoretical origin. It is clear that behaviour therapists do not have to restrict themselves only to methods derived from learning theory. Likewise, behavioural techniques can be incorporated into other approaches. Therapists are often quite creative in their interventions. A range of behavioural techniques available to the practitioner include applied behavioural analysis, relaxation training, systematic desensitization, exposure therapies, eye movement desensitization and reprocessing, social skills training, self-management programs and self-directed behaviour, multimodal therapy, and mindfulness and acceptance-based approaches.

**Applied Behavioural Analysis: Operant Conditioning Techniques:**

In applied behaviour analysis, operant conditioning techniques and methods of assessment and evaluation are applied to a wide range of problems in many different settings (Kazdin, 2001). The goal of reinforcement, whether positive or negative, is to increase the target behaviour. **Positive reinforcement** involves the addition of something of value to the individual (such as praise, attention, money, or food) as a consequence of certain behaviour. The stimulus that follows the behaviour is the positive reinforcer. **Negative reinforcement** involves the escape

from or the avoidance of aversive (unpleasant) stimuli. The individual is motivated to exhibit a desired behaviour to avoid the unpleasant condition. Another operant method of changing behaviour is extinction, which refers to withholding reinforcement from a previously reinforced response. In applied settings, extinction can be used for behaviours that have been maintained by positive reinforcement or negative reinforcement.

Another way behaviour is controlled is through **punishment**, sometimes referred to as aversive control, in which the consequences of a certain behaviour result in a decrease of that behaviour. The goal of reinforcement is to increase target behaviour, but the goal of punishment is to decrease target behaviour. Miltenberger (2012) describes two kinds of punishment that may occur as a consequence of behaviour: **positive punishment** and negative punishment. In positive punishment an aversive stimulus is added after the behaviour to decrease the frequency of a behaviour. In **negative punishment** a reinforcing stimulus is removed following the behaviour to decrease the frequency of a target behaviour (such as deducting money from a worker's salary for missing time at work, or taking television time away from a child for misbehaviour). In both kinds of punishment, the behaviour is less likely to occur in the future.

Some other important influential techniques in behaviour therapy are as follows in brief:

**Progressive muscle relaxation** initially developed by Jacobson (1938) which is a method of teaching people to cope with the stresses produced by daily living. It is aimed at achieving muscle and mental relaxation and is easily learned.

**Systematic desensitization**, which is based on the principle of classical conditioning, is a basic behavioural procedure developed by Joseph Wolpe, one of the pioneers of behaviour therapy. Clients imagine successively more anxiety-arousing situations at the same time that they engage in a behaviour that competes with anxiety. Gradually, or systematically, clients become less sensitive (desensitized) to the anxiety-arousing situation.

**Exposure therapies** are designed to treat fears and other negative emotional responses by introducing clients, under carefully controlled conditions, to the situations that contributed to such problems.

**Eye movement desensitization and reprocessing (EMDR)** is a form of exposure therapy that entails assessment and preparation, imaginal flooding, and cognitive restructuring in the treatment of individuals with traumatic memories.

**Social skills training** is a broad category that deals with an individual's ability to interact effectively with others in various social situations; it is used to help clients develop and achieve skills in interpersonal competence.

**Self-management programs** enable people to make decisions concerning specific behaviours they want to control or change.

**Multimodal therapy** is a comprehensive, systematic, holistic approach to behaviour therapy developed by Arnold Lazarus (1989, 1997a, 2005, 2008a). It is grounded in social-cognitive theory and applies diverse behavioural techniques to a wide range of problems.

**Mindfulness** involves being aware of our experiencing in a receptive way and engaging in activity based on this nonjudgmental awareness (Robins & Rosenthal, 2011). In mindfulness practice, clients train themselves to intentionally focus on their present experience while at the same time achieving a distance from it.

**Acceptance** is a process involving receiving one's present experience without judgment or preference, but with curiosity and kindness, and striving for full awareness of the present moment (Germer, 2005b).

**Dialectical Behaviour Therapy** (DBT) formulated by Linehan (1993a, 1993b), is a promising blend of behavioural and psychoanalytic techniques for treating borderline personality disorders.

**Mindfulness-Based Stress Reduction** (MBSR) aims to assist people in learning how to live more fully in the present rather than ruminating about the past or being overly concerned about the future. The essence of MBSR consists of the notion that much of our distress and suffering results from continually wanting things to be different from how they actually are (Salmon, Sephton, & Dreeben, 2011).

**Mindfulness-Based Cognitive Therapy** (MBCT) program is a comprehensive integration of the principles and skills of mindfulness applied to the treatment of depression (Segal, Williams, & Teasdale, 2002).

**Acceptance and Commitment Therapy** (Hayes et al., 2005, 2011), which involves fully accepting present experience and mindfully letting go of obstacles.

**Applications:**

- Group-based behavioural approaches emphasize teaching clients self-management skills and a range of new coping behaviours, as well as how to restructure their thoughts. Clients can learn to use these techniques to control their lives, deal effectively with present and future problems, and function well after they complete their group experience.
- Behaviour therapy has some clear advantages over many other theories in counselling culturally diverse clients.

**Shortcomings:**

- Behaviour therapy is sensitive to differences among clients in a broad sense.
- Race, gender, ethnicity, and sexual orientation are critical variables that influence the process and outcome of therapy.
- Instead of viewing clients in the context of their sociocultural environment, these practitioners concentrate too much on problems within the individual.

**Evaluation:**

**Contributions of Behaviour Therapy:**

- Behaviour therapy challenges us to reconsider our global approach to counselling.
- The specificity of the behavioural approaches helps clients translate unclear goals into concrete plans of action, and it helps both the counselor and the client to keep these plans clearly in focus.
- Techniques such as role playing, relaxation procedures, behavioural rehearsal, coaching, guided practice, modelling, feedback, learning by successive approximations, mindfulness skills, and homework assignments can be included in any therapist's repertoire, regardless of theoretical orientation.
- A major contribution of behaviour therapy is its emphasis on research into and assessment of treatment outcomes.
- A strength of the behavioural approaches is the emphasis on ethical accountability.

**Limitations and Criticisms of Behaviour Therapy:**

Behaviour therapy has been criticized for a variety of reasons. Here are four common criticisms and misconceptions about behaviour therapy:

1. Behaviour therapy may change behaviours, but it does not change feelings.

2. Behaviour therapy does not provide insight.

3. Behaviour therapy treats symptoms rather than causes.

4. Behaviour therapy involves control and social influence by the therapist.

## 3.4 AARON BECK – COGNITIVE THERAPY

**INTRODUCTION:**

Aaron Temkin Beck (b. 1921) found the cognitions of depressed individuals to be characterized by errors in interpretation that he called "cognitive distortions." For Beck, negative thoughts reflect underlying

dysfunctional beliefs and assumptions. When these beliefs are triggered by situational events, a depressive pattern is put in motion. Beck believes clients can assume an active role in modifying their dysfunctional thinking and thereby gain relief from a range of psychiatric conditions. His continuous research in the areas of psychopathology and the utility of cognitive therapy has earned him a place of prominence in the scientific community in the United States.

Beck is the pioneering figure in cognitive therapy, one of the most influential and empirically validated approaches to psychotherapy. He has successfully applied cognitive therapy to depression, generalized anxiety and panic disorders, suicide, alcoholism and drug abuse, eating disorders, marital and relationship problems, psychotic disorders, and personality disorders. He has developed assessment scales for depression, suicide risk, anxiety, self-concept, and personality.

All of the cognitive behavioural approaches share the same basic characteristics and assumptions as traditional behaviour therapy. Although the approaches are quite diverse, they do share these attributes: (1) a collaborative relationship between client and therapist, (2) the premise that psychological distress is largely a function of disturbances in cognitive processes, (3) a focus on changing cognitions to produce desired changes in affect and behaviour, (4) a present-centred, time-limited focus, (5) an active and directive stance by the therapist, and (6) an educational treatment focusing on specific and structured target problems (Beck & Weishaar, 2011).

**Both, cognitive therapy and the cognitive behavioural therapies -**

- Are based on a structured psychoeducational model,
- Emphasize the role of homework,
- Place responsibility on the client to assume an active role both during and outside therapy sessions,
- Emphasize developing a strong therapeutic alliance, and
- Draw from a variety of cognitive and behavioural strategies to bring about change.
- To a large degree, are based on the assumption that a reorganization of one's self-statements will result in a corresponding reorganization of one's behaviour.
- Include a variety of behavioural strategies as a part of their integrative repertoire.

Beck developed an approach known as cognitive therapy (CT) as a result of his research on depression (Beck 1963, 1967). Beck's observations of depressed clients revealed that they had a negative bias in their interpretation of certain life events, which contributed to their cognitive distortions (Beck, 1967).

