M. A. PART - I

SEMESTER - II (CBCS)

PSYCHOLOGY PAPER-COURSE VI

(CORE COURSE)

INTERVENTION SYSTEMS IN PSYCHOLOGY

SUBJECT CODE : PAPSY202

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CONTENTS

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Syllabus

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

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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: 25 marks
Semester end examination: 75 marks

Paper pattern: 7 questions to be set of 15 marks each, out of which 5 are to be attempted. One of them could be short notes question, which could combine more than one unit.

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1

INTERVENTION SYSTEMS EMPHASIZING BACKGROUND - I

Unit Structure

1.0 OBJECTIVES

After studying this unit you should be able to:

- Understand the structure of personality
- Know the stages of development
- Study the levels of consciousness
- Study anxiety and defense mechanisms
- To know the process of psychoanalysis and Understand its therapeutic techniques
- To understand strength and limitations of Psychoanalysis

1.1 INTRODUCTION: SIGMUND FREUD- CLASSIC PSYCHOANALYSIS

You must have learned about the psychotherapy, where 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. Sigmund Freud developed this traditional psychotherapy, which is also called as id Psychoanalysis, in early 1900. Freud is also regarded as father of psychotherapy. 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.

1.1.1 Structure of Personality:

According to Freud, Personality has three systems- the id, the ego, and the superego. Now, we will look at each system in detail. Though these structures of the personality are separated, in reality, they work together as the internal forces that form one's personality.

The id- Id is present at birth and it is largely unconscious i.e. 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 behavior.

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.

The superego:

You can think of superego, as an exact opposite of Id. Learning's 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 behavior.

1.1.2. 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. Now, we will take a look at these stages in detail.

The oral stage:

Oral stage is the first stage, and it makes up till about a first year of a child's life. In this stage, mouth is the most important zone of the body for the baby. 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.

The anal stage:

This is the second stage, between the age of 18 to 36 months (1.5 to 3 years). 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 potty training using punishment and restrictions are likely to promote compulsive, controlling characteristics in their children. Parents who use praise and rewards after appropriate behavior are likely to promote creativity. This stage deals with the inability to recognize, express anger.

The phallic stage:

This is the third stage, between the age of 3 to 5 years. Freud believed that this stage is complex and it is 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.

The latency stage- This is fourth stage, between the ages 5 to 11 years. It's 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.

The Genital stage- This is the final stage, after latency stage, which continues 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.

Table 1.1 Psychosexual stages of development, age group and their characteristics

Sr.no	Name of the stage	Age	Charecteristics
1	The oral stage	0-1 year	Mouth is an important zone in the body for pleasure.
2	The anal stage	1.5- 3 years	Obtaining social pleasure by impressing the parents and physical pleasure by emptying the bowels.
3	The phallic stage	3- 5 years	Genitals become one's source of gratification. Sexual fantasies are developed.
4	The latency stage	5-11 years	Increase in the level of social interest, engaging in social

			activities.
5	The genital stage	11- till death	Final stage where positive and loving sexual relationships are developed.

1.1.3 Levels of Consciousness:

Levels of consciousness and the concept of unconscious are considered as Freud's greatest contributions, which help us to understand human behavior and personality. We will look at each level in detail.

There are three levels of consciousness, according to Freud: the conscious, the preconscious, and the unconscious. 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.

The unconscious level contains memories that are highly charged. They include impulses, repressed drives (A boy's sexual feelings for his mother). 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.

Levels of conscious are compared with iceberg. Consciousness is considered as thin slice of the total mind. Conscious mind is considered only as the tip of an iceberg. Just like an iceberg has its larger part below the surface of water, greater part of mind is found below the surface of awareness (unconscious). 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.

1.1.4. 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: reality, neurotic, and moral. 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. Second type is

neurotic anxiety. It is the fear that instincts will be difficult to control and lead to punishment due to unacceptable behavior. Third one is moral anxiety. It is 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 defense mechanisms. Defense mechanisms are automatic i.e. Individual learns to spontaneously use a specific defense mechanism. Defense mechanisms either deny reality or distort reality; they operate on an unconscious level. Defense mechanisms are categorized in several ways. For example, Primary vs. Secondary defense mechanisms, psychotic vs. neurotic defenses, immature vs. healthy defenses.

We will now look at some defense mechanisms along with their examples.

Table 1.2 Defense mechanisms along with their depression and examples

Sr. no	Defense mechanisms	Description	Example
1	Denial	Not accepting threatening aspect of reality that is evident to others.	A person who has addiction of alcohol denying that drinking is not good for their health.
2	Reaction formation	Replacing unacceptable, threatening thoughts, emotions with active expression of their opposite, in order to overcompensate.	A person hates his boss, but behaves in an excessively nice, friendly manner with him.
3	Repression	According to Freud, it is involuntary removal of something from consciousness. Thoughts and feelings that are painful, threatening are relegated to the unconscious,	A person is sexually molested when she was 5 years old. There is behavioral evidence that it exists, but she genuinely cannot recall this event.

		excluding them from awareness.	
4	Projection	Projecting unacceptable thoughts, feelings, or impulses on another person.	A person hates his mother, but instead says that his mother is the one who hates him.
5	Displacement	Directing strong feelings from a threatening person/ object toward other person/object which is less threatening than the previous one.	A child is very angry with his mother, so he displaces these angry feelings toward his dog, by kicking it.
6	Rationalization	Using excessive explanations, to justify behavior in self-serving but invalid ways.	A person who is rejected by his date might say that he was not anyways attracted towards her.
7	Sublimation	Diverting potentially harmful emotions or impulses (sexual or aggressive energy) into other socially acceptable ways.	A person sublimating her aggressive impulses into athletic activities (playing football) where she finds a way to express these feelings.
8	Regression	Reverting to an earlier phase of development in thoughts, emotions, and behavior when there were fewer demands.	A child who is traumatized may regress to earlier developmental stage and start thumb sucking behavior.

1.2 PROCESS OF THERAPY

1.2.1 Therapeutic Goals:

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

behaviors, symptoms. According to this view, a "cure" for such symptoms & behaviors is built on revealing the meaning of symptoms, the causes of behavior 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 behavior, 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.

Now we will talk about the second goal- strengthening the ego. 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 behavior.

1.2.2. 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 as 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. 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.

Now we will understand countertransference. 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 countertransference.

1.3 THERAPEUTIC TECHNIQUES

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

Free Association:

Free association is a primary technique in psychoanalytic therapy. Free association is used as an approach to get access to repressed material. It's 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. We all experience automatic connecting of one thought to another, i.e. free association. 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.

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.

Interpretation and Analysis:

Interpretation and Analysis 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. We will now look at analysis and interpretation in detail.

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.

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 behavior 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.

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.

1.4 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.

Now, we will look at some limitations of classical psychoanalysis. 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".

1.5 SUMMARY

In this chapter, we learned about classic psychoanalysis. According to Freud, structure of personality has three systems – Id, Ego and Superego. We talked about Drive theory and two instincts- Eros (life instinct) and Thanatos (Death instinct). These two are in opposition to each other. Humans are filled with psychic energy which comes from these two sources. There are five stages of development- the oral stage, anal stage, phallic stage, latency stage and genital stage. If a child's needs are not

sufficiently met at each of these stages, later in life that child may become fixated at that particular stage, and behave in ways that are psychologically immature.

There are three levels of consciousness, according to Freud: the conscious, the preconscious, and the unconscious which are compared with iceberg. Each of these levels has specific characteristics. Anxiety is important concept in psychoanalysis and there are three types – Neurotic anxiety, Moral anxiety and Reality anxiety. To deal with anxiety, humans have defense mechanisms. They are automatic and they operate on unconscious level etc. Denial, Displacement, Repression, Projection, Rationalization, Sublimation, Regression are some examples of defense mechanisms. We also discussed about psychoanalytic therapy. Goals of psychoanalytic therapy include making the unconscious conscious and strengthening the ego. Therapeutic alliance has many factors such as approach of therapist (blank screen approach). 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. Countertransference is therapist's feelings about the client. Understanding resistance and its role, pointing it out and its confrontation are significant in the process of therapy.

There are therapeutic techniques such as free association, abreaction, dream analysis, interpretation and analysis. Freud's theory of psychoanalysis had significant impact on understanding of psychological concepts and became a foundation for other theories. There are some limitations of psychoanalysis, such as it being a long term, costly and intense treatment, which may not solve problems immediately. Anonymous role of therapist, lack of empirical research, Freud's ideas about women have received criticism.

1.6 QUESTIONS

A) Write long answers:

a) Write about developmental stages in detail.

b) Discuss about anxiety and defense mechanisms in detail.

c) Explain in detail about therapeutic goals and therapeutic alliance.

d) Explain in detail: Therapeutic techniques.

B) Write short notes:

a) The Structure of personality.

b) Levels of consciousness.

c) Strength and weakness of psychoanalysis.

1.7 REFERENCES

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2

INTERVENTION SYSTEMS EMPHASIZING BACKGROUND - II

Unit Structure

2.0 OBJECTIVES

After studying this unit you should be able to:

- To understand the basic concepts of individual psychology
- To understand the basic concepts of analytical psychology

- To know about treatment using individual psychology
- To know about treatment using analytical psychology
- To understand strengths and limitations of individual and analytical psychology

2.1 INTRODUCTION: 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, behaviors, 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.

2.2 BASIC CONCEPTS OF INDIVIDUAL PSYCHOLOGY

2.2.1 The Whole Person and Patterns of Human Personality:

Adler focused on the unity and indivisibility of the person. According to Adler, human behavior 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 behavior has a purpose. Human beings set goals for themselves, and behavior 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 behavior is considered as a function of a combination of many influences or contributing factors. Generally, no single, direct causal factor leads to a single behavior. Adler believed that each person is responsible for his/her behavior as they have the freedom to select from a variety of behavioral options. It shall be noted that though this approach says that an individual is responsible for his/her behavior, it doesn't blame them for their wrong deeds.

2.2.2 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.

2.2.3 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. For example, working hard in one area to compensate for flaw in other area.

From our earliest years, one recognizes that he or she is helpless is many ways which is characterized by feelings of inferiority. These 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.

2.2.4 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 behavior. Adler called this third force as "attitude toward life". Attitude toward life consists of individual human choice, individual sense of purpose.

2.2.5 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.

2.2.6 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.

2.2.7 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) behavioral strategies that an individual uses to achieve goals and negotiate the journey of life and 4) the outcomes of those behaviors.

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.

2.2.8 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. It shall be noted that one shall not stereotype people according to birth order, but remember that exploring birth order and its influence on the development of an individual's personality can help us to understand that person.

Table 2.1. Five psychological positions given by Adler

Sr. no.	Psychological Positions	Characteristics
1	The oldest child	The oldest child is likely to be the most intelligent and achieving among the five groups. Firstborn's 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 center 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.

2.3 TREATMENT USING INDIVIDUAL PSYCHOLOGY

2.3.1 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, behaviors, 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.

2.3.2 Techniques:

Adler's Individual Psychology has a lot of creative and useful interventions. We will look at few interventions in detail.

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 behavior patterns. The therapist teaches the client about how to catch himself/herself when he or she slips back into old and unhelpful behaviors. 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.

2.3.3 Phases of Treatment:

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

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 behaviors, realize the negative impact of such behaviors, 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 behavioral 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.

2.4 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.

2.5 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.

2.5.1 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. We will look at each level in detail.

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:

Ego is formed of perceptions, memories, thoughts, and feelings which are within one's awareness. Being the center 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:

This 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.

The Unconscious Mind:

Jung 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. We will later look at both in detail.

Complexes:

Complexes 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. We will look at some archetypes in detail.

The self:

It is a central, organizing archetype, which is regulating center 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.

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.

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. We project our 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.

2.5.2 Concept of Human Development:

According to Jung, people's lives are divided into two periods. In the first half of our life, we find our place and develop interests, values, find a partner, make career choice. In the second half, with established foundation, we 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.

2.5.3 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).

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.

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. We will know about each function in detail.

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).

2.6 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.

2.6.1 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. The 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. Transformation is the fourth stage. Transformation 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.

2.6.2 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.

2.6.3 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.

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.

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.

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.

Rituals:

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

2.7 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.

2.8 SUMMARY

Alfred Adler developed the theory of Individual Psychology which assumes that people are responsible for their own thoughts, feelings, behavior; they are the creators and creations of their own lives. Every individual has a unique private logic and people actively shape themselves and their lives. Human beings experience feelings of inferiority and strive for superiority. Adler gave five psychological positions and their characteristics. Among the four phases of treatment, therapist helps client by cooperative interaction, support; encouragement is important in the therapeutic relationship.

Jung's theory is known as analytical psychology. According to Jung, psychic functioning has three levels- The conscious mind, the collective unconscious, and the personal unconscious. The conscious mind includes the ego, the persona, two attitudes, and four functions. The collective unconscious and the personal unconscious are two levels of unconscious mind. Personal unconscious is unique to every person and contains repressed and forgotten memories, complexes, archetypes, shadow. The collective unconscious includes archetypes, such as the shadow, anima and animus, self, etc. The balance of polarities in our life determines our psychological health and development. There are two dimensions of personality- the two attitudes (introversion and extraversion) and four functions (thinking, feeling, sensation, intuition). The four functions can be paired with each of the two attitudes and we get eight possible personality types. Jungian treatment typically has four stages, and its final

goal is individuation. There are various techniques such as use of symbols, dream interpretation, word association test and rituals.

2.9 QUESTIONS

A) Write long answers:

a) Discuss in detail about social interest and phenomenology

b) Explain about birth order and family constellation.

c) Explain in detail about treatment using individual psychology.

d) Explain: Jung's concept of unconscious mind.

e) Write in detail about dimensions of personality.

f) Treatment using Jungian analytical psychology.

B) Write short notes:

a) Write about the whole person, patters of human personality and private logic.

b) Discuss about concept of inferiority and striving for superiority, striving with purpose and goals.

c) Write in detail about evaluation of individual and analytical psychology.

d) Explain about Jung's concept of human development along with balance and polarities.

e) Explain in detail: Jung's concept of conscious mind.

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3

INTERVENTION SYSTEMS EMPHASIZING HUMANISTIC, COGNITIVE AND BEHAVIORAL APPROACHES - I

Unit Structure

3.0 OBJECTIVES

After studying this unit students should be able to:

- Understand the importance of studying different therapeutic approaches.
- Know the nature of Carl Rogers Person Centered Approach.
- Study the the process of therapy
- To know application of therapeutic techniques and processes
- Understand Person-Centered Therapy from a multicultural perspective

3.1 INTRODUCTION

It is really important to understand different therapeutic approaches, their views and techniques. The information given in this chapter will help students to develop a balanced view of the major ideas of various therapists, theorists, and the practical techniques commonly used by counselors. Each therapeutic approach has useful dimensions. Interventions provided by each approach has a significant role in the therapy. It is not a matter of a theory being “right” or “wrong,” as each theory plays a significant role in understanding human behavior and has

unique practical implications. Accepting the validity of one approach does not necessarily imply rejecting another approach .Each intervention technique is based on what clients are thinking, feeling, and doing, and a complete therapy must address all three of these aspects. Combining all therapeutic dimensions gives the basis for a strong and complete therapy. In a developing diverse society theoretical pluralism has its own significant place. In this chapter we are going to study Carl Rogers-Person Centered Therapy in detail.