Cognitive therapy has a number of similarities to both rational emotive behaviour therapy and behaviour therapy. All of these therapies are active, directive, time-limited, present centred, problem-oriented, collaborative, structured, and empirical. They make use of homework and require explicit identification of problems and the situations in which they occur (Beck & Weishaar, 2011). Some of the important features of cognitive therapy are as follows:

- It perceives psychological problems as stemming from commonplace processes such as faulty thinking, making incorrect inferences on the basis of inadequate or incorrect information, and failing to distinguish between fantasy and reality.
- Like REBT, it is an insight-focused therapy with a strong psychoeducational component that emphasizes recognizing and changing unrealistic negative thoughts and maladaptive beliefs.
- It is highly collaborative and involves designing specific learning experiences to help clients (Dobson & Dozois, 2010; Dozois & Beck, 2011))
    - monitor their automatic thoughts
    - examine the validity of their automatic thoughts
    - understand the relationship among cognition, feelings, and behaviour
    - develop more accurate and realistic cognitions; and
    - change underlying beliefs and assumptions
- It is based on the theoretical rationale that the way people feel and behave is influenced by how they perceive and structure their experience.
- Its theoretical assumptions (Weishaar, 1993) are:

(1) that people's internal communication is accessible to introspection,

(2) that clients' beliefs have highly personal meanings, and

(3) that these meanings can be discovered by the client rather than being taught or interpreted by the therapist.

### 3.4.1 Basic Principles of Cognitive Therapy:

Beck, formerly a practicing psychoanalytic therapist for many years, grew interested in his clients' automatic thoughts (personalized notions that are triggered by particular stimuli that lead to emotional responses). As a part of a psychoanalytic research study, he was examining the dream content of depressed clients for anger that they were turning back on themselves. He began to notice that rather than retroflected anger, as Freud theorized with

depression, clients exhibited a negative bias in their interpretation or thinking.

Individuals tend to maintain their core beliefs about themselves, their world, and their future. A primary focus of cognitive therapy is to assist clients in examining and restructuring their core beliefs (or core schema) (Dozois & Beck, 2011). By encouraging clients to gather and weigh the evidence in support of their beliefs, therapists help clients bring about enduring changes in their mood and their behaviour.

Beck contends that people with emotional difficulties tend to commit characteristic "logical errors", called Arbitrary inferences, Selective abstraction, Overgeneralization, Magnification and minimization, Personalization, Labeling and mislabelling, and Dichotomous thinking that distort objective reality, and lead to faulty assumptions and misconceptions, which are termed cognitive distortions (J. Beck, 2011; Beck & Weishaar, 2011). In cognitive therapy, clients learn to engage in more realistic thinking, especially if they consistently notice times when they tend to get caught up in catastrophic thinking.

**The Client–Therapist Relationship:**

Beck (1987) emphasizes that the quality of the therapeutic relationship is basic to the application of cognitive therapy. A therapeutic alliance is a necessary first step in cognitive therapy, especially in counselling difficult-to-reach clients. In cognitive therapy, the aim is to identify specific, measurable goals and to move directly into the areas that are causing the most difficulty for clients (Dienes et al. 2011).

Some of the essential characteristics of cognitive therapists are as follows:

- must have a cognitive conceptualization of cases,
- be creative and active,
- be able to engage clients through a process of Socratic questioning, and
- be knowledgeable and skilled in the use of cognitive and behavioral strategies aimed at guiding clients in significant self-discoveries that will lead to change (Beck & Weishaar, 2011).
- strive to create "warm, empathic relationship with clients while at the same time effectively using cognitive therapy techniques that will enable clients to create change in their thinking, feeling, and behaving" (Macy, 2007).
- function as catalysts and a guide who helps clients understand how their beliefs and attitudes influence the way they feel and act
- emphasize the client's role in self-discovery aim to teach clients how to be their own therapist.

- educate clients about the nature and course of their problem, about the process of cognitive therapy, and how thoughts influence their emotions and behaviours
- realize that clients are more likely to complete homework if it is tailored to their needs, if they participate in designing the homework, if they begin the homework in the therapy session, and if they talk about potential problems in implementing the homework (J. Beck, 2005).

Clients, on the other hand, are expected to:

- identify the distortions in their thinking,
- summarize important points in the session, and
- collaboratively devise homework assignments that they agree to carry out.

Homework is often used as a part of cognitive therapy because practicing cognitive behavioural skills outside of the office facilitates more rapid gains (Dieneset al., 2011). A few characteristics of homework are:

- it is tailored to the client's specific problem and arises out of the collaborative therapeutic relationship
- its purpose is to teach clients new skills, and to enable them to test their beliefs and experiment with different behaviours in daily-life situations
- it is generally presented to clients as an experiment, which increases the openness of clients to get involved in an assignment
- its emphasis is placed on self-help assignments that serve as a continuation of issues addressed in a therapy session (Dattilio, 2002b).

One indicator of a good therapeutic alliance is whether homework is done and done well.

### 3.4.2 Applications of Cognitive Therapy:

Cognitive therapy initially gained recognition as an approach to treating depression, but extensive research has also been devoted to the study and treatment of many other psychiatric disorders. One of the reasons for the popularity of cognitive therapy is due to "strong empirical support for its theoretical framework and to the large number of outcome studies with clinical populations" (Beck & Weishaar, 2011, p. 305).

**Cognitive therapy has been successfully used to treat -**

- phobias, psychosomatic disorders, eating disorders, anger, panic disorders, and generalized anxiety disorders (Chambless & Peterman, 2006; Dattilio & Kendall, 2007; Riskind, 2006);

- posttraumatic stress disorder, suicidal behavior, borderline personality disorders, narcissistic personality disorders, and schizophrenic disorders (Dattilio & Freeman, 2007);
- personality disorders (Pretzer & Beck, 2006);
- substance abuse (Newman,2006);
- chronic pain (Beck, 1987);
- medical illness (Dattilio & Castaldo, 2001);
- crisis intervention (Dattilio & Freeman, 2007);
- couples and families therapy (Dattilio, 1993, 1998, 2001, 2005, 2010; Dattilio & Padesky, 1990; Epstein, 2006);
- child abusers, divorce counseling, skills training, and stress management (Dattilio, 1998; Granvold, 1994; Reinecke, Dattilio, & Freeman, 2002).
- There are several strengths of cognitive behavioral approaches in working with individuals from diverse cultural, ethnic, and racial backgrounds.

Clearly, cognitive therapy programs have been designed for all ages and for a variety of client populations.

### 3.4.3 EVALUATION:

**Contributions of the Cognitive Therapy:**

Research has demonstrated the efficacy of cognitive therapy for a variety of problems (Leahy, 2002; Scher, Segal, & Ingram, 2006). Cognitive therapy has been applied to a wide range of clinical populations. Beck demonstrated that a structured therapy that is present centred and problem oriented can be very effective in treating depression and anxiety in a relatively short time. One of Beck's major theoretical contributions has been bringing private experience back into the realm of legitimate scientific inquiry (Weishaar, 1993). A strength of cognitive therapy is its focus on developing a detailed case conceptualization as a way to understand how clients view their world.

**Limitations and Criticisms of the Cognitive:**

Cognitive therapy has been criticized for (Freeman & Dattilio, 1992; Weishaar, 1993) -

- Focusing too much on the power of positive thinking; being too superficial and simplistic;
- denying the importance of the client's past
- being too technique oriented;

- failing to use the therapeutic relationship;
- working only on eliminating symptoms,
- failing to explore the underlying causes of difficulties;
- ignoring the role of unconscious factors; and
- neglecting the role of feelings

Although the cognitive therapist is straightforward and looks for simple rather than complex solutions, this does not imply that the practice of cognitive therapy is simple. However, they do recognize that clients' current problems are often a product of earlier life experiences, and thus, they may explore with clients, especially those with Axis II disorders, the ways their past is presently influencing them.

## 3.5 REFERENCE

1. Corey, G. (2013). Theory and Practice of Counseling and Psychotherapy (9th ed.). CA: Thomson Brooks.

*****

# 4

# TECHNIQUES IN GROUP

**Unit Structure**



## 4.1 INTRODUCTION

Groups are a promising framework to deliver services to the largest number of people sharing the common qualities, whether demographic, cognitive, emotional, personality, values etc. Thus, many people can be addressed based on their common need at a time forming a group that allows to save time. For this reason, having several clients meet as a group for a common purpose can save considerable time and effort. Many people have feelings they believe to be unique. Being a member of a group allows them to discover that they are not the only ones to have those particular thoughts, concerns and feelings.

Group therapy/ psychotherapy means more than one individual are being treated at the same time by at least one therapist. Some groups may have more than one therapist. Group sizes vary depending on the type of therapy. Group psychotherapy is a valuable and, in some cases, indispensable treatment method. It may be utilized (1) independently, during which both intrapsychic and interpersonal operations are considered; (2) in combination with individual therapy conducted by the same therapist (“combined therapy”)—individual sessions deal with the patient’s resistances, transferential responses to the therapist, and primary separation anxiety, while group sessions focus chiefly on interpersonal phenomena; (3) in conjunction with individual therapy conducted by

another therapist ("conjoint therapy"); and (4) as leaderless groups particularly after formal group therapy has ended (Kline, 1975).

## 4.2 FUNDAMENTALS OF GROUP THERAPY

### 4.2.1 Influences:

Phenomena are mobilized that may have an influence on each individual, when people gather together in a group. This encourages one to express oneself openly. The person soon discovers that the group fosters free expression of feelings or attitudes on any subject. There are no social taboos on content usually avoided in everyday interactions. The recognition that fellow members harbour the same fears and doubts, can be reassuring in a group. Hence, the individual finds that problems can be shared with others without rejection or ridicule, apart from the emotional catharsis that is experienced. This enhances self-esteem and self-confidence.

People in a group may reinforce each other's rational reactions, as they collectively make up the norm from which they individually deviate. The fluctuating group interaction is influenced by levels of tension that affect participation, the sharing of ideas, and decision making. Feelings that are controlled and verbalizations related to them suppressed or repressed in the usual group setting, are encouraged and even rewarded in the therapeutic group by approval from the therapist. The individual gradually learns to accept criticism and aggression without falling apart. The fear of becoming violent and in turn being subject to physical attack and humiliation lessen. The group judgment is a moving force that cannot be resisted. Where a number of members share an opinion about an individual or behaviour, the effect may be more intense than an interpretation by the therapist.

The group strengthens the individual's ability to express feelings toward the therapist, whether rational or irrational; one may be unable to do this during individual therapy. One of the most important consequences of being in a group geared toward reconstructive goals is learning how emotional processes operate by observing how other members talk about and solve their problems. Dynamic thinking soon becomes a dominant mode in the group. Awareness of inner psychological operations is also sharpened through emotional involvements with other group members, through one's own spontaneous discoveries, and through interpretations from fellow members and the therapist. Instead of withdrawing, as in a usual life situation, the patient is encouraged to hold his or her ground and to express and analyze feelings and defenses.

### 4.2.2 Advantages:

Diversified intrapsychic defenses come out toward members of the group with whom the patient plays varying roles. Multiple transferences, both sequential and simultaneous, are readily established. The opportunity to relate in different ways to fellow members enables the individual to work

through insights in the direction of change. Within the group the patient feels more protected, both by the therapist and by members with whom alliances have been formed, and he or she may be able to practice new attitudes more propitiously. Some of the major advantages of group therapy are the opportunities to:

- see that one is not alone in one's suffering and that problems felt to be unique are shared by others;
- break down one's detachment and tendencies to isolate oneself
- correct misconceptions in ideas about human behaviour by listening to others and by exposing oneself to the group judgment
- observe dynamic processes in other people and to study one's own defenses in clear perspective in relation to a variety of critical situations that develop in the group;
- modify personal destructive values and deviancies by conforming with the group norm
- relieve oneself of tension by expressing feelings and ideas to others openly;
- gain insight into intrapsychic mechanisms and interpersonal processes,
- observe one's reactions to competition and rivalry that are mobilized in the group
- learn and to accept constructive criticism
- express hostility and to absorb the reactions of others to one's hostility
- consume hostility from others and to gauge the reasonableness of one's reactions
- translate understanding into direct action and to receive help in resolving resistances to action
- gain support and reassurance from the other members when one's adaptive resources are at a breaking point
- help others which can be a rewarding experience in itself
- work through problems as they precipitate in relationship with others
- share difficulties with fellow members;
- break down social fears and barriers
- learn to respect the rights and feelings of others, as well as to stand up to others when necessary

- develop new interests and make new friends;
- perceive one's self-image by seeing a reflection of oneself in other people;
- develop an affinity with others, with the group supplying identification-models
- relate unambivalently and to give as well as to receive
- enter into productive social relationships, the group acting as a bridge to the world

Thus, in a group therapy, the group is acting as a unit that replicates the family setting and sponsors reenactment of parental and sibling relationships.

### 4.2.3 Organizing Group:

Group participants should be those who are sufficiently advanced in their understanding of themselves to be able to perceive their patterns as they will appear in the group setting. Though clinical diagnosis is not too important in psychotherapy, the conditions and patients with - i) Psychopathic personalities and those with poor impulse control, ii) Acute depressions and suicidal risks, iii) Stutterers, iv) True alcoholics, v) Hallucinating patients and those out of contact with reality, vi) Patients with marked paranoidal tendencies, vii) Hypomanics, and viii) Patients with a low intelligence – perform poorly in a group, except perhaps when implemented by an experienced group therapist in a homogeneous group within an inpatient setup through supportive or reeducative group methods.

Some other essential characteristics that should be taken care of while organizing or forming a group are as follows:

- The age difference should preferably not exceed 20 years
- Homogeneity in educational background and intelligence is desirable, but not imperative
- A well-balanced group often contains an "oral-dependent," a "schizoid-withdrawn," a "rigid-compulsive," and perhaps a "provocative" patient, such as one who is in a chronic anxiety state
- The number of group members may range optimally from 6 to 10; which can be reduced in case a therapist feels uncomfortable with a large group.
- Marital status is relatively unimportant
- A balance of males and females, that allows for an opportunity to project and to experience feelings in relation to both sexes.

- A heterogeneous group in terms of age, sex, and syndrome is most effective for reconstructive goals
- A homogeneous group composed of patients with the same problem, is best for alcoholism, substance abuse, obesity, smoking, sexual problems, insomnia, phobias, depression, delinquency, stuttering, criminality, marital problems, divorce, and geriatric problems, although an occasional person with such problems may do well with and stimulate activity in a heterogeneous group.
- Adolescents seem to be more responsive in same-sex, same-age groups.
- The length of a group therapy session is approximately H to 2 hours.
- The frequency of meetings is one to two sessions weekly, with alternate sessions once weekly if desired
- The best seating arrangement is in a circle

### 4.2.4 Opening and Later Sessions:

**a) Opening Sessions:** At the first session the members are introduced by their first names, and the purpose of group discussions is clarified. This will vary with different therapists and different groups. The more passive-dependent the patient, the more leadership will be demanded of the therapist. The technique employed during the opening session will be determined by the therapist's orientation and level of anxiety.

Some therapists begin by simply stating that the group offers members an opportunity to talk about their feelings and eventually to understand their individual patterns. It is not necessary for the members to feel compelled to reveal something that they want to keep to themselves. However, communicating freely will help them to get a better grip on their problems. Before the close of the first session, some therapists find it advisable to stress the confidential nature of the meetings and to caution that each member is expected not to reveal to others the identity of the members and the subject matter discussed in the group.

Therapists who strongly believe that acting out is harmful will discourage any contact outside of the group, in all probability. Sexual involvements may be forestalled by fostering verbalization of the patients' feelings and impulses toward each other. Usually the anxiety level drops markedly at the end of the first session, but rises temporarily at the outset of the second session. During the early stages of treatment, some therapists who are anxious to prevent acting-out at any cost will, at first, assume a dictatorial role that contrasts sharply with their role in individual sessions. Parenthetically, this may lead to more acting-out. They may try to keep patients from exposing painful revelations before the group is ready to support them.

Free verbal interaction may be encouraged in the group in order to bring out each member's customary facades and defenses. Often individual members in their temporary authority posts may initiate ways of eliciting meaningful material. This may take the form of giving each person an opportunity to express him or herself at each session, or there may be a much more informal arrangement with the members spontaneously expressing what is on their minds at the moment. There is no need for procedural structuring; and it should not be rigidly controlled at any time.

Thus in the opening session, the content of discussions will vary greatly, covering current incidents of importance in the lives of each member, dreams, attitudes toward others in the group or toward the therapist, and general areas, such as family relations, sex, dependency, and competition.

**b) Later Sessions:** In later sessions, the therapists must be constantly on the alert for covert transference manifestations that relate directly to them but are being diluted by references to others. The therapist can advantageously analyze the structure of the group as it displays itself in a particular session and designate the roles played by the different members, thus delineating the defense mechanisms displayed by the individual members. As the group becomes integrated, the patient gains more insight into personal difficulties recognizing that many troubles previously believed unique have a common base.

Hence, the therapist should direct energies toward stimulating thinking around universally shared problems, getting responses from other group members even though the subject under consideration is out of the ordinary. The patients may be asked to talk about personal impressions of the role the therapist is playing in the group. There are three trends in transference, that may take place (Grotjahn, 1973) in later sessions: (1) transference to the therapist and central figure (e.g., paternal figure), (2) transference to peers (e.g., sibling), and (3) transference to the group itself (e.g., pregenital mother symbol). These different transference relationships are always present simultaneously, patients treating the group as if it were their own family. The basic rule in a group setting is for members individually to express themselves as freely and without restraint as possible. This encourages the disclosure of forbidden or fearsome ideas and impulses without threat of rejection or punishment.

In later sessions, The interactional processes virtually do put the various group members in the role of cotherapists. Under the guidance of the therapist this role can be enhanced. The specific effect of member "cotherapists" may be analytic or it may be more supportive, encouraging, accepting, and empathic, thus providing an important dimension to supplement the work of the therapist. Among the therapist's activities during these sessions, are clarifying, structuring, focusing, timing, interpreting individual and group resistances, encouraging group interaction, and clarifying group interrelations. Reactions of the patient occur in complex clusters as a release of feeling within the group is accelerated. Lack of restraint in one group member often results in a similar lack of restraint in the others.