3.2 CARL ROGERS- PERSON CENTERED THERAPY

The person-centered approach is one of the important approaches in the study of Psychology. It is mostly based on the concepts of humanistic psychology, in which many concepts were articulated by Carl Rogers in the early 1940s.Carl Rogers is one of the pioneers of a therapeutic approach, and Rogers stands out as one of the most influential figures in revolutionizing the direction of counseling theory and practice. A survey conducted by Psychotherapy Networker ("The Top 10," 2007), Identified Carl Rogers as the single most influential psychotherapist of the past quarter century. Rogers has become known as a "quiet revolutionary". He contributed to theory development .His influence continues to shape counseling practice even today (Rogers & Russell, 2002).

The person-centered approach shares many values and concepts with the existential approach.According to Rogers people are essentially trustworthy and they have a great potential of understanding themself and they can resolve their own problems without direct intervention on the therapist's part, If they are involved in a specific kind of therapeutic relationship they are capable of self-directed growth. According to Rogers the attitudes and personal characteristics of the therapist and the quality of the client–therapist relationship are the prime determinants of the outcome of the therapeutic process. Person-centered therapy is the result of an evolutionary process that continues to remain open to change and refinement (Cain & Seeman, 2002). Actually Rogers did not present the person-centered theory as a fixed and completed approach of therapy. He hoped that others would view his theory as a set of tentative principles which are relating to how the therapy process develops. Rogers expected his model to evolve and was open and receptive to change.

3.2.1 Four Periods of Development of the Approach:

To search for major turning points in Rogers's approach, Zimring and Raskin (1992) and Bozarth and colleagues (2002) identified four periods of development. During the first period, in the 1940s, Rogers evolved nondirective counseling, which provided a powerful and revolutionary alternative to the directive and interpretive approaches to therapy then being practiced. Rogers (1942) published Counseling and Psychotherapy: Newer Concepts in Practice, which elaborates the philosophy and practice of non-directive counseling, while he was a professor at Ohio State University. Rogers challenged the validity of most commonly accepted therapeutic procedures like direction, persuasion, advice, suggestion,

teaching, diagnosis, and interpretation. Rogers omitted diagnostic concepts and procedures from his approach.

During the second period, in the 1950s, Rogers (1951) wrote Client-Centered Therapy and renamed his approach as client-centered therapy, which shows its focus on the client rather than on non-directive methods. Then he opened the Counseling Center at the University of Chicago. This period was emphasized by a shift from clarification of feelings to a focus on the phenomenological world of the client. Rogers stated that the best view for understanding how people behave was from their own internal frame of reference.

The third period showed the necessary and sufficient conditions of therapy.This period began in the late 1950s and extended into the 1970s. Rogers (1957) set a hypothesis which resulted into three decades of research. An important publication was On Becoming a Person (Rogers, 1961), it showed the nature of "becoming the self that one truly is." In this book he explained the process of "becoming one's experience," which is emphasized by an openness to experience, an internal locus of evaluation,a trust in own experience, and the willingness to be present in the process. During the 1960s, Rogers and his associates continued to test the process and the outcomes of psychotherapy. He was interested in how people best progress in psychotherapy, and he studied the qualities of the client–therapist relationship. After this research, the approach was further refined and expanded (Rogers, 1961).

The fourth phase was about considerable expansion to education, industry, groups, conflict resolution, and the search for world peace during the 1980s and the 1990s. It was during the 1980s that Rogers directed his efforts toward applying the person-centered approach to politics, especially to the achievement of world peace.

In a comprehensive review of the research on person-centered therapy over a period of 60 years, Bozarth and colleagues (2002) concluded the following:

- In the earliest years of the approach, the client rather than the therapist was in charge. This style of nondirective therapy was associated with increased understanding, greater self-exploration, and improved self-concepts.
- Later a shift from clarification of feelings to a focus on the client's frame of reference developed. There was strong evidence for the value of the therapeutic relationship and the client's resources as the essence of successful therapy.
- As person-centered therapy developed further, research centered on the core conditions assumed to be both necessary and sufficient for successful therapy.

3.2.2 Existentialism and Humanism:

Both approaches place little value on the role of techniques in the therapeutic process, and emphasize the significance of genuine encounter. They differ in that existentialists take the position that we are faced with the anxiety of choosing to create an identity in a world that lacks intrinsic meaning.

The humanists, in contrast, take the somewhat less anxiety-evoking position that each of us has a natural potential that we can actualize and through which we can find meaning.

According to Rogers (1986b), when this philosophy is lived, it helps people develop their capacities and stimulates constructive change in others. Individuals are empowered, and they can use this power for personal and social transformation.

Both approaches focus on the client's perceptions and call for the therapist to enter the client's subjective world, and both approaches emphasize the client's capacity for self-awareness and self-healing.

3.2.3. View of Person Centered Therapy:

Rogers firmly believed that people are resourceful, trustworthy, capable of self understanding and self-direction, they can make Positive changes, and are able to live powerful and productive lives. Rogers shows little sympathy for approaches based on the assumption that the individual cannot be trusted and instead needs to be instructed, punished, controlled, and managed by others who are in an "expert" position. According to him three therapist attributes helps to create a growth-encouraging atmosphere in which individuals can grow forward and become what they are capable of becoming: (1) congruence (genuineness, or realness), (2) unconditional positive regard (acceptance and caring), and (3) accurate empathic understanding (an ability to deeply grasp the subjective world of another person). Rogers stated that , if therapists express these attitudes, clients will behave in prosocial and encouraging ways.

Rogers mentioned that "human beings are essentially forward-moving organisms drawn to the fulfillment of their own creative natures and to the pursuit of truth and social responsiveness" (Thorne, 1992, p. 21). It implies that people will move toward health if the way seems open for them to do so.This positive view of human nature has important implications for the practice of the therapy.

As the individual has an innate capacity to move away from maladjustment and toward psychological health, the therapist holds the primary responsibility on the client.

The person-centered approach rejects the role of the therapist as the superior who knows best and of the passive client who merely follows the instructions of the therapist.

The root of therapy is in the client's capability to be aware and make self directed change in attitudes and behavior. Therapists with a humanistic orientation encourage their clients to make changes which will lead to living authentically and fully, with the realization that this demands a continuing struggle. The emphasis is on how clients act in their world with others, how they can move forward in constructive directions, and how they can successfully encounter obstacles that are blocking their growth. People never come to a last stage of being self-actualized; in fact they are continually involved in the process of actualizing themselves.

3.2.4 The Process of Therapy:

Therapeutic Goals:

The goals of person-centered therapy are different from other traditional approaches. The main focus of a person-centered approach is that the client achieves a greater degree of independence. Its main focus is on the person, not on the person's existing issues.

Rogers (1961) wrote that people who enter psychotherapy often ask: "How can I discover my real self? How can I become what I deeply wish to become?"

Rogers (1977) believed that the goal of therapy was to assist clients in their growth process which encourages them to cope with their current and future problems rather than solving their problems. The underlying goal of the therapy is to bring an encouraging atmosphere to helping the individual become a fully functioning person.

Before clients move toward that goal, they must first get behind the masks they wear, which they intentionally or unintentionally develop through the process of socialization.

Encouraging (1) an openness to experience, (2) a trust in themselves, (3) an internal source of evaluation, and (4) a willingness to continue growing these characteristics is the basic goal of person-centered therapy. These four characteristics help to provide a kind of framework for understanding the exact direction of therapeutic movement. The therapist does not choose particular goals for the client. The foundation of person-centered theory is the view that clients in a relationship with an assisting therapist have the capacity to define and clarify their own goals.

Person-centered therapists believe that they are not setting goals for what clients need to change, yet they encourage them on how to best help clients to achieve their own goals (Bohart, 2003).

Therapist's Function and Role:

The role of person-centered therapists is based on their ways of being and their attitudes. Research based on person-centered therapy shows that the attitude of therapists encourages personality changes in the client (Rogers, 1961). Actually, therapists should see themselves as an instrument of change. Therapist's belief and attitude in the inner resources of the client

helps to create the therapeutic atmosphere for growth (Bozarth et al., 2002). Thorne (2002a) highlighted the significance of therapists communicating with clients in a person-to-person way. He suggested that this overemphasis on professionalism is directed towards protecting therapists from overinvolvement with clients, which mostly results in under involvement with them.

Person-centered theory states that the therapist's role is to be present and accessible for clients and to focus on their immediate experience. First of all, the therapist must be real in the relationship with clients. The therapist meets clients on a moment-to-moment experiential basis then enters their world. With the help of a therapist's attitude of genuine respect, caring, support, acceptance, and understanding, clients can loosen their defenses and rigid perspectives and can shift to a higher level of personal functioning.

With this positive attitude of therapist clients get necessary freedom to explore dimensions of their life which were either distorted or denied to awareness.

Person-centered therapists also avoid these functions: They generally do not take a history, and avoid asking probing and leading questions, they do not create interpretations of the client's behavior, they do not evaluate the client's plans, and they do not decide the frequency or length of their therapeutic venture (Broadley, 1997). Broadley (1997) states that "In more specific terms the client-centered therapist does not intend to diagnose, create treatment plans, strategize, employ treatment techniques, or take responsibility for the client in any way" (p. 25).

Client's Experience about Therapy:

Progress and changes occurring in therapy depends on clients' perspective both of their self-experience and the counselor's basic attitudes in therapy. If the therapist creates an atmosphere encouraging self-exploration, clients can explore their experience fully, including their beliefs, behavior, feelings and worldview. Clients come to the counselor in a state of a discrepancy between their self-perception and their experience in reality. clients come for therapy when they are feeling a little helpless, powerless, and are unable to make effective decisions in their lives. They might be hoping that they can find "the way" through the guidance of the therapist.

In Person Centered Therapy ,clients soon learn that they are responsible for themselves in the relationship and that they can learn to gain self-understanding. In this process, clients can explore a vast range of feelings and beliefs (Rogers, 1987c).They can express all their negative emotions like anxiety, fears, shame, hatred, guilt,anger that are hard to accept and incorporate into their self-image. With this therapy, clients can move to a greater acceptance and integration of conflicting and confusing feelings.

As clients feel understood and accepted, they feel less vulnerable, they become more realistic, perceive others more accurately and are able to understand and accept others.

They begin to behave truer to themselves. Clients can start to direct their own lives.

Clients become psychologically mature and more actualized:

According to Tallman and Bohart (1999), the framework of person-centered therapy is based on the assumption that clients heal themselves, can create their self-growth, and they are the primary agents of change. The therapy relationship gives a supportive Atmosphere within which clients' self-healing capacities are positively activated.

Therapist and Client Relationship:

Rogers hypothesized that If the therapeutic core conditions exist over some period of time, constructive personality change will occur. From Rogers's perspective the client–therapist relationship is characterized by equality. As clients experience the therapist listening in an accepting way to them, they slowly learn to accept themselves.

As they experience the realness of the therapist, they drop defenses and get real with both themselves and the therapist. The therapist can be a guide on this journey as he or she is usually more experienced and more psychologically mature than the client.

Mearns and Cooper (2005) states: "When two people come together in a wholly genuine, open and engaged way, we can say that they are both fully present" (p. 37). Being congruent might involve the expression of anger, liking, frustration, attraction, boredom,concern, annoyance, and a range of other feelings in the relationship.

Person-centered therapy stresses that counseling will be inhibited if the counselor feels one way about the client but acts in a different way.

Rogers's concept of congruence does not state that only a fully self-actualized therapist can be effective in counseling, because therapists are human, they cannot be expected to be fully authentic.If therapists are congruent in their relationships with clients, trust will be formed and the process of therapy will get under way.

Unconditional Positive Regard And Acceptance:

Therapists express through their behavior that they value their clients as they are and that clients are free to have feelings and experiences without risking the loss of their therapists' acceptance. It is not an attitude of "I'll accept you when . . ."; rather, it is one of "I'll accept you as you are." Therapists value and warmly accept clients without placing stipulations on their acceptance.

Acceptance is understanding of clients' rights to have their own beliefs and feelings;

it does not mean the approval of all behavior.Rogers's (1977) states that the greater the degree of accepting, caring and valuing of the client in a

non possessive way, the greater the chance that therapy will be successful.He also mentioned that it is not possible for therapists to genuinely feel acceptance and unconditional caring at all times. Still , if the therapists have little respect for their clients then it is not likely that the therapeutic work will be fruitful.

Accurate Empathic Understanding:

One of the important tasks of the therapist is to understand clients' experience and feelings accurately and sensitively. The goal is to motivate clients to get closer to themselves, to understand and resolve the incongruity that exists within them. Empathy is a deep and subjective recognition of the client with the client. Empathy is not sympathy, or feeling sorry for a client.

Rogers states that when therapists can grasp the client's private world as the client sees and feels it without losing the separateness of their own identity—constructive change starts to occur. Empathy helps clients to pay attention and value their experiences; to see earlier experiences in completely new ways; modify their perspectives of themselves, others, and the world; and to increase their confidence while making choices and actions.

It is important to understand that accurate empathy goes beyond recognition of obvious feelings to a sense of the less clearly experienced feelings of clients. This empathy results in clients' self-understanding and clarification of their self beliefs and worldviews. Watson (2002) mentioned that full empathy entails understanding the meaning and feeling of a client's experience. According to Watson, 60 years of research has consistently shown that empathy is the most strong factor of a client's progress in therapy.

3.2.5 Application of Therapeutic Techniques and Processes:

According to Rogers and other contributors the person-centered approach is basically a simple restatement of what the client just said. One of Rogers's main contributions to this field is the notion that the quality of the therapeutic relationship is the primary agent of growth in the client. Natalie Rogers mentioned the terms "techniques," "strategies," and "procedures" are seldom used in the person-centered approach (N. Rogers, Personal communication, February 9, 2006).She told students to use phrases such as "person centered philosophy" or "person-centered values." It is important for therapists to react in a therapeutically spontaneous manner to what is happening between themselves and their clients.

The person-centered philosophy is based on the assumption that clients have the resourcefulness for positive movement without the counselor assuming an active, directive role. The therapist is emphatically interested in the client, in order to understand the individual's inner world (Broadley, 2000).

This existence is far more strong than any other technique a therapist might use to bring about change. There has been increased latitude for therapists to share their reactions, to confront clients in a caring way, and to participate actively and fully in the therapeutic process (Bozarth et al., 2002).

This approach encourages the use of a wider variety of methods and allows for considerable diversity in personal style among person-centered therapists (Thorne, 2002b). Tursi and Cochran (2006) propose that cognitive behavioral techniques can be carefully applied within a person-centered relational framework, and that a high level of therapist self-development is not required to integrate these skills and techniques.

Cain (2002a, 2008) states it is important for therapists to modify their therapeutic style to accommodate the specific needs of each client. Person centered therapists have the freedom to use a variety of responses and methods to assist their clients.

Therapist congruence is basic to establishing trust and safety with clients, and the therapy process is likely to be adversely affected if the therapist is not fully authentic.

The Role of Assessment:

Many mental health agencies use a variety of assessment procedures. From a person-centered perspective, the best source of knowledge about the client is the individual client. For example, some clients may request certain psychological tests as a part of the counseling process. It is important for the counselor to follow the client's lead in the therapeutic engagement (Ward, 1994).

Rogers (1942) recommended caution in using psychometric measures or in taking a complete case history at the outset of counseling. If a counseling relationship began with a battery of psychological tests and a detailed case history, he believed clients could get the impression that the counselor would be giving the solutions to their problems. Assessment seems to be gaining in importance in short-term treatments in most counseling 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-Centered Approach:

Bozrath, Zimring, and Tausch (2002) cite studies done in the 1990s which revealed the effectiveness of person-centered therapy with a wide range of client problems including alcoholism, anxiety disorders, psychosomatic problems, depression, interpersonal difficulties, cancer, and personality disorders.

The basic philosophy of the person-centered approach has applications to education from elementary school to graduate school. Rogers and Freiberg (1994) describe journeys taken by different teachers who have moved from being controlling managers to facilitators of learning. These teachers

have explored their own pathways to freedom. According to Rogers and Freiberg, both research and experience indicates that more learning, more problem solving, and more creativity can be found in classrooms that operate within a person-centered climate. In such an atmosphere learners are able to become increasingly self-directing, able to assume more responsibility for the consequences of their choices, and can learn more than in traditional classrooms.

The person-centered approach is especially applicable in crisis intervention such as an unwanted pregnancy, an illness, a disastrous event, or the loss of a loved one. When people are in crisis, one of the first steps is to give them an opportunity to fully express themselves. Sensitive listening, hearing, and understanding are essential at this point.

Being heard and understood helps people in crises, it helps them to calm down in the midst of turmoil, and enables them to think more clearly and make better decisions. If the person in crisis does not feel understood and accepted, he or she may lose hope of "returning to normal" and may not seek help in the future. Genuine support, caring, and non-possessive warmth can go a long way in building bridges that can encourage people to do something to work through and resolve a crisis.

Communicating a deep sense of understanding should always be significant problem-solving interventions.

The person-centered approach puts the therapist in the directive position of making interpretations, probing the unconscious, analyzing dreams, and working toward personality changes. If counselors are lacking in these relationship and communication skills, they will not be effective in carrying out a treatment program for their clients. The person-centered approach demands a great deal of the therapist. An effective person-centered therapist must be grounded, centered, genuine, present, focused, patient, and accepting in a way that involves maturity.

Application to Group Counseling:

The person-centered approach implies 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 atmosphere —a place where the group members can interact in honest and meaningful ways. Members become more appreciative and start to trust in themselves as they are and are able to move toward self-direction and empowerment. so, group members started to make their own choices and bring about change in themselves.

Yet with the presence of the facilitator and the support of other members, participants realize that they do not have to experience the struggles of change alone and that groups as a collective whole have their own source of transformation.

Rogers (1970) clearly believed that groups tend to move forward if the facilitator exhibits a deep sense of trust in the members and refrains from using techniques or exercises to get a group moving. Group process observations should come from members. According to Raskin, Rogers, and Witty (2008), groups are fully capable of articulating and pursuing their own goals.

Person-Centered Expressive Arts Therapy:

Natalie Rogers (1993) expanded on her father, Carl Rogers's (1961), theory of creativity using the expressive arts to enhance personal growth for individuals and groups.

3.2.6. Person-Centered Therapy from a Multicultural Perspective:

Strengths from a Diversity Perspective:

One of the strengths of the person-centered approach is its impact on the field of human relations with diverse cultural groups. Carl Rogers has had a global impact. His work has reached more than 30 countries, and his writings have been translated into 12 languages. Person-centered philosophy and practice can now be studied in several European countries, South America, and Japan.

- In several European countries, person-centered concepts have had a significant impact on the practice of counseling as well as on education, cross-cultural communication, and reduction of racial and political tensions. In the 1980s Rogers (1987b) elaborated on a theory of reducing tension among antagonistic groups that he began developing in 1948.

- In the 1970s Rogers and his associates began conducting workshops promoting cross-cultural communication. Well into the 1980s he led large workshops in many parts of the world. International encounter groups have provided participants with multicultural experiences. Japan, Australia, South America, Mexico, and the United Kingdom have all been receptive to person-centered concepts and have adapted these practices to fit their cultures.

- Before his death, Rogers conducted intensive workshops with professionals in the former Soviet Union.

The underlying philosophy of person-centered therapy is grounded on the importance of hearing the deeper messages of a client. Empathy, being present, and respecting the values of clients are essential attitudes and skills in counseling culturally diverse clients.

This empathy may be expressed and communicated either directly or indirectly.

Bohart (2003) claims that the person-centered philosophy makes this approach particularly appropriate for working with diverse client populations because the counselor does not assume the role of expert who is going to impose a "right way of being" on the client. Instead, the therapist is a "fellow explorer" who assists to understand the client's phenomenological world in an interesting, accepting, and open way and checks with the client to confirm that the therapist's perceptions are accurate. Glauser and Bozarth mentioned that counseling in a multicultural context must embody the core conditions associated with all effective counseling.

Shortcomings From a Diversity Perspective:

Although the person-centered approach has made important contributions to counseling people with diverse social, political, and cultural backgrounds, there are some shortcomings to practicing it within this framework. Many clients who come to community mental health clinics or who are involved in outpatient treatment want more structure than this approach provides. Some clients seek professional help to deal with a crisis or to learn coping skills in dealing with everyday problems. Because of certain cultural messages, when these clients do seek professional help, it may be as a last resort. They expect a directive counselor and can be put off by one who does not provide sufficient structure.

Another shortcoming of the person-centered approach is that it is difficult to translate the core therapeutic conditions into actual practice in certain cultures. Communication of these core conditions must be consistent with the client's cultural framework

There is a shortcoming in applying the person-centered approach with clients from diverse cultures pertains to the fact that this approach praises the value of an internal locus of evaluation. In collectivist cultures, clients are likely to be highly influenced by societal expectations and not simply motivated by their own personal preferences. The focus on development of individual autonomy and personal growth may be viewed as being selfish in a culture that stresses the common good.

Cain (2008) contends that "many individuals from both the majority individualistic culture and from collectivistic cultures are oriented less toward self-actualization and more toward intimacy and connection with others and toward what is best for the community and the common good" (p. 217).

Although there may be particular shortcomings in practicing exclusively within a person-centered perspective, it should not be concluded that this approach is unsuitable for working with clients from diverse cultures. There is great diversity among any group of people, and therefore, there is room for a variety of therapeutic styles.

Counseling the culturally different client may need more activity and structuring than is usually the case in a person-centered framework, but the potential positive impact of a counselor who responds empathically to

a culturally different client cannot be overestimated. Often, the client has never met someone like the counselor who is able to truly listen and understand. Counselors will certainly find it challenging to empathize with clients who have had vastly different life experiences.

Contributions of the Person-Centered Approach:

Rogers was a pioneer in shifting the therapeutic focus from an emphasis on technique and reliance on therapist authority to that of the therapeutic relationship. Farber (1996) stated that Rogers's notions regarding empathy, the primacy of the therapeutic relationship, and the value of research are commonly accepted by many practitioners and have been incorporated into other theoretical orientations with little acknowledgment of their origin.

Person-centered therapy is strongly represented in Europe, and there is continuing interest in this approach in both South America and the Far East. The person-centered approach has established a firm foothold in British universities. Some of the most in-depth training of person-centered counselors is in the United Kingdom (Natalie Rogers, personal communication, February 9, 2006). In addition, British scholars including Fairhurst (1999), Keys (2003), Lago and Smith (2003), Mearns and Cooper (2005), Mearns and Thorne (1999, 2000), Merry (1999), Natiello (2001), Thorne (2002a, 2002b), and Watson (2003) continue to expand this approach.

Natalie Rogers has been instrumental in the evolution of the person-centered approach by using nonverbal methods to enable individuals to heal and to develop. Many individuals who have difficulty expressing themselves verbally can find new possibilities for self-expression through nonverbal channels (Thorne, 1992).

Limitations and Criticisms of the Person-Centered Approach:

There are some criticisms of this approach. Some researchers have been critical of the methodological errors contained in some of these studies. therapeutic modalities fail to emphasize the role of techniques aimed at bringing about change in clients' behavior.

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

These basic attitudes are the foundation on which counselors must then build the skills of therapeutic intervention. A related challenge for counselors using this approach is to truly support clients in finding their own way. Counselors sometimes experience difficulty in allowing clients to decide their own specific goals in therapy. Perhaps the main limitations of the approaches are a reflection of the personal limitations of the therapist (Thorne, 2002b). Because the therapeutic relationship is so central to the outcomes of the therapeutic venture, a great deal is expected of the therapist as a person. From Bohart's (2003) perspective, the

majority of errors that person-centered or experiential therapists can commit are the result of "failing to be warm, empathic, and genuine; imposing an agenda upon the client; or failing to be in touch with the moment by-moment process" (p. 126). These are not limitations of the theory as much as they are limitations of the practitioner.

3.3 SUMMARY

In this unit we began by explaining the Different approaches and then we focused on Person Centered therapy by Carl Rogers. Person-centered therapy is based on a philosophy of human nature which encourages self-actualization. Further, Rogers's view of human nature is phenomenological; Rogers's theory is based on the assumption that clients can understand the factors in 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.

The person-centered approach emphasizes this personal relationship between client and therapist; the therapist's attitudes are more critical than are knowledge, theory, or techniques. Clients are encouraged to use this relationship to unleash their growth potential and become more of the person they choose to become. 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 general goals of therapy are becoming more open to experience, achieving self trust, developing an internal source of evaluation, and being willing to continue growing. Current applications of the theory emphasize more active participation by the therapist than was the case earlier.

3.4 QUESTIONS

A) Write long answers:

a) Discuss in detail about View of Person Centered Therapy

b) Discuss about Person-Centered Therapy From a Multicultural Perspective

c) Explain the Process Of Therapy.

B) Write short notes:

a) Therapist's Function and Role

b) UNCONDITIONAL POSITIVE REGARD AND ACCEPTANCE

c) Therapeutic Goals

d) The Role of Assessment

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4

INTERVENTION SYSTEMS EMPHASIZING HUMANISTIC, COGNITIVE AND BEHAVIORAL APPROACHES - II

Unit Structure

4.0 OBJECTIVES

After studying this unit students should be able to:

- Understand nature of Behaviour Therapy
- Know the process of therapy
- Study nature of Beck's Cognitive Therapy
- To know application of therapeutic techniques and processes
- Understand Both therapies from a multicultural perspective

4.1 BEHAVIOR THERAPY: INTRODUCTION

Behavior therapy practitioners focus on observable behavior, current determinants of behavior, learning experiences that promote change, tailoring treatment strategies to individual clients, and rigorous assessment and evaluation (Kazdin, 2001; Wilson, 2008).Its focus was on demonstrating that behavioral conditioning techniques were effective and were a viable alternative to psychoanalytic therapy. Behavior therapy has been used to treat a wide range of psychological disorders with different client populations (Wilson, 2008). Anxiety disorders, depression, substance abuse, eating disorders, domestic violence, sexual problems, pain management, and hypertension have all been successfully treated using this approach. Behavioral 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 behaviors, and gerontology (Miltenberger, 2008). Historical Background The behavioral approach had its origin in the 1950s and early 1960s, and it was a radical departure from the dominant psychoanalytic perspective. In spite of harsh criticism and resistance from psychoanalytic psychotherapists, the approach survived.

In the 1960s Albert Bandura developed social learning theory, which combined classical and operant conditioning with observational learning. Bandura made cognition an authorized focus for behavior therapy. During the 1960s a number of cognitive behavioral approaches sprang up, and they still have a significant impact on therapeutic practice. Contemporary behavior 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. Behavioral techniques were expanded to provide solutions for business, industry, and child-rearing problems as well.

The 1980s were characterized by a search for new horizons in concepts and methods that went beyond traditional learning theory.Two of the most significant developments in the field were

(1) the continued emergence of cognitive behavior therapy as a major force and

(2) the application of behavioral techniques to the prevention and treatment of health related disorders.Cognitive therapy is considered to be the "second wave" of the behavioral tradition.

By the early 2000s, the "third wave" of the behavioral tradition emerged, enlarging the scope of research and practice. This newest development includes dialectical behavior therapy, mindfulness-based stress reduction, mindfulness based cognitive therapy, and acceptance and commitment therapy.

Four Areas of Development:

Contemporary behavior therapy can be understood by considering four major areas of development:

(1) classical conditioning,

(2) operant conditioning,

(3) social learning theory, and

(4) cognitive behavior 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 behavior. 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. This technique illustrates how principles of learning derived from the experimental laboratory can be applied clinically. Desensitization can be applied to people who, through classical conditioning, developed an intense fear of flying after having a frightening experience while flying. Most of the significant responses we make in everyday life are examples of operant behaviors, such as reading, writing, driving a car, and eating with utensils.

Operant conditioning involves a type of learning in which behaviors are influenced mainly by the consequences that follow them. Positive and negative reinforcement, punishment, and extinction techniques illustrate how operant conditioning in applied settings can be instrumental in developing prosocial and adaptive behaviors. The behaviorists of both the classical and operant conditioning models excluded any reference to mediational concepts, such as the role of thinking processes, attitudes, and values. 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 learning and cognitive theory involves a triadic reciprocal interaction among the environment, personal factors (beliefs, preferences, expectations, self-perceptions, and interpretations), and individual behavior.

In the social cognitive approach the environmental events on behavior are mainly determined by cognitive processes governing how environmental influences are perceived by an individual and how these events are interpreted (Wilson, 2008). A basic assumption is that people are capable of self-directed behavior 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 behavior therapy and social learning theory now represent the mainstream of contemporary behavior therapy. Since the early 1970s, the behavioral 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 behavioral problems.

By the mid-1970s cognitive behavior therapy had replaced behavior therapy as the accepted designation and the field began emphasizing the interaction among affective, behavioral, and cognitive dimensions (Lazarus, 2003; Wilson, 2008).

4.1.1 Nature of Behaviour Therapy:

Behavior therapy aims to increase people's skills so that they have more options for responding. The current trend in behavior therapy is toward developing procedures that actually give control to clients and thus

increase their range of freedom. By overcoming debilitating behaviors that restrict choices, people are freer to select from possibilities that were not available earlier, increasing individual freedom (Kazdin, 1978, 2001). It is possible to make a case for using behavioral methods to attain humanistic ends (Kazdin, 2001; Watson & Tharp, 2007).