### 4.2.5 Technical Functions of Group Therapists:

Therapist's roles, as a group leader, include many technical functions. They are listed down below:

- to catalyze participation of the various members,
- to maintain an adequate level of tension,
- to promote decision making and problem solving,
- to encourage identifications, to foster an interest in the goals to be achieved, and
- to resolve competitiveness, resentments, and other defenses that block activity
- to deal with overt obstructions in the form of resistances from group members, like coming late, socializing too much, getting frozen into interlocking roles
- to constantly remind the members that they are not there to act as professional psychoanalysts, attempting to figure out dynamics and to expound on theory
- to focus on the conversational theme around pertinent subjects when topics become irrelevant
- to creating tension by asking questions and pointing out interactions when there is a slackening of activity in the group
- to pose pointed questions to facilitate participation
- to deal with individual and group resistances
- to support upset members
- to encourage withdrawn members to talk.
- to interfere with hostile pairings who upset the group with their quarrelling
- to reminding the group that communication about and understanding of mutual relationships is more important than interpreting dynamics
- to manage silence, which tends to mobilize tension in the group
- to gauge and regulate group tension and anxiety
- to detect resistances of the group as a whole as well as of the individual members.

## 4.3 SPECIAL PROBLEMS DURING GROUP THERAPY

The management by the therapist of special problems among patients will be essential where they obstruct group interaction. Some of the examples of such special problems are as follows:

**The Salient Patient:**

Since the response will be hesitant and unsure, more aggressive patients may attempt to interrupt to take the floor over for themselves. The therapist may block this subterfuge and continue to encourage the reluctant patient to articulate. The patient may also be asked directly to report on any dreams.

**The Monopolizer**:

The aggressive, narcissistic patient, often called monopolizer, who insists on dominating the session will usually be interrupted by one or more members who resent this takeover. Where this does not occur, the therapist may halt the patient by asking another member what he or she is thinking about or by directing a question at the group as to whether they want the monopolizing patient to carry on all the discussion.

**The Quarreling Dyad:**

The best way to deal with this phenomenon is by working toward each participant's tracing of the transferential roots of the enmity in order to recognize how both are projecting unconscious aspects of themselves on each other.

**Acting-out Patients**:

acting-out can be a disturbing phenomenon in groups. The therapist may caution the members to talk out rather than to act out. The group members may be required to report at a regular session the activities engaged in between members outside the group. The therapist may try to reduce the anxiety level of the group.

**The Private Session in the Group:**

Some patients will attempt to utilize the group time to get a private session with the therapist. They will look at and direct their conversation to the therapist, ignoring the presence of the group. The therapist may ask the patient to focus remarks on the group, may question the group as to how they feel about the patient's carrying on an intimate discussion with the therapist, may ask other members to associate to the patient's verbalizations, and finally, may suggest that the patient come in for a private session.

**The Habitual Latecomer:**

The latecomer ultimately may be threatened with removal from the group if he or she does not come on time. The group members should be encouraged to deal with this problem, not just the therapist.

**The Patient Who Insists that He or She Is Getting Worse not Better**:

Such patients can influence the group morale and may be disturbing, especially to new members. The therapist may handle such a reaction by nondefensively citing examples from the progress made by various members of the group to disprove the thesis that therapy does not help and, where applicable, may point out the aim of the complainant to drive certain members (especially new members) out of the group.

**The Accessory Therapist:**

It may be a way of seeking favour with the therapist. It may be a gesture to compete with and replace the therapist. Irrespective of its basis, the patient may soon gather about him a group of followers as well as adversaries. The best way to handle this maneuver is to ask the other members what they think is happening, until the therapeutic pretender quiets down. The therapist may also ask the competing patient why he or she feels obliged to "play psychoanalyst."

**Mobilizing Activity:**

Where progress has bogged down and members seem to be in a stalemate, one may stir up activity by (1) asking the group why this is so, (2) introducing psychodrama or role playing, (3) asking a member to talk about the role assumed in the group, then going around the group requesting the other members to comment, (4) asking each member to talk about feelings concerning the two people on either side of him or her, (5) utilizing one or more techniques of encounter or Gestalt therapy, (6) extending the length of a session up to the extent of a marathon session, (7) introducing several new members into the group, (8) determining the nature of the resistance and interpreting it, (9) shifting some old members to a new group, (10) introducing a borderline patient into the group whose anxiety level is high, (11) taking and playing back video tapes of the group in action, (12) pointing out which stimuli in the group release repetitive patterns in each patient and interpreting their ramifications in outside relationships.

## 4.4 GROUP THERAPY APPROACHES:

### 4.4.1 Pre-Intake and Post-Intake Groups:

**Pre-Intake Groups:**

These groups act as a forum for discussion and orientation, and are a valuable aspect of clinic functioning where a delay is unavoidable before formal intake. Up to 20 people may attend, and sessions may be given at weekly, bimonthly, and even monthly intervals. Example, Parents of children awaiting intake may be organized into such type of group, which may meet for 3 to 6 monthly sessions.

**Post-Intake Groups:**

They may take place before permanent assignment, and meetings may be spaced weekly or up to 1 month apart. Here some therapeutic changes are

possible as disturbing problems are introduced and elaborated. These preliminary groups serve as useful means of selecting patients for ongoing group therapy. They are worthy orientation and psychoeducation devices and help prepare and motivate patients for therapy.

### 4.4.2 Special Age Groups:

- **Group therapy with children** is usually of an activity nature. The size of children's groups must be kept below that of adult groups (Geller, 1962). Single-sex groups are (1) from 6 to 8 years, which optimally consist of three to five members; (2) from 8 to 12 years, which may have four to six members; (3) from 12 to 14 years, which may contain six to eight youngsters; and (4) from 14 to 16 years, which have the same number. Mixed-sex groups at the oldest age level are sometimes possible. Play therapy is the communicative medium up to 12 years of age, the focus being on feelings and conflicts. Beyond 12 years discussions rather than play constitute the best activity medium. Techniques include analysis of behaviour in the group, confrontation, and dream and transference interpretation. Techniques include analysis of behaviour in the group, confrontation, and dream and transference interpretation. discussion take place at various intervals. Interventions of the therapist should be such so as not to hamper spontaneity. Discussion is stimulated by the therapist, and silences are always interrupted. individual therapy is carried on conjointly with group therapy, particularly at the beginning of treatment.

- **Group psychotherapy with older people** has met with considerable success in maintaining interest and alertness, managing depression, promoting social integration, and enhancing the concept of self in both affective and organic disorders (Goldfarb & Wolk, 1966). Here, the goal is reconstructive, and old individuals may be mixed with younger people.

### 4.4.3 Behaviour Therapy:

Behavioral techniques (Lazarus 1968; Meacham & Wiesen, 1974; Wolpe, 1969; Liberman, 1970; Fensterheim, 1971) are largely used in groups. behavioural change may be achieved by the employment of methods such as behavioural rehearsal, modelling, discrimination learning, and social reinforcement. Homogeneous groups seem to do best, the selection of members being restricted to those who may benefit from the retraining of specific target behaviours. Individually oriented behavioural interventions may be employed alone in a group setting, or in combination with psychodrama, role playing, Gestalt tactics, encounter maneuvers, or formal group therapy procedures (inspirational, educational, or analytic) depending on the training and flexibility of the therapist.

The size of the group varies from 5 to 10 individuals. A cotherapist is valuable and sometimes indispensable as in the treatment of sexual problems. The initial few sessions may be relatively unstructured to help facilitate the group process. The time of sessions varies from 1½ to 3 or 4

hours. During the starting sessions members are encouraged to voice their problems and to define what they would like to achieve in the sessions, the therapist helping to clarify the goals.

Feedback is provided with confrontation of the reactions of the other members to the patient's own verbalizations and responses. This gives the patient an opportunity to alter these if it is desired. Modelling oneself after how others approach and master the desired behaviour is an important learning modality. The therapists may engage in role playing or psychodrama to facilitate modelling. Behaviour rehearsal similarly employs role playing involving the patient directly. Repetition of the process with different members helps solidify appropriate reactions, the patient engaging in role reversal when necessary. Counterconditioning and extinction methods (systematic desensitization, role playing with the introduction of the anxiety provoking stimulus, encouraging expression of forbidden emotions in the group like anger) eventually lead to desensitization. The therapist provides direction and guidelines for appropriate behaviour, which with the pressure of the group, helps create motivation and social reinforcement. Support is provided the patient when necessary. Specific assignments outside the group may be given the patient.

Relaxation methods may be employed in a group for the relief of tension and such symptoms as insomnia. Behavioural tactics are ideally suited for habit disorders related to eating, such as obesity, smoking, gambling, alcoholic over-indulgence, and substance abuse. Where problems are centred around lack of assertiveness, assertiveness training can be highly effective. Special exercises are employed with role playing depending on problems of individual members, such as talking in a loud voice, behaving unpleasantly, telling an interesting story, expressing a warm feeling toward other group members, practicing progressive expressions of anger. Phobias respond remarkably well to group behavioural methods. Here, the patient selection must also be homogeneous as in assertive training. Other phobias may be treated in a group setting introducing whatever modifications are essential considering the nature of the target symptom. Videotaping and playback may be employed in the sessions.