4.1.2 The Therapeutic Process:

Therapeutic Goals :

The general goals of behavior 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. Although assessment and treatment occur together, a formal assessment takes place prior to treatment to determine behaviors that are targets of change. 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. Contemporary behavior therapy stresses clients' active role in deciding about their treatment. 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 counselor and client discuss the behaviors associated with the goals, the circumstances required for change, the nature of subgoals, and a plan of action to work toward these goals. This process of determining therapeutic goals entails a negotiation between client and counselor that results in a contract that guides the course of therapy. Behavior therapists and clients alter goals throughout the therapeutic process as needed

Therapist's Function and Role Behavior therapists conduct a thorough functional assessment (or behavioral analysis) to identify the maintaining conditions by systematically gathering information about situational antecedents, the dimensions of the problem behavior, and the consequences of the problem. This is known as the ABC model, which addresses antecedents, behaviors, and consequences. This model of behavior suggests that behavior (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 are ones that cue or elicit a certain behavior. For example, with a client who has trouble going to sleep, listening to a relaxation tape may serve as a cue for sleep induction. Turning off the lights and removing the television from the bedroom may elicit sleep behaviors as well. Consequences are events that maintain a behavior in some way either by increasing or decreasing it. For example, a client may be more likely to return to counseling after the counselor offers verbal praise or encouragement for having come in or having completed some homework. A client may be less likely to return after the counselor is consistently late to sessions. In doing an 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 behavior (Cormier, Nurius, & Osborn, 2009).

Behaviorally oriented practitioners tend to be active and directive and to function as consultants and problem solvers. They pay close attention to the clues given by clients, and they are willing to follow their clinical hunches. Behavioral practitioners must possess skills, sensitivity, and clinical acumen (Wilson, 2008). They use some techniques common to other approaches, such as summarizing, reflection, clarification, and open-ended questioning. However, behavioral clinicians perform other functions as well (Miltenberger, 2008; Spiegler & Guevremont, 2003):

- Based on a comprehensive functional assessment, the therapist formulates initial treatment goals and designs and implements a treatment plan to accomplish these goals.
- 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. Clients learn how to identify and cope with potential setbacks. The emphasis is on helping clients maintain changes over time and acquire behavioral and cognitive coping skills to prevent relapses.

A large part of the therapist's role is to teach concrete skills through the provision of instructions, modeling, and performance feedback. The client engages in behavioral rehearsal with feedback until skills are well learned and generally receives active homework assignments (such as self-monitoring of problem behaviors) to complete between therapy sessions. Clients must be motivated to change and are expected to cooperate in carrying out therapeutic activities, both during therapy sessions and in everyday life.

Relationship Between Therapist and Client:

Clinical and research evidence suggests that a therapeutic relationship, even in the context of a behavioral orientation, can contribute significantly to the process of behavior change (Granvold & Wodarski, 1994). Most behavioral practitioners stress the value of establishing a collaborative working relationship (J. Beck, 2005). The skilled behavior therapist conceptualizes problems behaviorally and makes use of the client–therapist relationship in facilitating change. In contrast, most behavioral practitioners contend that factors such as warmth, empathy, authenticity, permissiveness, and acceptance are necessary, but not sufficient, for behavior change to occur. The client–therapist relationship is a foundation on which therapeutic strategies are built to help clients change in the direction they wish. However, behavior therapists assume that clients make progress primarily because of the specific behavioral techniques used rather than because of the relationship with the therapist.

Application:

Therapeutic Techniques and Procedures A strength of the behavioral approaches is the development of specific therapeutic procedures that must be shown to be effective through objective means. The results of behavioral interventions become clear because therapists receive continual direct feedback from their clients. According to Arnold Lazarus (1989, 1992b, 1996b, 1997a, 2005, 2008), a pioneer in contemporary clinical behavior therapy, behavioral practitioners can incorporate into their treatment plans any technique that can be demonstrated to effectively change behavior. Lazarus advocates the use of diverse techniques, regardless of their theoretical origin. It is clear that behavior therapists do not have to restrict themselves only to methods derived from learning theory. Likewise, behavioral techniques can be incorporated into other approaches. This is illustrated later in this chapter in the sections on the integration of behavioral and psychoanalytic techniques and, as well, by the incorporation of mindfulness and acceptance-based approaches into the practice of behavior therapy. The therapeutic procedures used by behavior therapists are specifically designed for a particular client rather than being randomly selected from a "bag of techniques." Therapists are often quite creative in their interventions. These techniques do not encompass the full spectrum of behavioral procedures, but they do represent a sample of the approaches used in contemporary behavior therapy.

4.1.3 Applied Behavioral Analysis:

Operant Conditioning Techniques: In applied behavior 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 most important contribution of applied behavior analysis is that it offers a functional approach to understanding clients' problems and addresses these problems by changing antecedents and consequences (the ABC model). Behaviorists believe we respond in predictable ways because of the gains we experience (positive reinforcement) or because of the need to escape or avoid unpleasant consequences (negative reinforcement). Once clients' goals have been assessed, specific behaviors are targeted. The goal of reinforcement, whether positive or negative, is to increase the target behavior. Positive reinforcement involves the addition of something of value to the individual (such as praise, attention, money, or food) as a consequence of certain behavior. The stimulus that follows the behavior is the positive reinforcer. Another operant method of changing behavior is extinction, which refers to withholding reinforcement from a previously reinforced response. In applied settings, extinction can be used for behaviors that have been maintained by positive reinforcement or negative reinforcement. Extinction can reduce or eliminate certain behaviors, but extinction does not replace those responses that have been extinguished. The goal of reinforcement is to increase target behavior, but the goal of punishment is to decrease target behavior. Miltenberger (2008) describes two kinds of punishment that may occur as a consequence of behavior: positive punishment and negative

punishment. In positive punishment an aversive stimulus is added after the behavior to decrease the frequency of a behavior (such as withholding a threat from a child for misbehavior or reprimanding a student for acting out in class). In negative punishment a reinforcing stimulus is removed following the behavior to decrease the frequency of a target behavior (such as deducting money from a worker's salary for missing time at work, or taking television time away from a child for misbehavior). In both kinds of punishment, the behavior is less likely to occur in the future. These four operant procedures form the basis of behavior therapy programs for parent skills training and are also used in the self-management procedures.

Skinner (1948) believed punishment had limited value in changing behavior and was often an undesirable way to modify behavior. He opposed using aversive control or punishment, and recommended substituting positive reinforcement. The key principle in the applied behavior analysis approach is to use the least aversive means possible to change behavior, and positive reinforcement is known to be the most powerful change agent. Skinner believed in the value of analyzing environmental factors for both the causes and remedies for behavior problems and contended that the greatest benefits to the individual and to society occur by using systematic positive reinforcement as a route to behavior control (Nye, 2000). In everyday life, punishment is often used as a means of getting revenge or expressing frustration.

However, as Kazdin (2001) has noted, "punishment in everyday life is not likely to teach lessons or suppress intolerable behavior because of the specific punishments that are used and how they are applied" (p. 231). Even in those cases when punishment suppresses undesirable responses, punishment does not result in teaching desirable behaviors. Punishment should be used only after nonaversive approaches have been implemented and found to be ineffective in changing problematic behavior (Kazdin, 2001; Miltenberger, 2008). It is essential that reinforcement be used as a way to develop appropriate behaviors that replace the behaviors that are suppressed.

Relaxation Training and Related Methods:

Jacobson (1938) is credited with initially developing the progressive muscle relaxation procedure. Relaxation training involves several components that typically require from 4 to 8 hours of instruction. Clients are given a set of instructions that teaches them to relax. They assume a passive and relaxed position in a quiet environment while alternately contracting and relaxing muscles. This progressive muscle relaxation is explicitly taught to the client by the therapist. Deep and regular breathing is also associated with producing relaxation. At the same time clients learn to mentally "let go," perhaps by focusing on pleasant thoughts or images. Clients are instructed to actually feel and experience the tension building up, to notice their muscles getting tighter and study this tension, and to hold and fully experience the tension. Also, it is useful for clients to experience the difference between a tense and a relaxed state. The client is

then taught how to relax all the muscles while visualizing the various parts of the body, with emphasis on the facial muscles. The arm muscles are relaxed first, followed by the head, the neck and shoulders, the back, abdomen, and thorax, and then the lower limbs. Relaxation becomes a well-learned response, which can become a habitual pattern if practiced daily for about 25 minutes each day.Dattilio (2006) Relaxation procedures have been applied to a variety of clinical problems, either as a separate technique or in conjunction with related methods. The most common use has been with problems related to stress and anxiety, which are often manifested in psychosomatic symptoms. Some other ailments for which relaxation training is helpful include asthma, headache, hypertension, insomnia, irritable bowel syndrome, and panic disorder (Cormier et al., 2009). Systematic Desensitization Systematic desensitization, which is based on the principle of classical conditioning, is a basic behavioral procedure developed by Joseph Wolpe, one of the pioneers of behavior therapy. Clients imagine successively more anxiety-arousing situations at the same time that they engage in a behavior that competes with anxiety. Gradually, or systematically, clients become less sensitive (desensitized) to the anxiety-arousing situation. This procedure can be considered a form of exposure therapy because clients are required to expose themselves to anxiety-arousing images as a way to reduce anxiety. Systematic desensitization is an empirically researched behavior therapy procedure that is time consuming, yet it is clearly an effective and efficient treatment of anxiety-related disorders, particularly in the area of specific phobias (Cormier et al., 2009; McNeil & Kyle, 2009; Spiegler & Guevremont, 2003). Before implementing the desensitization procedure, the therapist conducts an initial interview to identify specific information about the anxiety and to gather relevant background information about the client. This interview, which may last several sessions, gives the therapist a good understanding of who the client is. The therapist questions the client about the particular circumstances that elicit the conditioned fears. Some therapists also administer a questionnaire to gather additional data about situations leading to anxiety. If the decision is made to use the desensitization procedure, the therapist gives the client a rationale for the procedure and briefly describes what is involved.

McNeil and Kyle (2009) describe several steps in the use of systematic desensitization: (1) relaxation training, (2) development of the anxiety hierarchy, and (3) systematic desensitization proper.

The steps in relaxation training, which were described earlier, are presented to the client. The therapist uses a very quiet, soft, and pleasant voice to teach progressive muscular relaxation. The client is asked to create imagery of previously relaxing situations, such as sitting by a lake or wandering through a beautiful field. It is important that the client reach a state of calm and peacefulness. The client is instructed to practice relaxation both as a part of the desensitization procedure and also outside the session on a daily basis. The therapist then works with the client to develop an anxiety hierarchy for each of the identified areas. Stimuli that elicit anxiety in a particular area, such as rejection, criticism, jealousy, disapproval, or any phobia, are analyzed. The therapist constructs a ranked

list of situations that elicit increasing degrees of anxiety or avoidance. The hierarchy then arranged in order from the worst situation the client can imagine down to the situation that evokes the least anxiety. If it has been determined that the client has anxiety related to fear of rejection, for example, the highest anxiety-producing situation might be rejection by the spouse, next, rejection by a close friend, and then rejection by a coworker. The least disturbing situation might be a stranger's indifference toward the client at a party.

Desensitization does not begin until several sessions after the initial interview has been completed. Enough time is allowed for clients to learn relaxation in therapy sessions, to practice it at home, and to construct their anxiety hierarchy. The desensitization process begins with the client reaching complete relaxation with eyes closed. A neutral scene is presented, and the client is asked to imagine it. If the client remains relaxed, he or she is asked to imagine the least anxiety-arousing scene on the hierarchy of situations that has been developed. The therapist moves progressively up the hierarchy until the client signals that he or she is experiencing anxiety, at which time the scene is terminated. Relaxation is then induced again, and the scene is reintroduced again until little anxiety is experienced.

Then Treatment will end when the client is able to remain in a relaxed state while imagining the scene that was formerly the most disturbing and anxiety-producing. The core of systematic desensitization is repeated exposure in the imagination to anxiety-evoking situations without experiencing any negative consequences. In this process homework and follow-up are essential components. Clients can practice selected relaxation procedures daily, at which time they visualize scenes completed in the previous session. Gradually, they also expose themselves to daily-life situations as a further way to manage their anxieties.

Systematic desensitization is an appropriate technique for treating phobias, but it is a misconception that it can be applied only to the treatment of anxiety. It has also been used to treat anger, asthmatic attacks, insomnia, motion sickness, nightmares, and sleepwalking (Spiegler, 2008). A safeguard is that clients are in control of the process by going at their own pace and terminating exposure when they begin to experience more anxiety than they want to tolerate (Spiegler & Guevremont, 2003).

In Vivo Exposure and Flooding:

Exposure is a key process in treating a wide range of problems associated with fear and anxiety. Exposure therapies treat fears and other negative emotional responses by introducing clients, under carefully controlled conditions, to the situations that contributed to such problems. Exposure therapy involves systematic confrontation with a feared stimulus, either through imagination or in vivo (live). Whatever the route used, exposure involves contact by clients and what they find fearful (McNeil & Kyle, 2009).

Desensitization is one type of exposure therapy, but there are others. Two variations of traditional systematic desensitization are in vivo exposure and flooding.

IN VIVO EXPOSURE- In vivo exposure involves client exposure to the actual anxiety-evoking events rather than simply imagining these situations. Live exposure has been a cornerstone of behavior therapy for decades (Hazlett-Stevens & Craske, 2003). Together, the therapist and the client generate a hierarchy of situations for the client to encounter in ascending order of difficulty. Clients engage in brief and graduated series of exposures to feared events. Clients can terminate exposure if they experience a high level of anxiety. In some cases the therapist may accompany clients as they encounter feared situations. People who have extreme fears of certain animals could be exposed to these animals in real life in a safe setting with a therapist.

Self-managed in vivo exposure is a procedure in which clients expose themselves to anxiety-evoking events on their own. It is an alternative when it is not practical for a therapist to be with clients in real-life situations.

FLOODING - Another form of exposure therapy is flooding. It refers to either in vivo or imaginal exposure to anxiety-evoking stimuli for a prolonged period of time. In vivo flooding consists of intense and prolonged exposure to the actual anxiety-producing stimuli. In flooding, clients are prevented from engaging in their usual maladaptive responses to anxiety arousing situations. In vivo flooding tends to reduce anxiety rapidly. An advantage of using imaginary flooding over in vivo flooding is that there are no restrictions on the nature of the anxiety-arousing situations that can be treated. In vivo exposure to actual traumatic events (airplane crash, rape, fire, flood) is often not possible nor is it appropriate for both ethical and practical reasons. Imaginal flooding can re-create the circumstances of the trauma in a way that does not bring about adverse consequences to the client. Survivors of an airplane crash, for example, may suffer from a range of debilitating symptoms. They are likely to have nightmares and flashbacks to the disaster, they may avoid travel by air or have anxiety about travel by any means, and they probably have a variety of distressing symptoms such as guilt, anxiety, and depression. Flooding is frequently used in the behavioral treatment for anxiety-related disorders, posttraumatic stress disorder, phobias, obsessive-compulsive disorder and agoraphobia. Prolonged and intense exposure can be both an effective and efficient way to reduce clients' anxiety. It is important for the behavior therapist to work with the client to create motivation and readiness for exposure. Clients need to make informed decisions after considering the pros and cons of subjecting themselves to temporarily stressful aspects of treatment. Research consistently indicates that exposure therapy can reduce the client's degree of fear and anxiety (Tryon, 2005). The repeated success of exposure therapy in treating various disorders has resulted in exposure being used as a part of most behavioral and cognitive behavioral treatments for anxiety disorders (McNeil & Kyle, 2009).

Spiegler and Guevremont (2003) conclude that exposure therapies are the single most potent behavioral procedures available for anxiety-related disorders, and they can have long-lasting effects. However, using exposure as a sole treatment procedure is not always sufficient.

Eye Movement Desensitization and Reprocessing:

Eye movement desensitization and reprocessing (EMDR) is a form of exposure therapy which involves imaginal flooding, cognitive restructuring, and the use of rapid, rhythmic eye movements and other bilateral stimulation to treat clients who have experienced traumatic stress.It is developed by Francine Shapiro (2001).It draws from a wide range of behavioral interventions. Designed to assist clients in dealing with posttraumatic stress disorders, Shapiro (2001) emphasized the importance of the safety and welfare of the client when using this approach.

Social Skills Training:

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 correct deficits clients have in interpersonal competencies (Spiegler, 2008). Social skills involve being able to communicate with others in a way that is both appropriate and effective. Social skills training includes psychoeducation, modeling, reinforcement, behavioral rehearsal, role playing, and feedback (Antony & Roemer, 2003).

Assertion Training:

One specialized form of social skills training that has gained increasing popularity is teaching people how to be assertive in a variety of social situations. Many people have difficulty feeling that it is appropriate or right to assert themselves. People who lack social skills frequently experience interpersonal difficulties at home, at work, at school, and during leisure time.

Assertion training can be useful for those

(1) who have difficulty expressing anger or irritation,

(2) who have difficulty saying no,

(3) who are overly polite and allow others to take advantage of them,

(4) who find it difficult to express affection and other positive responses,

(5) who feel they do not have a right to express their thoughts, beliefs, and feelings, or

(6) who have social phobias.

The basic assumption underlying assertion training is that people have the right (but not the obligation) to express themselves. One goal of assertion training is to increase people's behavioral repertoire so that they can make the choice of whether to behave assertively in certain situations.

Self-Modification Programs and Self-Directed Behavior:

An advantage of self-modification (or self-management) techniques is that treatment can be extended to the public in ways that cannot be done with traditional approaches to therapy. Another advantage is that costs are minimal. Because clients have a direct role in their own treatment, techniques aimed at self-change tend to increase involvement and commitment to their treatment. Self-modification strategies include self-monitoring, self-reward, self contracting, stimulus control, and self-as-model.

In self-modification programs people make decisions concerning specific behaviors they want to control or change. People frequently discover that a major reason that they do not attain their goals is the lack of certain skills or unrealistic expectations of change. Hope can be a therapeutic factor that leads to change, but unrealistic hope can pave the way for a pattern of failures in a self-change program. A self-directed approach can provide the guidelines for change and a plan that will lead to change.

Self-modification strategies have been successfully applied to many populations and problems, a few of which include coping with panic attacks, helping children to cope with fear of the dark, increasing creative productivity, managing anxiety in social situations, encouraging speaking in front of a class, increasing exercise, control of smoking, and dealing with depression (Watson & Tharp, 2007).

Integrating Behavioral Techniques With Contemporary Psychoanalytic Approaches

Certain aspects of behavior therapy can be combined with a number of other therapeutic approaches. Morgan and MacMillan (1999) developed a three-phase integrated counseling model based on theoretical constructs of object-relations and attachment theory that incorporates behavioral techniques. In the first phase, object-relations theory serves as the conceptual basis for the assessment and relationship-building process. What children learn from early interactions with parents clearly affects personality development and may result in problematic adult relationships. During this phase, therapists provide a supportive holding environment that offers a safe place for clients to recall and explore painful earlier memories. At this phase counseling includes an exploration of clients' feelings regarding past and present circumstances and thought patterns that influence the clients' interpretation of the world.

In the second phase, the goal is to link insights gleaned from the initial assessment phase to the present to create an understanding of how early relational patterns are related to present difficulties. This insight often enables clients to acknowledge and express painful memories, feelings,

and thoughts. As clients are able to process previously repressed and dissociated memories and feelings in counseling, cognitive changes in perception of self and others often occur. Both experiential and cognitive techniques are utilized in the second phase.

In the third and final phase of treatment, behavioral techniques with goal setting and homework assignments are emphasized to maximize change. This is the action phase, a time for clients to attempt new behaviors based on the insight, understanding, and cognitive restructuring achieved in the prior phases of counseling. Clients take action, which leads to empowerment.

The counseling interventions:

Morgan and MacMillan claim that if these treatment goals are well defined it is possible to work through all three phases in a reasonable amount of time. Adapting the conceptual foundation of psychoanalytic thinking to relatively brief therapy makes this approach useful in time limited therapy.

Application to Group Counseling:

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. Many groups are designed primarily to increase the client's degree of control and freedom in specific aspects of daily life.

4.1.4 Behavior Therapy from a Multicultural Perspective:

Strengths from a Diversity Perspective:

Behavior therapy has some clear advantages over many other theories in counseling culturally diverse clients. Behavioral counseling does not generally place emphasis on experiencing catharsis. Rather, it stresses changing specific behaviors and developing problem-solving skills. Some potential strengths of the behavioral approaches in working with diverse client populations include its specificity, task orientation, focus on objectivity, focus on cognition and behavior, action orientation, dealing with the present more than the past, emphasis on brief interventions, teaching coping strategies, and problem-solving orientation.

Behavior 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 color through discriminatory practices and economic problems, and the behavioral approach takes into consideration the social and cultural dimensions of the client's life. Assessment methods should be chosen with the client's cultural background in mind (Spiegler & Guevremont, 2003; Tanaka-Matsumi et al., 2002).

Shortcomings From a Diversity Perspective:

According to Spiegler and Guevremont (2003), a future challenge for behavior therapists is to develop empirically based recommendations for how behavior therapy can optimally serve culturally diverse clients. Although behavior therapy is sensitive to differences among clients in a broad sense, behavior therapists need to become more responsive to specific issues pertaining to all forms of diversity. Because race, gender, ethnicity, and sexual orientation are critical variables which influence the process and outcome of therapy, it is essential that behavior therapists pay greater attention to these factors than they often do. The fact that behavioral interventions often work well raises an interesting issue in multicultural counseling. When clients make significant personal changes, it is very likely that others in their environment will react to them differently. Before deciding too quickly on goals for therapy, the counselor and client need to discuss the challenges inherent in change. It is essential for therapists to conduct a thorough assessment of the interpersonal and cultural dimensions of the problem. Clients should be helped in assessing the possible consequences of some of their newly acquired social skills.

Contributions of Behavior Therapy:

Behavior therapy challenges us to reconsider our global approach to counseling.Ledley and colleagues (2005) state that therapists can help clients to learn about the contingencies that maintain their problematic thoughts and behaviors and then teach them ways to make the changes they want. Techniques such as role playing, behavioral rehearsal, coaching, guided practice, modeling, feedback, learning by successive approximations, mindfulness skills, and homework assignments can be included in any therapist's repertoire, regardless of theoretical orientation. An advantage behavior therapists have is the wide variety of specific behavioral techniques at their disposal. The basic therapeutic conditions stressed by person-centered therapists—active listening, accurate empathy, positive regard, genuineness, respect, and immediacy—need to be integrated in a behavioral framework. Behavioral techniques have been extended to more areas of human functioning than have any of the other therapeutic approaches Behavior therapy is deeply enmeshed in medicine, geriatrics, pediatrics, rehabilitation programs, and stress management. This approach has made significant contributions to health psychology, especially in helping people maintain a healthy lifestyle. A major contribution of behavior therapy is its emphasis on research into and assessment of treatment outcomes. It is up to practitioners to demonstrate that therapy is working. If progress is not being made, therapists look carefully at the original analysis and treatment plan. Another strength of the behavioral approaches is the emphasis on ethical accountability.

Limitations and Criticisms of Behavior Therapy:

Behavior therapy has been criticized for a variety of reasons. There are five common criticisms and misconceptions people often have about behavior therapy,

1. Behavior therapy may change behaviors, but it does not change feelings. Some critics argue that feelings must change before behavior can change. Behavioral practitioners hold that empirical evidence has not shown that feelings must be changed first, and behavioral clinicians do in actual practice deal with feelings as an overall part of the treatment process. A general criticism of both the behavioral and the cognitive approaches is that clients are not encouraged to experience their emotions. In concentrating on how clients are behaving or thinking, some behavior therapists tend to play down the working through of emotional issues.

2. Behavior therapy ignores the important relational factors in therapy. The charge is often made that the importance of the relationship between client and therapist is discounted in behavior therapy.

3. Behavior therapy does not provide insight. If this assertion is indeed true, behavior therapists would probably respond that insight is not a necessary requisite for behavior change. A change in behavior often leads to a change in understanding or to insight, and often it leads to emotional changes

4. Behavior therapy treats symptoms rather than causes. The psychoanalytic assumption is that early traumatic events are at the root of present dysfunction. Behavior therapists may acknowledge that deviant responses have historical origins, but they contend that history is seldom important in the maintenance of current problems. However, behavior therapists emphasize changing current environmental circumstances to change behavior.

5. Behavior therapy involves control and manipulation by the therapist. All therapists have a powerful relationship with the client and thus have control. Behavior therapists are just clearer with their clients about this role (Miltenberger, 2008).

4.2 AARON BECK'S COGNITIVE THERAPY: INTRODUCTION

Aaron Beck's Cognitive Therapy:

Aaron T. 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 (Dattilio, 2000a).

Cognitive therapy has a number of similarities to both rational emotive behavior therapy and behavior therapy. All of these therapies are active, directive, time-limited, present-centered, collaborative, problem-oriented, empirical, structured, make use of homework, and require explicit identification of problems and the situations in which they occur (Beck & Weishaar, 2008).

The basic theory of Cognitive Therapy states that to understand the nature of an emotional episode it is essential to focus on the cognitive content of an individual's reaction to the upsetting event or stream of thoughts (DeRubeis & Beck, 1988). The goal is to change the way clients think by using their automatic thoughts to reach the core schemata and begin to introduce the idea of schema restructuring. This can be done by encouraging clients to collect and weigh the evidence in support of their beliefs.

Cognitive therapy is based on the theoretical rationale that the way people feel and behave is determined by how they perceive and structure their experience. The theoretical assumptions of cognitive therapy are

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

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

(3) these meanings can be discovered by the client rather than being interpreted by the therapist (Weishaar, 1993).

Basic Principles of Cognitive Therapy:

Beck was practicing psychoanalytic therapy for many years. As a part of his psychoanalytic study, he was examining the dream content of depressed clients for anger that they were turning back on themselves. He then noticed that clients exhibited a negative bias in their interpretation or thinking. Beck asked clients to observe negative automatic thoughts that persisted even though they were contrary to objective evidence, and then he developed a comprehensive theory of depression.

Beck mentioned that people with emotional difficulties tend to commit characteristic "logical errors" that tilt objective reality in the direction of self deprecation. some of the systematic errors are

Arbitrary Inferences:

Arbitrary inferences refer to making conclusions without supporting and relevant evidence. it includes "catastrophizing," or thinking of the absolute worst scenario and outcomes for most situations. For example ,You are convinced that you fooled your professors and somehow just managed to get your degree, but now people will certainly see through you!

Selective abstraction:

Selective abstraction consists of forming conclusions based on an isolated detail of an event. In this process other information is ignored, and the

significance of the total context is missed. The assumption is that the events that matter are those dealing with failure and deprivation.

Overgeneralization:

Overgeneralization is a process of holding extreme beliefs on the basis of a single incident and applying them inappropriately to dissimilar events or settings, for example If you have difficulty working with one colleague at work, you might conclude that you will not be effective in communication at the workplace. You might also conclude that you will not be effective working with any Colleagues!

Magnification:

Magnification and minimization consist of perceiving a case or situation in a greater or lesser light than it truly deserves. Person might make this cognitive error by assuming that even minor mistakes in work could easily create a crisis for the individual and might result in damage.

Personalization;

Personalization is a tendency for individuals to relate external events to themselves, even when there is no basis for making this connection.

Labeling and mislabeling:

Labeling and mislabeling involve portraying one's identity on the basis of imperfections and mistakes made in the past and allowing them to define one's true identity.

Dichotomous thinking:

Dichotomous thinking involves categorizing experiences in either-or extremes. With such polarized thinking, events are labeled in black or white terms. You might give yourself no latitude for being an imperfect person.

The cognitive therapist operates on the assumption that the most direct way to change dysfunctional emotions and behaviors is to modify inaccurate and dysfunctional thinking. The cognitive therapist guides clients how to identify these distorted and dysfunctional cognitions through a process of evaluation.

In this therapy, clients learn to be involved in more realistic thinking, especially if they consistently notice times when they are caught up in catastrophic thinking. After they have understood how their unrealistically negative thoughts are affecting them, clients are trained to test these automatic thoughts against reality by examining the evidence for and against them. They can begin to monitor the frequency with which these beliefs intrude in situations in everyday life. The frequently asked question is, "Where is the evidence for _____?" If this question is raised often enough, clients are likely to make it a practice to ask themselves this question. This process of critically examining their core beliefs involves

empirically testing them by actively engaging in a Socratic dialogue with the therapist, carrying out homework assignments, gathering data on assumptions they make, keeping a record of activities, and forming alternative interpretations (Dattilio, 2000a; Freeman & Dattilio, 1994; Tompkins, 2004, 2006).

Clients form hypotheses about their behavior and slowly learn to employ specific problem-solving and coping skills. Through a process, clients acquire insight about the connection between their thinking and the ways they act and feel.

Cognitive therapy is focused on present problems.The past may be brought into therapy when the therapist feels it essential to understand how and when certain core dysfunctional beliefs originated and how these ideas have a current impact on the client's specific schema (Dattilio, 2002a).

The Client–Therapist Relationship:

Beck (1987) emphasizes that the quality of the therapeutic relationship is basic to the application of cognitive therapy. Beck believes that effective therapists are able to combine empathy and sensitivity, along with technical competence. The core therapeutic conditions described by Rogers in his person-centered approach are viewed by cognitive therapists as being necessary, but not sufficient, to produce optimum therapeutic effect. therapists must also 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 focused at guiding clients in significant self-discoveries that will lead to change (Weishaar, 1993).

Cognitive therapists are continuously active and deliberately interactive with clients, to help clients frame their conclusions in the form of testable hypotheses. Therapists engage clients' active participation and collaboration throughout all phases of therapy, including deciding how often to meet, how long therapy should last, what problems to explore, and setting an agenda for each therapy session (J. Beck & Butler, 2005). Clients 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 (J. Beck, 1995, 2005; J. Beck & Butler, 2005; Beck & Weishaar, 2008).

Cognitive therapists emphasize the client's role in self-discovery. Cognitive therapists aim to teach clients how to be their own therapist. Typically, a therapist will educate clients about the nature and course of their problem, about the process of cognitive therapy, and how thoughts influence their emotions and behaviors. Cognitive therapy has been known to the general public through self-help books.