### 4.4.4 Experiential Therapy:

The traditional model, which focused on inspiration, education, and insight acquisition, has been supplemented by groups whose objective is experiential with a wide variety of techniques. Many names have been given to these new arrangements including Gestalt, human relations training, human awareness, leadership training, T-groups, sensitivity therapy, and encounter therapy. The time element (traditionally 90 minutes) has been stretched sometimes to several hours, 12 hours, 24 hours, or several days with time off for sleep (marathon groups). Encounter therapy may be an ongoing process like any other form of group therapy, or it may be brief, from one to a dozen sessions. A constructive group experience with a small group of people who are educationally on a relatively equal level and who permit themselves to

disclose their self-doubts and personal weaknesses can be most liberating to the participants. Interpersonal confrontations, while temporarily upsetting, may even ultimately bring the individual into contact with repudiated aspects of himself or herself in such therapy sessions.

Under the guidance of a skilled group leader the encounter group becomes a means through which the members become aware of how they are creating many of their own troubles. By talking things out they are able to correct some of their misperceptions. The effects of the encounter group can be psychotherapeutic, particularly in persons who are ready for change and who already have, perhaps in previous psychotherapeutic experiences, worked through their resistances to change.

The usual marathon group exposes group members to constant association of approximately 30 hours, generally in the course of which a 5-hour break is taken. During the first 15 hours of interaction there is a gradual sloughing off of defenses, and, in the last hours, a "feedback" is encouraged in which the therapist enjoins the patients to utilize the understanding of themselves to verbalize or execute certain constructive attitudes or patterns. Experiential therapies are sometimes resorted to by psychotherapists when their patients have reached a stalemate in individual or group therapy. Generally, the individual entering an experiential or marathon group is instructed in the responsibility that he or she has in the group, the need for physical restraint and abstinence from drugs and alcohol, and the fact that while one's behaviour in the group is related to one's life style, that there may be new and better ways of relating that one can learn. Negative outcomes with experiential groups are to be expected in view of the superficial screening of the participants and the large number of untrained leaders who contact these groups with few or no limits on the selection of techniques.

### 4.4.5 Psychodrama and Role Play:

Moreno (1934, 1946, 1966b) created a useful group therapy method, "psychodrama," which he first introduced in 1925 and that has evolved into a number of clinical methods, including sociodrama, the axiodrama, role playing, and the analytic psychodrama. Many of these have been incorporated into modern Gestalt, encounter, and marathon therapy. In the hands of a skilled therapist psychodrama is a valuable adjunct in helping patients work through resistances toward translating their insights into action.

The initial tactic in the group is the "warm-up" process to facilitate movement. This may take the form of the director (the therapist) insisting that the group remain silent ("cluster warm up") for a.period. As tension mounts, it will finally be broken by some member expostulating about a problem, the verbalizations drawing a "cluster" of persons around the member. Other members may similarly come forth with feelings and stimulate "clusters" interested in what they are saying. Soon the whole group is brought together around a common theme.

Another warm-up method is the "chain of association." Here the group spontaneously brings up fears and associations until an engrossing theme evolves.

A third warm-up is initiated by the director ("directed warm-up") who, knowing the problems of the constituent members, announces the theme. A "patient-directed warm-up" is one in which a patient announces to the group the subject with which he or she would like to deal.

The director facilitates the working together of the group on their problems, while focusing on one person (the "protagonist"). Among the techniques are (1) "role reversal," during which a protagonist and auxiliary reverse positions; (2) "the double," another member seconding for and supporting the protagonist; (3) "the soliloquy," characterized by a recitation by the protagonist of self-insights and projections; and (4) "the mirror," auxiliary egos portraying what the protagonist must feel. Role reversal is a useful technique in psychodrama, two related individuals, for example, taking the role of one another expostulating how they imagine the other feels or portraying the behaviour of the other. Where a protagonist is involved emotionally with an absent person, the latter may be portrayed by an auxiliary ego. The psychodramatic technique has given rise to a number of role-playing methods that are being applied to education, industry, and other fields.

## 4.5 REFERENCE

1. Wolberg, L. R. (2005). The Technique of Psychotherapy Part I and II: NJ: Jason Aronson, Inc.

*****

# 5

# INTERVENTIONS EMPHASIZING INTEGRATION, ECLECTIC SYSTEMS, MULTICULTURAL PERSPECTIVES

**Unit Structure**



## 5.1 INTRODUCTION

In this chapter, we will learn other important counselling approaches, known as integrated and eclectic interventions, multicultural counselling, and some influential approaches to multicultural counselling. Let us have a detailed look at each of them.

## 5.2 INTEGRATED AND ECLECTIC INTERVENTIONS

Many factors account for this trend toward integrative and eclectic treatment. Chief among them is the fact that no single theory has yet been found that can clearly capture the entire range of human experiences across the life span. Instead of viewing clients in the context of their sociocultural environment, these practitioners concentrate too much on

problems within the individual. A large number of therapists identify themselves as "eclectic," and this category covers a broad range of practice. The integrative approach is characterized by openness to various ways of integrating diverse theories and techniques.

### 5.2.1 Reasons for the Growth of Eclectic and Integrated Apporach:

The following 12 factors have combined during the past 30 years to move clinicians in the direction of preferring integrative and eclectic approaches over adherence to one specific treatment system (Prochaska & Norcross, 2007):

1. The large and growing number of approaches to treatment; more than 400 treatment systems have been identified

2. The increasing diversity and complexity of clients and their concerns

3. The inability of any one treatment system to successfully address all clients and all problems

4. The growing importance of solution-focused brief approaches that encourage clinicians to draw on and combine interventions from various systems of therapy to find the most effective and efficient strategy for each treatment situation

5. The availability of training opportunities, as well as case studies and other informative literature, that give clinicians the opportunity to study, observe, and gain experience in a wide variety of treatment approaches

6. The requirement of some state and national credentialing bodies that clinicians obtain post graduate continuing education units; this encourages continued professional growth and development of new skills and ideas

7. Increasing pressure from managed care organizations, governmental agencies, consumers, and others for clinicians to determine the most effective and efficient treatment approach for each client, to plan and document their work, and to maintain accountability

8. The growing body of compelling research demonstrating which treatment approaches are most likely to be successful in the treatment of particular people, disorders, or problems (Seligman & Reichenberg, 2007).

9. The increasing availability of manuals, providing detailed and empirically validated treatment plans for specific mental disorders

10. The development of organizations such as the Society for the Exploration of Psychotherapy Integration that focus on studying and promoting treatment integration

11. The emergence of models providing blueprints or guidelines for logical and therapeutically sound integration of treatment approaches

12. Clinicians' increasing awareness that common factors among treatment approaches, such as the nature of the therapeutic alliance, are at least as important in determining treatment success as are specific strategies.

### 5.2.2 Nature of Integrated and Eclectic Approaches:

When clinicians first began to describe their theoretical orientations as eclectic, the term lacked a clear meaning; it simply suggested that clinicians drew on more than one approach to treatment. While some clinicians who characterized their work as eclectic were gifted therapists and astute theoreticians with a clear rationale for combining interventions in their work, some clinicians who characterized their work as eclectic were gifted therapists and astute theoreticians with a clear rationale for combining interventions in their work, others lacked a thoughtful and systematic approach to treatment. Without a logic or structure, eclecticism can lead to treatment that is haphazard and inconsistent, lacking in direction and coherence.

Eysenck (1970) denounced what he referred to as "lazy eclecticism" (p. 140) the use of a grab bag of interventions, combined without an overriding logic. Such an approach reflects a lack of knowledge and professionalism and is incompatible with current emphases on accountability and treatment planning in counselling and psychotherapy. Following are the four identified types of eclecticism listed below with the brief description of each approach:

1. **Atheoretical eclecticism** is characterized by combining interventions without an overriding theory of change or development.

2. **Common factors eclecticism** hypothesizes that certain elements of treatment, notably a therapeutic alliance that communicates support, empathy, and unconditional positive regard, are primarily responsible for promoting client growth and change (Hansen, 2002).

3. **Technical eclecticism** provides a framework for combining interventions from different treatment systems without necessarily subscribing to the theories or philosophies associated with those interventions.

4. **Theoretical integration** offers conceptual guidelines for combining two or more treatment approaches to provide a clearer understanding of clients and more effective ways to help them.

### 5.2.3 Integrating Treatment Systems:

Although most clinicians do not adhere to a systematic approach to theoretical integration, they probably have formulated their own logic for combining compatible theories. The most common combinations of theories, in descending order of frequency, include (1) cognitive and

behavioural treatment systems, (2) humanistic and cognitive approaches, and (3) psychoanalytic and cognitive approaches (Prochaska & Norcross, 2007).

**Characteristics of Sound Integrated and Eclectic Approaches:**

Sound eclecticism has the following characteristics: i) Evidence of building on the strengths of existing theories, ii) A coherent combination of theories that creates a unified whole, iii) An underlying theory of human behaviour and development, iv) A philosophy or theory of change, v) Logic, guidelines, and procedures for adapting the approach to a particular person or problem, vi) Strategies and interventions, related to the underlying theories, that facilitate change, vii) Inclusion of the commonalities of effective treatment, such as support, positive regard, empathy, and client–clinician collaboration.