Homework is often used as a part of cognitive therapy. The homework is focused on the client's specific problem and arises out of the collaborative therapeutic relationship. The purpose of homework is not merely to teach

clients new skills but also to enable them to test their beliefs in daily-life situations.

Emphasis is placed on self-help assignments that serve as a continuation of issues addressed in a therapy session (Dattilio, 2002b). Cognitive therapists 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 & Butler, 2005). Tompkins (2006) points out that there are clear advantages to the therapist and the client working in a collaborative manner in negotiating mutually agreeable homework tasks. He believes that one of the best indicators of a working alliance is whether homework is done and done well.

4.3 APPLICATIONS OF COGNITIVE THERAPY

Applying Cognitive Techniques:

The goal of Techniques are correcting errors in information processing and modifying core beliefs which result in faulty conclusions. Cognitive techniques focus on identifying and examining a client's beliefs, exploring the origins of these beliefs, and modifying them if the client cannot support these beliefs. For Example, skills training, role playing, behavioral rehearsal, and exposure therapy. Regardless of the nature of the specific problem, the cognitive therapist is mainly interested in applying procedures that will assist individuals in making alternative interpretations of events in their daily lives.

Treatment of Depression:

Beck Focuses on the content of the depressive negative thinking and biased interpretation of events (DeRubeis & Beck, 1988). In an earlier study that provided much of the backbone of his theory, Beck (1963) even found cognitive errors in the dream content of depressed clients.

Beck (1987) writes about the cognitive triad as a pattern that triggers depression. In the first component of the triad, clients hold a negative view of themselves and blame their setbacks on personal inadequacies without considering circumstantial explanations. They are convinced that they lack the qualities essential to bring them happiness. The second component of the triad consists of the tendency to interpret experiences in a negative manner. It almost seems as if depressed people select certain facts that conform to their negative conclusions, a process referred to as selective abstraction by Beck. Selective abstraction is used to support the individual's negative schema, giving further acceptance to core beliefs. The third component of the triad pertains to depressed clients' gloomy vision and projections about the future. They expect their present difficulties to continue, and they anticipate only failure in the future. Depression-prone people often set perfectionist goals for themselves that are impossible to attain. Their negative expectations are so strong that even if they experience success in specific tasks they anticipate failure the

next time. They screen out successful experiences that are not consistent with their negative self-concept. The thought content of depressed individuals centers on a sense of irreversible loss that results in emotional states of sadness and disappointment.

Beck's therapeutic approach to treating depressed clients focuses on specific problem areas and the reasons clients give for their symptoms. Some of the behavioral symptoms of depression are inactivity, withdrawal, and avoidance. To assess the depth of depression, Beck (1967) designed a standardized device known as the Beck Depression Inventory (BDI).Clients are asked to complete easy tasks first, so that they will meet with some success and become slightly more optimistic. The point is to enlist the client's cooperation with the therapist on the assumption that doing something is more likely to lead to feeling better than doing nothing.

Cognitive therapy techniques may include exposing the client's ambivalence, generating alternatives, and reducing problems to manageable proportions. Further, if the client can develop alternative views of a problem, alternative courses of action can be developed. This can result not only in a client feeling better but also behaving in more effective ways (Freeman & Reinecke, 1993).

A central characteristic of most depressive people is self-criticism. Underneath the person's self-hate are attitudes of weakness, inadequacy, and lack of responsibility.Many techniques can help in this situation. Clients can be asked to identify and provide reasons for their excessively self-critical behavior. The therapist may ask the client, "If I were to make a mistake the way you do, would you despise me as much as you do yourself?" A skillful therapist may play the role of the depressed client, portraying the client as inadequate and weak. This technique can be effective in demonstrating the client's cognitive distortions and unpredictable inferences. The therapist can then discuss with the client how the "tyranny of shoulds" can lead to self-hate and depression.

Depressed clients typically experience painful emotions. One procedure to counteract painful effects is humor. A therapist can demonstrate the ironic aspects of a situation. If clients can even briefly experience some lightheartedness, it can serve as an antidote to their sadness. Such a shift in their cognitive set is simply not compatible with their self-critical attitude. Another specific characteristic of depressed people is an exaggeration of external demands, problems, and pressures. Such people often exclaim that they feel overwhelmed and that there is so much to accomplish that they can never do it. A cognitive therapist might ask clients to list things that need to be done, set priorities, check off tasks that have been accomplished, and break down an external problem into manageable units. When problems are discussed, clients often become aware of how they are magnifying the importance of these difficulties. Through rational exploration, clients are able to regain a perspective on defining and accomplishing tasks. The therapist typically has to take the lead in helping clients make a list of their responsibilities, set priorities, and develop a

realistic plan of action. Because carrying out such a plan is often inhibited by self-defeating thoughts, it is well for therapists to use cognitive rehearsal techniques in both identifying and changing negative thoughts. If clients can learn to combat their self-doubts in the therapy session, they may be able to apply their newly acquired cognitive and behavioral skills in real-life situations.

The cognitive behavioral approach Concentrates on family interaction patterns, and family relationships, cognitions, emotions, and behavior are viewed as exerting a mutual influence on one another. Cognitive therapy, as set forth by Beck (1976), places a heavy emphasis on schema, or what have elsewhere been defined as core beliefs. A key aspect of the therapeutic process involves restructuring distorted beliefs (or schema), which has a crucial impact on changing dysfunctional behaviors.

Strengths From a Diversity Perspective:

There are several strengths of cognitive behavioral approaches from a diversity perspective. If therapists understand the core values of their culturally diverse clients, they can help clients to explore these values and gain a full awareness of their conflicting feelings. Then client and therapist can work together to modify selected beliefs and practices.

Shortcomings From a Diversity Perspective:

Exploring values and core beliefs plays an important role in all of the cognitive behavioral approaches, and it is crucial for therapists to have some understanding of the cultural background of clients and to be sensitive to their struggles. Therapists would do well to use caution in challenging clients about their beliefs and behaviors until they clearly understand their cultural context.

One of the shortcomings of applying cognitive behavior therapy to diverse cultures pertains to the hesitation of some clients to question their basic cultural values. Dattilio (1995) notes that some Mediterranean and Middle Eastern cultures have strict rules with regard to religion, marriage and family, and child-rearing practices. These rules are often in conflict with the cognitive behavioral suggestions of disputation.

4.4 SUMMARY

Behavior therapy is diverse with respect not only to basic concepts but also to techniques that can be applied in coping with specific problems with a diverse range of clients. The behavioral movement includes four major areas of development: classical conditioning, operant conditioning, social learning theory, and increasing attention to the cognitive factors influencing behavior In helping clients achieve their goals, behavior therapists typically assume an active and directive role. Although the client generally determines what behavior will be changed, the therapist typically determines how this behavior can best be modified. In designing a treatment plan, behavior therapists employ techniques and procedures from a wide variety of therapeutic systems and apply them to the unique

needs of each client. Behavioral strategies can be used to attain both individual goals and societal goals. Because cognitive factors have a place in the practice of behavior therapy, techniques from this approach can be used to attain humanistic ends. It is clear that bridges can connect humanistic and behavioral therapies, especially with the current focus of attention on self-directed approaches and also with the incorporation of mindfulness and acceptance-based approaches into behavioral practice

In cognitive therapy, it is presumed that clients are helped by the skillful use of a range of cognitive and behavioral interventions and by their willingness to perform homework assignments between sessions. All of the cognitive behavioral approaches stress the importance of cognitive processes as determinants of behavior. It is assumed that how people feel and what they actually do is largely influenced by their subjective assessment of situations. Because this appraisal of life situations is influenced by beliefs, attitudes, assumptions, and internal dialogue, such cognitions become the major focus of therapy.

4.5 QUESTIONS

A) Write long answers:

a) Discuss in detail about nature of Behaviour Therapy

b) Discuss about Behaviour Therapy from a Multicultural Perspective

c) Explain the Application Of Cognitive Therapy.

B) Write short notes:

a) Relaxation training and related methods

b) Client Therapist Relationship in Behaviour Therapy

c) Basic Principles of Cognitive Therapy

d) Client Therapist Relationship in Cognitive Therapy

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5

TECHNIQUES IN GROUP - I

Unit Structure

5.0 OBJECTIVES

After reading this unit, you would be able to understand:

- The fundamentals of group therapy
- The influences and advantages of group therapy
- The basics of organizing a group for therapy
- The nature of opening and later sessions of group therapy
- The technical functions of group therapists

5.1 INTRODUCTION

Groups enable professionals from the various fields to deliver services to the largest number of people, who share the common qualities, whether demographic, cognitive, emotional, personality, values etc. Forming groups helps them save time and effort, where several clients can be addressed based on their common needs at a time. Therefore it is imperative for professionals, such as counselors, psychologists, social workers, ministers, teachers, and others who work with people that they should learn to lead groups. Here, we will be learning about various group dynamics, leadership qualities and techniques used in group therapy/psychotherapy. Many people believe that they have unique feelings. However, when they become a member of a group, it allows them to discover that they are not the only ones to have those particular thoughts, concerns and feelings. Thus, working in groups is often effective in helping individuals resolve their personal and interpersonal concerns.

In the counselling service, groups have a long and distinguished history. A Boston physician, Joseph Hersey Pratt is generally credited for starting the first group-psychotherapy in 1905 – with tubercular outpatients at Massachusetts General Hospital. Other pioneers to contribute to group therapy are Jacob L. Moreno (who introduced the term group psychotherapy and psychodrama in a group setting), Kurt Lewin (who formed the basis for the T-group movement), Fritz Perls (Gestalt approach in groups), W. Edwards Deming (conceptualized and implemented the idea of quality work groups), William Schutz and Jack Gibb (who emphasized a humanistic aspect to T-groups), and Carl Rogers (who devised the basic encounter group, i.e. the model for growth-oriented group approaches). Among many valid reasons for using a group approach, two are common to all groups (Jacobs et al., 2016):

i) groups are more efficient and offer more resources and viewpoints, and

ii) groups have the feeling of commonality, the experience of belonging, the chance to practice new behaviours, the opportunity for feedback and vicarious learning by listening and observing others, the approximation to real-life encounters, and the pressure to uphold commitments.

Groups can be categorized into seven categories, based on their different goals (Jacobs, et al., 2016). They are:

i) education groups, in which helping professionals, that is, group leaders provide information and then elicit reactions and comments from members. Thus, they play the role of educators in such groups (e.g., students learning study skills, women learning how to protect themselves from being raped, etc.).

ii) discussion groups, in which the focus is usually on topics or issues rather than any member's personal concerns. The purpose of such groups is to give participants the opportunity to share ideas and exchange information.

iii) task groups, in which a specific task is to be accomplished, such as discussing a client, deciding policies for a school, etc.

iv) growth and experiential groups, in which the group activities are focused on group members' relevant self-exploration and personal growth.

v) counselling and therapy group, in which certain problems in group participants' lives are dealt with, with the help of therapist/s and other group members.

vi) support groups, in which group members learn about something in common that they share. They also learn that other people struggle with the same problems, feel similar emotions, and think similar thoughts.

vii) self-help groups, in which group members mainly learn to develop and enhance their decision-making capacity.

5.1.2 Nature of Group Therapy/Psychotherapy:

In group therapy/ psychotherapy, there is at least one therapist to treat more than one individual at the same time. Some groups may have more than one therapist. Group sizes vary depending on the type of therapy. Group therapy is a valuable and, in some cases, essential treatment method. Developing group cohesiveness and mutual assistance are among the most important processes that evolve during group psychotherapy. Other important processes that evolve are i)manifestations of empathy, support, challenge, confrontation, and interpretation; ii) availability of identification models; iii) opportunities for introducing projective identifications; iv) investigative explorations, and v) a joint sharing of problems. It may be utilized in the following four different ways:

(1) Independently: Here, both intrapsychic and interpersonal operations are considered;

(2) As a "combined therapy": It can be utilized in a combination with individual therapy conducted by the same therapist. 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) As a "conjoint therapy": in conjunction with individual therapy conducted by another therapist; and

(4) As leaderless groups: It is particularly after formal group therapy has ended (Kline, 1975).

Meetings in independent, combined, conjoint therapy may take place once or twice weekly or even daily in institutional settings. At times, there may be regularly scheduled meetings that are not attended by the therapist/s, called "coordinated meetings".

Coordinated Meetings:

In coordinated meetings, the members may assemble -

- before a regular session (i.e., "pre-meetings"),
- after a regular session (i.e., post-meetings), or
- at other times at specially selected places (i.e., "alternate meetings").

Such coordinated meetings enable clients to discuss their feelings about the therapist more freely. Meetings are generally less formal and more spontaneous than regular meetings.

There are two types of groups:

i) closed groups that maintain a constant membership, although new members may be added to it for special reasons. They can be time-limited and goal-oriented.

ii) open groups that operate continuously with new members being added as regular members operate therapy and leave the group.

Treatment in group therapy may be "therapist-centred", "group-centred", and "authority-denying" at times. When it is therapist-centred, therapists have a range of diverse roles to play, which will be discussed in Section 5.2.5 in detail.

5.2 FUNDAMENTALS OF GROUP THERAPY

Group, as we have come to know up to this point, is the essential and leading factor in group psychotherapy which has the potential to make the therapy effective and successful. When the treatment in group therapy is "group-centred", the group operates as the primary authority, while therapists function in a consultative role. Thus, peer and authority relationships are considered equally important. Here, two types of communication take place:

i) Circular communication, where rotating leadership is encouraged, with no interference with the relationships between clients (i.e., group participants) that are constantly broken, restored, and reorganized. Here, the therapists control their anxiety about neurotic alliances.

ii) Horizontal communication, which is also known to be authority-denying, may occur in which the therapists are on an equal plane with the clients. Here, emotional interactions are considered most important, and direct experience in the group is encouraged. Also, therapists present their own problems to the group

Let us now discuss some fundamental aspects of the group that makes the therapy work in an effective manner.

5.2.1 Influences of Group Therapy:

Group may have an influence on each individual, when people gather together in a group. This encourages one to express oneself openly. The person soon realizes that the group fosters free expression of feelings or attitudes on any subject, without any social taboos on content usually avoided in everyday interactions. Recognizing that fellow members have the same fears and doubts, can be supportive 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 therapists. Thus, 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 lessens. Group judgment is a moving force that cannot be resisted. As compared to an interpretation by the therapist, an opinion Where shared by many members about an individual or behaviour brings a more intense effect.

During individual therapy, one may be unable to express feelings toward the therapist. However, the group strengthens the individual's ability to express feelings toward the therapist, whether rational or irrational. Learning how emotional processes operate by observing how other members talk about and solve their problems is one of the most important consequences of being in a group geared toward reconstructive goals. This soon turns the dynamic thinking into a dominant mode in the group. Also, awareness of inner psychological operations is sharpened through emotional involvement with other group members, through one's own spontaneous discoveries and interpretations from fellow members and the therapist. In group therapy, thus, the client is encouraged to hold his or her ground and to express and analyze feelings and defences, instead of withdrawing as in a usual life situation.

5.2.2 Advantages of Group Therapy:

In group therapy, diversified intrapsychic defences come out toward members of the group with whom the client 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 clients feel more protected, both by the therapist and by members with whom alliances have been formed, and they may be able to practice new attitudes more favourably.

Yalom and Leszcz (2005) noted down some positive forces of groups in group therapy, in terms of their general advantages as therapeutic factors, which include:

• **Installation of hope** (i.e., assurance that treatment will work)
• **Universality** (i.e., the realization that one is not alone, unique, or abnormal)
• **Imparting of information** (i.e., instruction about mental health, mental illness, and how to deal with life problems)
• **Altruism** (i.e., sharing experiences and thoughts with others, helping them by giving of oneself, working for the common good)
• **Corrective recapitulation of the primary family group**

(i.e., reliving early family conflicts and resolving them)
• **Development of socializing techniques** (i.e., interacting with others and learning social skills as well as more about oneself in social situations)
• **Imitative behaviour** (i.e., modelling positive actions of other group members)
• **Interpersonal learning** (i.e., gaining insight and correctively working through past experience)
• **Group cohesiveness** (i.e. bonding with other members of the group)
• **Catharsis** (i.e., experiencing and expressing feelings)
• **Existential factors** (i.e., accepting responsibility for one's life in basic isolation from others, recognizing one's own mortality and the capriciousness of existence)

Source: Gladding, S. T. (2018). Counseling: A Comprehensive Profession (8th Ed.) Pearson Education}.

Here are some of the major advantages in terms of a number of opportunities that group therapy provides:

An opportunity 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 study one's own defences 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 accept constructive criticism
- express hostility and absorb the reactions of others to one's hostility
- consume hostility from others and determine the reasonableness of one's reactions
- translate understanding into direct action and receive help in

resolving resistance to actions

- 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 the 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 group therapy, the group is acting as a unit that replicates the family setting and sponsors the re-enactment of parental and sibling relationships. Thus, Group therapy is effective for clients experiencing isolation and social disengagement, especially those with posttraumatic stress disorder (PTSD), and complex traumatic stress disorders following childhood sexual abuse in women (Ford et al., 2009). It assures being in a group that offers safety, respect, honesty, privacy, and dedication to recovery for people who struggle with anxiety, fear, shame, guilt, alienation, loneliness, and a sense of powerlessness and of being permanently damaged which is profoundly demoralizing and isolating for trauma survivors (Courtois, 1988; Mendelsohn, Zachary, & Harney, 2007). Overall, group therapy helps one find his or her authentic voice and reclaim one's memories and sense of self.

Although group therapy assures several above-listed advantages, it is found that the integration of the therapist's guidance and peer support in group therapy may be especially challenging when participants with a deep distrust for people in the role of authority and caregivers (Courtois, 1988) and whose attachment styles are insecure and/or dysregulated (Ford et al., 2009).

5.2.3 Organizing Group:

Before conducting a group for a therapy purpose, therapists need to consider the following factors that will determine how to form a group:

1. Goals that are set by the therapists, whether supportive, reeducative, or reconstructive.

2. Constituent members of the group, whether alcoholics, drug addicts, psychotics, stutterers, delinquents, psychoneurotics, character disorders, or clients with heterogeneous problems.

3. Therapist's training, whether related to group dynamics, rehabilitation, behaviour therapy, cognitive therapy, existential therapy, psychodrama, psychoanalytically oriented psychotherapy, or psychoanalysis.

4. Therapists' personal ambitions and needs, whether characterologic or countertransferential.

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 clients with the following conditions are likely to perform poorly in a group. They are:

i) Psychopathic personalities and those with poor impulse control,

ii) Acute depression and suicidal risks,

iii) Stutterers,

iv) True alcoholics,

v) Hallucinating patients and those out of contact with reality,

vi) Patients with marked paranoic tendencies,

vii) Hypomanics, and

viii) Clients with low intelligence.

Such clients 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 experience feelings in relation to both sexes.

- A heterogeneous group in terms of age, sex, and the 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 1 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

5.2.4 Opening and Later Sessions:

Let us now understand, in this section, how the opening and later sessions should be conducted and the precautions that need to be taken by the therapists while conducting the opening and later sessions.

a) Opening Sessions:

Opening sessions include the entire first session, the last part of the first session, or even the first couple of sessions. In the first session, the members are introduced by their first names, and the purpose of group discussions, what to expect, fears, group rules, comfort levels, and the content of the group are clarified. This will vary with different therapists and different groups. Thus, members check out other members and their own level of comfort with sharing in the group during opening sessions. In the case of groups with a culturally diverse membership, the opening sessions may get extended longer based on the level of discomfort of group members. On the other hand, for some groups, the opening sessions may last only a few minutes since the purpose is clear and the trust and comfort levels are already high. Thus, the more passive-dependent the clients are, the therapist should exercise the more demanded leadership. 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 to understand their individual patterns eventually. Though, it is not necessary for the members to feel compelled to reveal something that they want to keep to themselves, communicating freely will help them to get a better grip on their problems. Before the close of the first session, some therapists may stress the confidential nature of the meetings and 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 involvement may be prevented 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. This may lead to more acting-out. They may try to keep clients from exposing painful revelations before the group is ready to support them.

In a group, free verbal interaction may be encouraged in order to bring out each member's habitual disguises and defences. 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; 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. Interpretation of transference with the therapists brings the clients closer to behaviour patterns that the clients have been disclaiming. It also permits reality testing. The therapists can advantageously analyze the structure of the group as it displays itself in a particular session. They also define the defence mechanisms displayed by the individual members by designating the roles played by the different members. As the group becomes integrated, the clients gain more insight into personal difficulties. Clients recognize that many troubles that they previously believed to be unique, have a common base.

For this reason, the therapists 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., siblings), and

(3) transference to the group itself (e.g., pregenital mother symbol).

These different transference relationships are always present simultaneously, where clients treat the group as if it were their own family. During this transference phase, defences dreams are also utilized advantageously in a different manner than in individual therapy. Thus, systematic analysis of intragroup transferences may be helpful in successful transference interpretations. This further can lead to reconstructive personality changes of a deep and enduring nature.

The basic rule in a group setting is for members to express themselves individually and as freely and without restraint as possible. This encourages the disclosure of prohibited or fearsome ideas and impulses without the threat of rejection or punishment.

In later sessions, the interactional processes virtually do put the various group members in the role of co-therapists. Under the guidance of the therapist, this role can be enhanced. The specific effect of member "co-therapists" 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. Here, a lack of control in one group member often results in a similar lack of control in others.

Alternate sessions: Alternate sessions are those apart from opening and later sessions as they suggest. These sessions can provide opportunities for free interaction, testing, and exploring. They enable some patients to speak more freely about their feelings about the therapist and thereby consolidate their separation from parental authority. However, it is essential that activities at alternate sessions or elsewhere involving group members with each other be reported at the regular group sessions.

5.2.5 Technical Functions of Group Therapists:

As discussed before, some sessions of the group therapy may take place without the presence of the therapist/s may be in informal way, allowing some degree of freedom to group participants, where they may discuss their feelings about the therapist/s more openly and freely.

However, treatment in group therapy may be "therapist-centred" at times, where therapists take a directive and more authoritarian role. The leader's feelings about leading a group affect how the group will work. Four leadership qualities of a group leader, when not used excessively, have a positive effect on the outcome of groups (Yalom & Leszcz, 2005). They are as follows:

1. Caring – the more caring nature, the better the outcome.
2. Meaning attribution, which includes clarifying, explaining, and providing a cognitive framework for change.

3. Emotional stimulation, which involves activity, challenging, risk-taking, self-disclosure; and

4. Executive function, which entails developing norms structuring, and suggesting procedures.

Hence, the group therapist must be a good leader and beyond those of a therapist, with these four positive and essential leadership qualities.

The 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,
- to resolve competitiveness, resentments, and other defences that block the activity
- to deal with overt obstructions in the form of resistance 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 explain the theory.
- to resolve resistance to talking about feelings regarding one another
- to try to break up fixed role behaviour patterns
- to focus on the conversational theme around pertinent subjects when topics become irrelevant
- to create tension by asking questions and pointing out interactions when there is a reduction of activity in the group
- to pose pointed questions to facilitate participation
- to deal with individual and group resistance
- to support upset members
- to encourage withdrawn members to talk.
- to interfere with hostile pairings who upset the group with their quarrelling
- to remind 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. Here, the therapist can step in and deal with excessive tension and maintain an optimal level of tension.
- to detect resistances of the group as a whole as well as of the individual members.
- to bring out one's serious neurotic problems that may destroy the confidence of some group members in the therapist's capacity for objectivity and ability to help them and the impair effectiveness of the therapeutic process.
- to share feelings and reactions that will reveal the therapist as more human and less omniscient and give the patients confidence to talk more openly about their own anxieties.

This way, therapists' efforts to expedite group therapy and catalyze movement result in their own evolving techniques.

Ethical Considerations in the context of Group Therapy (Jacobs et al., 2016):

An effective therapist as a group leader must be aware of ethical considerations. Unethical behaviour on therapists' part usually consists of therapists being incompetent to lead the groups they are leading, and/or not caring properly for the group members. Here are noted down ethical considerations to be taken care of by the couselors/therapists as leaders regarding a few aspects:

Training:

The fundamental ethical principle for leading groups is that the group counselors should be thoroughly trained in using any technique or should use it under supervision by a counselor familiar with the intervention (Association of Specialists in Group Work [ASGW], 2008).

Knowledge:

Counselors/therapists should have a good grasp of the material being discussed in the group and they should know how to deal with such material. Also, they should have an understanding of crucial aspects, like cultural and gender issues of the group members.

Personal Growth:

Couselors should not use groups for their own personal growth.

Dual Relationships:

Dual relationship, in the group context, is a relationship that exists in addition to the therapeutic relationship established between the leader and the members. Counselors should make sure that the therapeutic

relationship is not being put at risk. For this purpose, they should not enter into any dual relationship without caution. They should avoid any exploitative dual relationship since doing so is unethical.

Role in Making Referrals:

Counselors as group leaders should make sure, as an ethical responsibility, that the group members are made aware of proper follow-up treatment possibilities. It is because follow-up becomes important since very often, members in the therapy groups need additional individual, group, or family counselling.

In the next chapter, we will be learning about other aspects of group therapy, that is, about managing special problems in group therapy and other group approaches.

5.3 SUMMARY

Groups enable professionals from different fields to deliver services to the largest number of people, who share the common qualities, whether demographic, cognitive, emotional, personality, values etc. There are seven categories of groups, namely, educations groups, discussion groups, task groups, growth and experiential groups, counselling and therapy groups, support groups, and self-help groups. We have learned many aspects of groups in the context of group therapy. During group therapy, becoming a member of the therapeutic group allows people to discover that they are not the only ones to have particular thoughts, concerns and feelings. In group therapy/ psychotherapy, there is at least one therapist to treat more than one individual at the same time, while some groups may have more than one therapist. Group sizes vary depending on the type of therapy.

Developing group cohesiveness and mutual assistance are among the most important processes that evolve during group psychotherapy. Other important processes are i) manifestations of empathy, support, challenge, confrontation, and interpretation; ii) availability of identification models; iii) opportunities for introducing projective identifications; iv) investigative explorations, and v) a joint sharing of problems. Group therapy may be utilized in four ways, as independently, combined therapy, conjoint therapy and leaderless groups. At times, there may be regularly scheduled meetings may be arranged called “coordinated meetings” that are not attended by the therapist/s, for which members may assemble either before a regular session (i.e., “pre-meetings”), after a regular session (i.e., post-meetings), or at other times at specially selected places. There are either open groups or closed groups for group therapy.

Communication in group therapy takes place in two ways, that is, circular and/or horizontal. Group and group therapy have many influences on individuals, such as encouraging the persons to express themselves openly and enhancing persons’ self-esteem and self-confidence as being two major influences. Some of the major advantages of group therapy include the opportunity to break down one’s detachment and tendencies to isolate

oneself, observe dynamic processes in other people and study one's own defences in a 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, etc. Group therapy has been found effective for clients experiencing isolation and social disengagement, especially those with posttraumatic stress disorder (PTSD), and complex traumatic stress disorders following childhood sexual abuse in women. On the other hand, it is challenging for clients with a deep distrust for people in the role of authority and caregivers, and with insecure and/or dysregulated attachment styles.

Before conducting a group for a therapy purpose, therapists need to consider the goals set by them, constituent members of the group, therapists' training, and their personal ambitions and needs. Clients with certain conditions, that is, psychopathic personalities and those with poor impulse control, acute depression and suicidal risks, stutterers, true alcoholics, hallucinating patients and those out of contact with reality, patients with marked paranoic tendencies, hypomanics, and clients with low intelligence, are likely to perform poorly in a group. Also, some other essential characteristics should be taken care of while organizing or forming a group considering age difference, homogeneity in educational background and intelligence (which may be desirable, but not imperative), number of group members, a balance of male and female participants, and heterogeneity of group in terms of age, sex, and the syndrome.

Group therapy proceeds through opening sessions, later sessions and also alternate sessions and these sessions are dependent on the therapists' skills, preferences, anxiety level etc. Transference is likely to take place in three types during later sessions - to the therapist and central figure, to peers, to the group itself (Grotjahn, 1973). The therapist as a good leader should possess the four leadership qualities (i.e., caring, meaning attribution, emotional stimulation, and executive function) that have a positive effect on the outcome of groups. The therapist's roles, as a group leader, include many technical functions. Some of them are: to catalyze participation of the various members, to maintain an adequate level of tension, to promote decision-making and problem-solving, to try to break up fixed role behaviour patterns, etc. Lastly, we also learned about ethical considerations in brief on part of the therapists considering their training, knowledge, personal growth, dual relationships, and role in making referrals. The next chapter will throw light on managing special problems in group therapy and other group approaches.

5.4 QUESTIONS

1. Write a note on the nature of group therapy/psychotherapy.
2. Discuss the influences and advantages of group therapy as its fundamentals.
3. Write a note on organizing a group.

4. Discuss the opening sessions, later sessions, and alternate sessions in group therapy.
5. Discuss the technical functions of group therapists.
6. Write short notes on:

a) Influences of group therapy

b) Advantages of group therapy

c) Opening sessions

d) Later sessions

5.5 REFERENCES

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6

TECHNIQUES IN GROUP - II

Unit Structure

6.0 OBJECTIVES

After reading this unit, you would be able to understand:

- Special problems during group therapy
- Different group therapy approaches
- Pre-intake and Post-intake groups
- Special age groups for group therapy
- Behaviour therapy, experiential therapy, and psychodrama and role play

6.1 INTRODUCTION

Previously, we discussed the various aspects of group therapy, its fundamentals in terms of its influences and advantages in dealing with problems in groups that are experienced by its members in common. We gained knowledge about how the groups are organized based on the problems to be treated, and how opening and later sessions are conducted considering the needs of the clients in the groups. Besides, we also had a glance at the various technical functions of the group therapists including ethical considerations pertaining to their roles as group leaders. Extended to this, the present chapter will impart knowledge about the various special problems or situations that should be dealt with during group therapy and various group therapy approaches.