### 5.2.4 Formulating An Integrated Eclectic/Treatment System:

When clinicians formulate an integrated or eclectic treatment system, they must address many questions, including the following:

1. What model of human development underlies the theory?
2. How does this treatment approach suggest that change is best facilitated?
3. What information should be obtained in an intake interview?
4. What conception does this approach have of the influence of the past on the present, and how should past experiences and difficulties be addressed in treatment?
5. How important is insight in promoting change, and how much attention should be paid in treatment to improving insight?
6. How important is exploration of emotions in promoting change, and how much attention should be paid in treatment to helping people identify, express, and modify their emotions?
7. How important is identification and modification of dysfunctional cognitions in promoting change, and how much attention should be paid in treatment to helping people alter their cognitions?
8. How important is identification and modification of self-destructive and unhelpful behaviours in promoting change, and how much attention should be paid in treatment to helping people alter their behaviours?
9. What sorts of people and problems are likely to respond well to this approach?
10. In what treatment settings and contexts is this approach likely to be successful?

### 5.2.5 Skill Development: Treatment Planning:

Treatment planning serves the following four purposes (Seligman, 2004a): i) A carefully developed plan, grounded in research on treatment effectiveness, provides assurance that counselling or psychotherapy is likely to succeed, ii) A treatment plan specifying goals and strategies helps clinicians and clients to track progress, determine whether goals are being met, and, if not, revise and improve the plan, iii) Treatment plans provide structure and direction to the therapeutic process. They help clinicians and clients to develop shared and realistic expectations for treatment and promote optimism that treatment will be helpful, and iv) Treatment plans, in conjunction with post-treatment evaluations, allow clinicians to determine and demonstrate their effectiveness. Treatment planning is particularly important for clinicians who follow integrated or eclectic approaches to treatment. A treatment plan can organize the disparate elementsof various theories into a cohesive whole, clarify the sequence of interventions, and help ensure that treatment strategies address the entire range of clients' concerns.

Clinicians should explore clients' difficulties and symptoms; gain some understanding of their strengths, weaknesses, and context; and develop at least a preliminary connection with clients before moving into treatment planning. In addition, the treatment plan should be viewed as a work in progress; as clients develop hope that treatment can help them, as theyshare more of themselves in their sessions, and as they make progress, the treatment plan may need to be changed. Adhering doggedly to an outdated and inappropriate treatment plan can lead to ineffective treatment and can damage the therapeutic alliance. The purpose of the plan is, of course, to map out the treatment process for a given client. The 12 steps in this comprehensive treatment process include:

i) **Diagnosis:** The first step in treatment planning is making an accurate diagnosis of a person's difficulties using the multiaxial assessment format and diagnostic terminology of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000).

ii) **Objective of treatment**: Once problems and symptoms have been explored and a diagnosis formulated, client and clinician collaborate in establishing written objectives for treatment that address the diagnoses and problems presented by the client.

iii) **Assessments:** Clinicians often use assessment tools to enhance their efforts to make accurate diagnoses, establish worthwhile and viable objectives, and measure progress.

iv) **Clinician:** Variables that characterize the sort of clinician likely to work well with a given client are specified in this section of the treatment plan.

v) **Location of treatment**. This item specifies whether treatment should be inpatient, outpatient, or an alternative such as a day treatment program and might suggest a specific agency or treatment facility,

vi) **Interventions.** This part of the plan provides two important pieces of information. First, the treatment approach is specified (e.g., cognitive therapy, solution-focused brief therapy, Gestalt therapy).

vii) **Emphasis.** Although many clinicians share a particular theoretical orientation, no clinician ever does exactly the same thing as another clinician, nor does a given clinician practice in exactly the same way with each client.

viii) **Number of people seen in treatment.** This section of the treatment plan specifies whether individual, family, or group therapy will be the primary mode of intervention.

ix) Timing. This part of the plan encompasses four scheduling aspects of the therapeutic process: the length of each session, the frequency of sessions, the duration of treatment, and the pacing of the treatment process.

x) **Medication.** Psychologists, counselors, and social workers often collaborate with psychiatrists in treating clients who require medication.

xi) **Adjunct services.** Most clients benefit from adjunct services

xii) **Prognosis.** This last step specifies the likelihood of clients achieving the specified objectives according to the treatment plan.

### 5.2.6 Benefits of and Integrated Eclectic Approaches:

Some of the benefits of integrated and Eclectic interventions are as follows:

- They bring flexibility to the treatment process
- Enable clinicians to tailor their work to specific clients and concerns in an effort to find a good fit between treatment and client
- Enable clinicians to demonstrate multicultural competence by creating integrated treatment plans that reflect sensitivity to clients' culture and context.
- Allow clinicians to adapt standard treatment approaches to their own beliefs about human growth and development as well as to their natural style and personality.
- Clinicians can expand on that foundation by incorporating into their work ideas that have face validity as well as strategies that they have used successfully with other clients.

### 5.2.7 Challenges of Integrated and Eclectic Approaches:

Clinicians who view their primary theoretical orientation as eclectic or integrated need expertise in a range of treatment systems so they can draw on those approaches in creating effective treatment plans. Clinicians who have an eclectic or integrated orientation also set limits on the scope of their practice; no clinician could have sufficient knowledge and expertise in the entire range of therapeutic approaches to treat all clients and all problems. They must carefully think through their treatment of each client to ensure that the disparate parts of treatment comprise a seamless whole in which each intervention is chosen deliberately to accomplish a purpose. Their treatment must not just be an amalgam of "tricks of the trade" but, rather, should reflect coherence, relevance, and planning and be solidly grounded in both theory and empirical research. Thus, clinicians who prefer eclectic or integrated treatment approaches still have a professional role that is more comprehensive and challenging than that of clinicians with a specific theoretical orientation.

## 5.3 EFFECTIVE MULTICULTURAL COUNSELLING

Theories of multiculturalism are considered the fourth force in the family of theories. Multiculturalism argues that people are a product of their culture and deserve to be understood foremost as such. Considering counselling and psychotherapy from a multicultural view is challenging in that these are professional endeavors conceived of and developed within a very Western cultural frame. As is true with the definition of multicultural, there is controversy within the domain of multicultural counselling about what groups to include when one considers diversity (D. W. Sue & Sue, 2003). Most multicultural thinkers acknowledge these differences but believe that to call all counseling multicultural misses the point of the power of culture in our lives.

### 5.3.1 Historical Context And Important Contributors to Multiculturalism:

Many writers, practitioners, and researchers have contributed to current multicultural theories. Few of them are mentioned here. Second-generation Chinese brothers (all of whom are trained in psychology) Derald Wing Sue, Stanley Sue, and David Sue have been strong voices in general multicultural theory for well over 30 years. Apart from them, Allen and Mary Bradford-Ivey, along with many coauthors and researchers, namely, Paul Pederson, Joseph Trimble, Pat Arredondo, and Teresa LaFromboise have also contributed to multiculturalism. Also, Freddy Paniagua has worked steadily on the issues of diagnosis and assessment in a multicultural society.

It came into existence—or, more accurately, was driven into being—by the painful recognition that the worldview of the privileged White male was not the only viable worldview on the face of the planet. There are many appalling historic examples of the misapplication of Western psychological theory and technique to non-White and non-male

populations. In the worst scenarios, White, upper-class males made sweeping statements about what was good or bad for individuals from other cultures.

For one group to claim that another group is benefiting from systematic oppression is a foundation for stereotyping, prejudice, and all forms of racism, classism, ageism, and sexism. From the multicultural perspective, the dominant culture's tendency to identify what's good for nondominant groups includes a series of amazing oversights. That is, the dominant culture forgot to (and still forgets to):

- Try systematically to understand the perspective of the nondominant group by simply asking them for their opinion on the subject—and listening to their answers!
- Step into the alternative culture in an effort to deepen mutual understanding and respect.
- Consider that the nondominant group might not speak up on its own behalf for fear of reprisal.

Before understanding multiculturalism, it is imperative to understand culture. While describing culture, Christopher (1996) states:

Culture permeates our lives much more thoroughly or pervasively than we tend to consider. Because of Western culture's individualistic orientation, we tend to think of the individual first and of culture second. . . . What this tendency to give primacy to the self overlooks is the manner in which culture precedes us. (p. 17).

Christopher helps us understand that cultural development often precedes individual development. He further states, "Our social practices, institutions, family structures, and daily life make sense and 'hang together' because of these webs of significance" (p. 17). Further, he points out that culture shapes us, gives us views of human nature, and provides our moral frame work. Thus, culture tells us both what should be considered a good life and what should be considered deviant. Humans are group-seeking creatures. Even as scholars have tried to understand the irrational social forces behind the rise of racism, fascism, or other fundamentalist movements, they recognize that "the striving for self-worth by belonging to a strong and glorious 'we' is an important force even in the development of 'normal' ethnic, religious, and national movements" (Suleiman, 2002, p. 33). Thus, Culture plays a central role in defining what it means to be human. Culture is understood as a set of learnings one obtains from the environment into which one has been born or the environment in which one is functioning (Axelson, 1999). There are many dimensions to culture, and specific definitions of culture are often based on whether or not certain of these dimensions are included.

Counselors working with young people can find the application of multicultural counselling principles most helpful. The term **multicultural** is relatively new and is not without political baggage. Webster's

Dictionary offers this definition: "Of, relating to, or designed for a combination of several distinct cultures." Terms like cross-cultural and intercultural tend to insinuate the same set of values and concerns, but most writers have settled on a preference for the term multicultural. Transculturalists are more focused on the commonalities between cultures and are more oriented toward universals that might be applicable to all humankind (Rouchy, 2002).

At the core, the term multicultural acknowledges the idea of culture, and by acknowledging that there is more than one viable culture, it might be said to insinuate value in the existence of more than one. The mere act of attempting to accommodate more than one culture is a political act. Gender, disability, sexual orientation, and class also represent cultures within the meaning of multicultural. It is believed that the term multicultural should indeed include class, as well as the other categories named, and perhaps others as well. Although there are problems with the term and struggles within the dominant culture for both definition and sincere expression, the idea of multiculturalism is profound and will be pivotal in the coming decades.

D.W. Sue et al. (1999) write, "**Multiculturalism** is not only about understanding different perspectives and worldviews but also about social justice. As such it is not value neutral. Multiculturalism stands against beliefs and behaviours that oppress other groups and deny them equal access and opportunity". (p. 1064).

**What Is Multicultural Counselling?:**

Derald Wing Sue offers the following definition of multicultural counselling, "Multicultural counselling and therapy can be defined as both a helping role and a process that uses modalities and defines goals consistent with the life experiences and cultural values of clients, recognizes client identities to include individual, group, and universal dimensions, advocates the use of universal and culture-specific strategies and roles in the healing process, and balances the importance of individualism and collectivism in the assessment, diagnosis, and treatment of client and client systems. (Sue, in press). A multicultural worldview and multicultural practices are essential to development on both individual and global levels.

### 5.3.2 Theoretical Principles:

At the theoretical level, multiculturalism as applied to mental health elevates and centralizes the role of culture in defining psychological functioning, psychological distress, and psychological well-being (D. W. Sue, Bingham, Porche-Burke, & Vasquez, 1999). There is no definitive agreed-upon set of principles for multicultural theories because of diversity of opinion in the finer points of what it means to be multiculturally oriented. However, there is significant common ground as well. Here are some principles guiding to understanding general multicultural theory, as follows:

**Principle 1**:.We were born and raised in a culture (or set of cultures) that influence our ways of being (or cosmologies; Duran & Duran, 1995). Politically, these memberships can either enhance or limit our life opportunities.

**Principle 2:** We make distinctions between groups of people based on race, religion, sex, sexual orientation, ethnicity, physical and mental disabilities, and socioeconomic status.

**Principle 3:** A multiculturalist stance is intended to foster greater understanding between members of different cultural groups and to strive toward egalitarian treatment of all humans, inclusive of their cultural identities.

**a) Theory of Personality:**

From a multicultural perspective, individual personality is heavily influenced by cultural experience. In fact, multicultural counselors note that even the idea of personality is an essentialist way of approaching human beings and is therefore a culture-bound concept (Markus & Kitayama, 1998). There are many dimensions of intra- and interpersonal functioning that vary by culture.

**Individualistic versus Collectivist Orientation:**

One of the most common dialectical discussions in the multicultural literature is that of individualistic versus collectivist cultures. Individualistic cultures, like the dominant culture in the United States, place enormous value on the personal liberty of the individual and the supremacy of self-interests over those of the group. Autonomy is a highly regarded goal and virtue, and personality is often viewed as separate from family and culture.

On the other hand, In collectivist cultures, values and norms are more shared. The self and the personality are defined in terms of group memberships, and the group needs and values are more central than those of the individual. Collectivists tend to evaluate themselves based on the attainment of commonly held group goals, whereas individualists are more likely to orient toward individual responsibility and to establish personal goals (Earley & Gibson, 1998; Triandis, 1994 #654).

Although this individualistic orientation is still predominant, theorists within Western culture point to problems with this value orientation. Collectivist cultural values and personality traits are difficult for a counselor raised in an individualistic culture to understand and honour in the counselling process.

**Acculturation and the Infamous Melting Pot:**

On an individual level, acculturation (or ethnocultural orientation) refers to “a process of giving up one’s traditional cultural values and behaviours while taking on the values and behaviours of the dominant social

structure" (Atkinson, Lowe, & Mathews, 1995, p. 131). Garrett and Pichette (2000) identified five cultural orientation types within American Indian populations that were previously discussed in the literature (Herring, 1996; LaFromboise, Trimble, & Mohatt, 1990):

1. **Traditional.** The individual thinks in the native tongue and practices traditional tribal customs and tribal worship methods.
2. **Marginal.** The individual is not fully connected with traditional Indian culture or mainstream society. Both languages may be spoken.
3. **Bicultural.** The individual is relatively comfortable and conversant in both sets of cultural values.
4. **Assimilated.** The individual is oriented toward the mainstream social culture and has little interest in traditional tribal practices.
5. **Pantraditional.** The individual has been exposed to and perhaps adopted mainstream values but has made an intentional effort to return to traditional values.

Cultural identity and even racial identity, at the individual level, can be unique mixtures and expressions. Multicultural counselors realize that cultural identity is not static and that racial identity and affiliation cannot be assumed by glancing at the colour of one's skin or the shape of one's eyes. However, culturally sensitive counselors also realize that a client's personality can be greatly influenced by the experience of being a minority within a dominant culture. Family functioning and identity also can be challenged and severely stressed by second-generation members assuming the values and practices of the dominant culture (McGoldrick, 1998).

Swartz-Kulstad and Martin (1999) identified five separate contextual factors serving as building blocks for human behavior: 1.Ethnocultural orientation or acculturation, 2. Family environment, 3. Community environment, 4. Communication style, and 5. Language usage (see also J. Sommers-Flanagan & Sommers-Flanagan, 2003).

**b) Theory of Psychopathology:**

Multicultural theory acknowledges the role of social forces in the understanding and causation of suffering and pathology. Multicultural practitioners are extremely cautious in using standardized assessment instruments and diagnoses and take care to explore any concerns within the beliefs and practices of the client's culture (Paniagua, 2001). Multicultural counselors do not quickly impose pathological labels on troubling behaviours but instead seek to understand the meaning of the behaviours from within the cultural context of each individual or family.

### 5.3.3 The Practice of Multicultural Counselling:

Practicing multicultural counselling means including client's cultures and their culturalvalues and experiences centrally and directly in the

counselling process. However, this requires sensitivity and flexibility in application. Das (1995) offers the following reminders for practitioners:

- Culture shapes the behaviour, values, and beliefs of all humans. Both client and counselor are products of their cultures.
- Problems that minority cultures face in accessing mental health services stem both from different worldviews and cultural values and from narrow attitudes and ignorance on the part of service providers.
- All counselling can be regarded as multicultural when culture is defined as including not only race, ethnicity, and nationality but also gender, age, social class, sexualorientation, and disability.
- People in minority groups experience life stress due to sociocultural pressures and stressors and often seek counselling due to these difficulties
- Traditional counselling still mirrors the overdeveloped Western value of individualism.

Even when clients insist that their particular cultural background isn't relevant to the counselling process, multiculturally aware mental health counselors realize the power of one's cultural background and membership. It is not necessary to work directly with cultural material or conflicts, but this awareness informs the counselor's understanding nonetheless.

**Preparing Yourself to Do Therapy from a Multicultural Perspective:**

The American Counselling Association has established a set of multicultural competencies, based on an article by D. W. Sue, Arredondo, and McDavis (1992):

**Awareness and Acceptance:** Culturally competent mental health professionals are aware of their own cultural background and experiences. They can articulate what it means to be a member of their culture.

**Knowledge:** Culturally competent mental health professionals realize that they must seek specific knowledge about the cultures they are most likely to encounter in their work.

**Skills:** Culturally competent mental health professionals realize that techniques and strategies for change must be tailored to meet the needs of clients from diverse cultures.

**Preparing Your Client for Multicultural Therapy:**

If you are a member of a minority culture and are training to be a mental health professional in the dominant culture, you face unique challenges in preparing your clients from a multicultural perspective.

**Assessment Issues and Procedures:**

Any assessment done with culturally different clients must be done with extreme caution to avoid being unethical and inaccurate. Multicultural therapists look first to their clients' cultures for clues about how best to assess the nature of the presenting problems. Further, they look to culture to define appropriate treatment goals. Historically, psychological and intellectual assessment has been used in biased and prejudicial ways with ethnic minorities and women. Multicultural assessment requires significant training and experience. conducting skilled assessments of people from other cultures requires a great deal of training, supervision, and experience. Overdiagnosing, underdiagnosing, and misdiagnosing psychopathology in clients from diverse cultures has been a critical problem for many years (Paniagua, 2001).

To provide culturally competent assessment, therapists should use a culture-specifi service delivery, possibly including test administration in the client's native language; evaluate the client as a cultural being prior to testing; observe for culture-specific syndromes; select culture-specific tests; and critically examine the standardization procedures and norms used in testing procedures (Dana, 1996).

**Specific Therapy Techniques:**

Multicultural counselling is not an approach that emphasizes techniques. multicultural counselling emphasizes a relationship that respects the client's cultural identity and affiliation. It is also inappropriate to outline specific techniques for multicultural counselling because clients with different ethnocultural backgrounds will prefer different therapy approaches. S. Sue (1998) identified three specific skills that he considers indicative of cross-cultural therapeutic competency. These skills include:

**Scientific mindedness**: Therapists who use scientific mindedness form hypotheses about their clients rather than coming to firm and premature conclusions.

**Dynamic sizing:**Therapists with this skill know when to generalize and be inclusive and when to individualize and be exclusive.

**Culture-specific expertise:** This involves acquiring knowledge about one's own cultureand about the client's culture.

Thus, S. Sue (1998) emphasizes that effective multicultural therapy requires more than just familiarity with the client's culture and intercultural sensitivity.

**5.3.4 Non-Western Theories and Techniques:**

It has been noted that Western cultural view is biased toward masculinist, individualistic, essentialist, and rationalist worldviews. Diverse cultural approaches to human psychological distress include viewing both the concept of mind and ideas about human functioning through different lenses. Far more than in Western theories, these lenses include

philosophical-ethical, religious-spiritual, ancestral-familial, and even political considerations.

**Buddhism:**

Buddhism and one of Buddhism's central tenets, mindfulness, have become part of some Western treatment modalities. Buddhism has been said to be the most psychological of the world's religions and the most spiritual of the world's psychologies (Epstein, 1998, p. 16). However, attempting to classify Buddhism is controversial. Buddhists do not believe in a creator, higher power, or godlike entity, so Buddhism can therefore perhaps more accurately be called an applied philosophy.

**Four Noble Truths taught by Buddha,** are: 1. All is suffering (or suffering is everywhere), 2. The cause of suffering is craving, desiring, or having greed, 3. Suffering can be stopped or eliminated, 4. To eliminate suffering, one must follow the Eightfold path. Morgan (1996, pp. 57–58) explains the Eightfold path as containing guidance for attaining wisdom, for being moral, and for meditation. She names these as follows:

**Wisdom**

- Right understanding is the perception of the world as it really is, without delusions. This involves particularly understanding suffering, the law of cause and effect, and impermanence.
- Right thought involves the purification of the mind and heart and the growth of thoughts of unselfishness and compassion, which will then be the roots of action.

**Morality:**

- Right speech means the discipline of not lying and not gossiping or talking in any way that will encourage malice or hatred.Ø Right action is usually expanded into the five precepts: avoid taking life, stealing, committing sexual misconduct, and taking stimulants and intoxicants.
- Right livelihood is a worthwhile job or way of life that avoids causing harm or injustice to other beings.

**Meditation:**

- Right effort is the mental discipline that prevents evil arising, tries to stop evil that has arisen, and encourages what is good.
- Right mindfulness involves total attention to the activities of the body, speech, and mind.
- Right concentration is the training of the mind in meditation stages.

Some mental health professionals have integrated Buddhist perspectives into their work with clients. Meditation, or seeking mindfulness through emptying one's mind, is a core value of Buddhism, and meditation practices have been increasingly used in various combinations with other treatment modalities and mixed in with other theoretical orientations.

- **Meditation:** G. Alan Marlatt (2002) explores the important contributions that meditation and mindfulness can make to understanding and treating addictions.

- **Mindfulness**: Along with in understanding and treating addictions, it has also been used in treating pain (Kabat-Zinn,1990), in promoting holistic health in persons with HIV and AIDS (Logsdon-Conradsen, 2002), and perhaps most notably, in Marsha Linehan's (1993) dialectical behavior therapy for persons diagnosed with borderline personality disorder.

If spirituality and psychology are to be reunited, serious implications for therapists and therapy follow. Karasu (1999) contends that counseling and psychotherapy stemming from the traditional-psychoanalytic, behavioural, and humanistic-approaches leave clients spiritually bereft. Some criticisms are as follows:

- There has been no systematic effort to empirically evaluate spiritual approaches to counseling and psychotherapy.

- Karasu (1999) clearly states that the effectiveness of spiritual psychotherapy is immeasurable:

## 5.4 PSYCHOANALYTICAL, ADLERIAN, PERSON-CENTERED, BEHAVIOUR THERAPY FROM MULTICULTURAL PERSPECTIVE

This section introduces strengths and shortcomings of some influential therapies, namely Psychoanalytic therapy, Adlerian Therapy, Person-Centred Therapy, and Behaviour Therapy in counselling practice from multicultural perspective:

### 5.4.1 Psychoanalytic Therapy from Multicultural Perspective

**Strength:**

- Psychoanalytically oriented therapy can be made appropriate for culturally diverse populations if techniques are modified to fit the settings in which a therapist practices.

- Erikson's psychosocial approach, with its emphasis on critical issues in stages of development, has particular application to people of colour.

- It helps therapists become aware of their own sources of countertransference, including their biases, prejudices, and racial or ethnic stereotypes.

**Shortcomings:**

- Traditional psychoanalytic approaches are costly, and psychoanalytic therapy is generally perceived as being based on upper- and middle-class values. For many, the cost of treatment is prohibitive.
- Ambiguity inherent in most psychoanalytic approaches can be problematic for clients from cultures who expect direction from a professional.
- The psychoanalytic approach can be criticied for failing to adequately address the social, cultural, and political factors that result in an individual's problem.
- There are likely to be some difficulties in applying a psychoanalytic approach with low-income clients.

### 5.4.2 Adlerian Therapy from Multicultural Perspective

**Strength:**

- Adlerian theory addressed social equality issues and social embeddedness of humans long before multiculturalism assumed central importance in the profession (Watts & Pietrzak, 2000).
- Adler introduced notions with implications toward multiculturalism that have as much or more relevance today as they did during Adler's time (Pedersen, as cited in Nystul, 1999b).
- Although, the Adlerian approach is called Individual Psychology, its focus is on the person in a social context.
- Adlerians allow broad concepts of age, ethnicity, lifestyle, sexual/ affectional orientations, and gender differences to emerge in therapy.

**Shortcomings:**

- Because other cultures have different conceptions, this primary emphasis on changing the autonomous self may be problematic for many clients.
- For people brought up in extended family contexts, some of its ideas may be less relevant or at least may need to reconfigured.
- Adlerian therapy has some potential drawbacks for clients from those cultures who are not interested in exploring past childhood experiences, early memories, family experiences, and dreams.

### 5.4.3 Person-Centered Therapy from Multicultural Perspective

**Strength:**

- Person-centred approach has its impact on the field of human relations with diverse cultural groups.
- Empathy, being present, and respecting the values of clients are essential attitudes and skills in counselling culturally diverse clients.
- It is ideally suited to clients in a diverse world.
- Motivational interviewing which is based on the philosophy of person-centred therapy is a culturally sensitive approach that can be effective across population domains, including age, ethnicity, and sexual orientation (Levensky et. Al., 2008).

**Shortcomings:**

- Many clients who come to community mental health clinics or who are involved in outpatient treatment want more structure than this approach provides.
- It is difficult to translate the core therapeutic conditions into actual practice in certain cultures.
- It is difficult to apply this approach with the person-centred approach with clients from diverse cultures pertains to the fact that this approach extols the value of an internal locus of evaluation.

### 5.4.4 Behaviour Therapy from Multicultural Perspective:

**Strength:**

- Behaviour therapy has some clear advantages over many other theories in counselling culturally diverse clients.
- Behaviour therapy focuses on environmental conditions that contribute to a client's problems. Social and political influences can play a significant role in the lives of people of colour through discriminatory practices and economic problems, and the behavioural approach takes into consideration the social and cultural dimensions of the client's life.
- The foundation of ethical practice involves a therapist's familiarity with the client's culture, as well as the competent application of this knowledge in formulating assessment, diagnostic, and treatment strategies.
- In designing a change program for clients from diverse backgrounds, effective behavioural practitioners conduct a functional analysis of the problem situation. This assessment includes the cultural context in which the problem behaviour occurs, the consequences both to the client and to the client's sociocultural environment, the resources

within the environment that can promote change, and the impact that change is likely to have on others in the client's social surroundings.

**Shortcomings:**

- Behaviour therapy is sensitive to differences among clients in a broad sense.
- Instead of viewing clients in the context of their sociocultural environment, these practitioners concentrate too much on problems within the individual.

## 5.5 REFERENCE

1. Flanagan, J. S. & Flanagan, R. S. (2004). Counselling and psychotherapy theories in context and practice: Skills strategies and techniques. Hoboken, NJ: John Wiley & Sons, Inc.
2. Corey, G. (2013).Theory and Practic of Counselling Psychotherapy: Systems, strategies, and skills (3rd Ed.) Pearson Education.
3. Seligman, L., & Reichenberg, L. W. (2010). Theories of counselling and psychotherapy: Systems, strategies, and skills (3rd Ed.). Pearson Education.

*****