6.1.1 Special Problems During Group Therapy:

The management by the therapists of special problems among clients will be essential where they obstruct group interaction. Problematic behaviours and situations illustrate the need for learning effective leadership skills. Some of the examples of such special problems or problematic behaviours are as follows:

The Silent Patients/Clients:

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

The Monopolizer:

The aggressive, narcissistic clients – often called the monopolizers – who insist 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 clients 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 clients 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 Clients/Client:

acting-out can be a disturbing phenomenon in groups. The therapist may caution the members to talk out rather than act out. The group members may be required to report at a regular session on 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 clients 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 clients to focus remarks on the group, may question the group as to how they feel about the clients' carrying on an intimate discussion with the therapist, may ask other members to associate with the clients' verbalizations, and finally, may suggest that the clients 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 Clients/Client Who Insists that He or She Is Getting Worse, not Better:

Such clients 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 clients may soon gather about him a group of followers as well as adversaries. The best way to handle this manoeuver is to ask the other members what they think is happening, until the therapeutic pretender quiets down. The therapist may also ask the competing clients 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 clients 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 clients and interpreting their ramifications in outside relationships.

When a Therapist Becomes Bored with a Session:

At some point in time, therapists also may experience boredom, while treating the problems of the group. In this situation, the therapists are likely to ask whether anyone else besides him or her is bored with the ongoing conversation. Such a reaction (and its basis) from the therapists can be explored by the group.

Added to this list, some other problematic behaviours and situations are also present in certain or all kinds of groups. They are:

i) skipping from topic to topic,

ii) dominating the discussion,

iii) being "chit-chatty" rather than personal and focused,

iv) attending infrequently,

iv) being shy and withdrawn,

v) getting angry at the leader,

vi) getting angry at one another,

vii) pressurizing (forcing) others to speak,

viii) preaching their personal morality,

ix) being resistant because forced to attend,

x) disliking other members, and

xi) stopping attending the group.

Such behaviours of the group or group members further illustrate the need for therapists/counselors to learn effective leadership skills.

6.2 GROUP THERAPY APPROACHES

6.2.1 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 this group. Sessions of this group may take place weekly, bimonthly, and even monthly intervals. For example, parents of children awaiting intake may be organized into a pre-intake group, which may meet for 3 to 6 monthly sessions.

Post-Intake Groups:

These groups may take place before permanent assignment. Meetings for post-take groups may be spaced weekly or up to 1 month apart. Some therapeutic changes are possible here as disturbing problems are introduced and elaborated. These preliminary groups serve as useful means of selecting clients for ongoing group therapy. They are worthy orientation and psychoeducation devices and help prepare and motivate clients for therapy.

6.2.2 Special Age Groups:

Group therapy with children :

It is usually activity-based in nature. The size of children's groups must be kept below that of adult groups (Geller, 1962). Single-sex groups are in the following age groups:

(1) 6 to 8 years: This group optimally consists of three to five members;

(2) 8 to 12 years: This group may have four to six members;

(3) 12 to 14 years: This group may contain six to eight youngsters; and

(4) 14 to 16 years: This group has 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, in which the focus is on feelings and conflicts. Rather than play, discussions constitute the best activity medium beyond 12 years.

Techniques in group therapy with children include i) analysis of behaviour in the group, ii) confrontation, and iii) dream and transference interpretation. Both - activity and discussion take place at various intervals. Interventions of the therapist should be such that do not hamper spontaneity. Therapists should stimulate the discussion and should always interrupt the silence in appropriate way. individual therapy is ideally carried on conjointly with group therapy, particularly at the beginning of treatment.

Group psychotherapy with older people:

Group psychotherapy has been considerably successful 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). The goal of group psychotherapy with older people is reconstructive, in which old individuals may be mixed with younger people.

6.2.3 Behaviour Therapy in Groups:

Behavioural techniques (Lazarus 1968; Meacham & Wiesen, 1974; Wolpe, 1969; Liberman, 1970; Fensterheim, 1971) are largely used in groups. Employment of methods such as behavioural rehearsal, modelling, discrimination learning, and social reinforcement enables us to achieve behavioural change, while the group process tends to accelerate such behavioural strategies to facilitate the change. In this context, homogeneous groups seem to do best, where the selection of members is restricted to those who may benefit from the retraining of specific target behaviours.

Examples of some problems are obesity, shyness, speaking anxiety, insomnia, and phobias that can be best dealt with by achieving control over them in a group. It is because participants in such groups are focused

on the abolition of similar undesirable behaviour. Group decision-making strategies may be practised in institutional settings, particularly with psychotic clients, where they will be offered reinforcement through token economies. On the other hand, short hospitalization can be provided to severe clients or clients with obsessive-compulsive disorder, and perhaps alcoholics and drug addicts too. If such clients are treated in special groups of populations with similar maladaptive behaviours, it can often be a rewarding course of action (Rachman et al., 1971).

Individually oriented behavioural interventions may be employed alone in a group setting or a combination with psychodrama, role-playing, Gestalt tactics, encounter manoeuvers, or formal group therapy procedures (inspirational, educational, or analytic) depending on the training and flexibility of the therapist. However, if group therapy is planned to apply, it is best to introduce the individual into a newly formed group with persons suffering from the same difficulties and having approximately the same level of intelligence and knowledge of psychological processes.

The size of the group varies from 5 to 10 individuals. The role of the co-therapist is valuable and sometimes crucial, especially 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 these initial sessions, members are encouraged to voice their problems and define what they would like to achieve in the sessions, and the therapist helps them clarify the goals.

Here are some important operations in group behavioural treatment, outlined by Goldstein and Wolpe (1971):

Feedback:

It is provided with the confrontation of the reactions of the other members to the clients' own verbalizations and responses. Clients get an opportunity through feedback to alter these if it is desired.

Modelling:

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:

Behavioural rehearsal similarly employs role-playing and involves the clients directly. Repetition of the process with different members helps solidify appropriate reactions, and the clients engage in role reversal when necessary.

Desensitization:

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.

Motivational Stimulation and Social Reinforcement:

The therapists provide direction and guidelines for appropriate behaviour with which the pressure of the group helps create motivational stimulation and social reinforcement.

Apart from this, support is provided to the clients when necessary. Clients also may be given specific assignments outside the group.

Conditions for Behaviour Therapy in Treating Various Problems in Groups:

Habit disorders:

Behavioural tactics are ideally suited for habit disorders related to eating, such as obesity, smoking, gambling, alcoholic over-indulgence, and substance abuse. Here, the members of each group must be chosen who suffer from the same problem and possess the adequate motivation to cooperate with the interventions.

Lack of Assertiveness:

Assertiveness training can be highly effective in problems that are centred around a lack of assertiveness. As Fensterheim (1971) describes the method to deal with this problem, groups can be formed that consist of 9 or 10 men or women in approximately the same number, and are roughly homogeneous considering their age, marital status, achievement, education, and socio-economic status to enhance modelling. These groups can meet 2½ hours once a week. For these sessions, seats are arranged in a horseshoe configuration in which the opening serves as a stage for role-playing and behaviour rehearsal.

Being very intense, the sessions begin with each member reporting on the assignment proposed the previous week. Following this, successes are rewarded with approval by the therapists and members, while failures are discussed. The assignment for the following week may be formulated based on the report. Special problems will evoke discussion in the group. Group members are asked to keep their own records of assertive incidents that they indulged in during the past week.

Special exercises are employed with role-playing depending on the 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, and practising progressive expressions of anger. These exercises include reading dialogues and portraying an angry role, improvising one's own dialogue, and role-playing scenes from one's life and experience. Thus, about 5 to 10 minutes of each session is spent doing these exercises over a period of 4-months. Thus, roughly 10 to 15 minutes may be used for systematic group desensitization from a common hierarchy prepared by the group. Finally, at the end of each session

members formulate their own next assignment or if they are blocked, this is suggested.

Tension and Symptoms like Insomnia:

Relaxation methods may be employed in a group for the relief of tension and symptoms like insomnia. In this case, any of the hypnotic or meditational methods explained by Wolberg (2005) may be utilized which will have the best impact in a group atmosphere.

Phobia:

Group behavioural methods are remarkably successful in treating phobias to which persons with phobias respond well. Here, the clients' selection must also be homogeneous as in assertive training. Aronson (1974) describes a program designed for fear of flying that has been successful in treating 90% of his clients completing it. In this program, initial individual consultations are geared toward establishing a working relationship with the clients and essentially for doing a behavioural analysis. A high degree of motivation for the clients is desirable in this program in which they may be asked how much they want to get over that particular fear. For this purpose, the therapist structures the program in the first session as follows:

- First five sessions – for a discussion of fear of flying.
- Next one or two sessions – for educational briefings with safety experts, pilots, and other air personnel to answer questions.
- Next seven to eight sessions – for discussion and methods of overcoming the fears.

The optional size of the group is 8 to 12 persons and the meetings are conducted for 1½ hours once a week. Also, pre-session and post-session meetings of ½ hour each without the therapists may be recommended, in which reading materials on air travel and development should be made available. Besides, the following rules are defined for the group members suffering a phobia:

In the first session - each member will be permitted to talk freely about their existing fears within the time limitation

In the second session - each member is asked to bring in a drawing depicting the most pleasurable aspect that he or she can imagine about a commercial air flight and a second drawing depicting the most unpleasant consequences.

The individuals are also invited to talk about any personal dreams about travel. However, neither any associations nor interpretations regarding defences are encouraged in recounting such dreams.

Some exercises aimed at anxiety control, offered by some researchers, are also introduced in these sessions. They are described (in Wolberg, 2005) below:

Exercise 1 - based on Wolpe (1969):	While lying down or seated comfortably on a chair, visualize all the sensations and anxieties you experience while on a plane. Simply visualizing yourself on a plane may make you anxious at first. You may find yourself wanting to avoid thinking about it. If so, let your mind dwell on pleasant thoughts for a while. As soon as you feel somewhat more relaxed, reenter the fantasy of being anxious on a plane. Focus initially on the least frightening aspects of flight. Gradually allow yourself to visualize more frightening fears. Each time you practice this exercise, you will be able to get closer to the dangerous situation and stay with it longer. Do this exercise twice a day for a week.
Exercise 2 - based on Perls (1969):	Picture yourself in the most pleasant situation you can imagine. Let your mind dwell on this situation as long as possible. Then imagine yourself on a plane. Some of the positive feelings you experienced in your fantasy will come back with you and help calm your anxiety when you next imagine yourself on a plane on the ground or actually flying.
Exercise 3 - based on Perls (1969):	Visualize the most unpleasant situation you can possibly think of a situation even more unpleasant to you than being on a plane. You will find that when you leave this fantasy and imagine yourself flying or actually on a flight, you will experience less anxiety.

{Source for the exercises: Wolberg, L. R. (2005). The Technique of Psychotherapy Part I and II: NJ: Jason Aronson, Inc.}

- In case, any of these exercises stir up anxiety, the members must indicate in order to prevent it from getting too deep.
- In case, group members start feeling strongly hostile to each other, the therapists encourage verbalization and explain that strong, positive feelings among all group members will be necessary for success.
- Talking about personal matters other than those related to fears of flying should be discouraged.
- After the fourth or fifth session – one or two educational sessions are held with local airline representatives to answer technical questions about flying and safety measures.
- After the eighth session – the entire group visits an airport, and if possible, meets in a stationary airliner for about 1 hour. Here, group members talk about their fears every step of the way.

- Around the tenth and twelfth session – the group leader suggests a target date for a short flight. This date can be temporarily postponed if too much anxiety prevails and until it recedes. During this period, the leader must set the time with the airline representatives and accompany the group. After the flight, the group reconvenes to discuss the reactions.

- Finally, group members are encouraged to arrange their own flights and to continue in group therapy for a few sessions thereafter.

The ideas of this program can also be adapted to other phobias, such as fear of cars, ships, elevators, tunnels, bridges, high places, etc., in a group setting following this format, considering the nature of the target symptom and introducing essential modifications accordingly. Videotaping and playback also may be employed in the sessions.

6.2.4 Experiential Therapy in Groups:

Experiential therapy is of two types: Encounter therapy or Marathon therapy. Its traditional model focused on inspiration, education, and insight acquisition. Later it is 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 Group Therapy:

Like any other form of group therapy, encounter therapy may be an ongoing process or it may be brief, from one to a dozen sessions. A constructive group experience with a small group of people can be most healing to the participants, when group members are educationally on a relatively equal level and permit themselves to disclose their self-doubts and personal weaknesses. In such therapy sessions, interpersonal confrontations may even ultimately bring the individual into contact with denied aspects of himself or herself, which may be temporarily upsetting.

In a group, a person can expose himself to others and reveal fears and desires of which he or she is ashamed, without being rejected or ridiculed. This leads person's acceptance of himself or herself with all of the flaws, rather than for the pose presented to the world. Thus, as communication between the members broadens, they share more and more their hidden secrets and anxieties. They begin to trust and accept themselves as they learn to trust and accept the other participants.

Such frequent "encounters" in the group further will probably sooner or later release underlying patterns of conflict, such as hostility toward certain members, excessive tendencies to defy and obstruct, inferiority feelings, unrealistic expectations, grandiose boastings, and other exercises

that have little to do with the immediate group situation. However, they are manifestations of fundamental characterologic flaws.

Encounter groups are organized on a long-term basis and focused on neurotic symptoms and intrapsychic processes. 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. Thus, people become able to correct some of their misperceptions by talking things out and they accomplish an educational realignment that challenges certain attitudes and teaches the person how to function better in certain situations. Thus, 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, and worked through their resistances to change.

There is some evidence that shows that the encounter group experiences may have a therapeutic effect on neurotic personality structure. However, in the Postgraduate Centre for Mental Health, Wolberg (2005) observed that personality changes are temporary when they occur during encounter group therapy sessions. However, they disappear rapidly in case of some participants once they leave the encounter group and return to their habitual life setting. In many instances, the encounter group makes individuals alert regarding many neurotic shortcomings and motivates them to seek psychotherapy on a more intensive level. Many of the apparently cured clients are likely to ask for thorough psychotherapeutic help, once they have the hints of their problems.

Marathon Group Therapy:

In the usual marathon group, members are exposed to a 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 defences. In the last hours, "feedback" is encouraged in which the therapist directs the clients to utilize the understanding of themselves to verbalize or execute certain constructive attitudes or patterns. In such groups, highly emotional outbursts are encountered with this intensity of exposure, where corrective emotional experiences seem to occur. The therapists participate actively with the group, and express their own reactions to the members. However, they avoid interrupting personal needs and problems. A variety of techniques with a combination of theories and methods, such as Perls' Gestalt therapy, Freud's unconscious motivational ideas, Rolf's structural integration and body balance, Lowen's bioenergetic theory, Moreno's psychodrama, Shutz's encounter tactics, and other sensitivity training methods (Quaytman, 1969) may be employed in the sessions,

Experiential therapies are sometimes resorted to by psychotherapists when their clients have reached a deadlock in individual or group therapy. There are circumstances, where some clients seem unable to move ahead, productivity reduces, boredom develops and motivation to continue individual or group therapy decreases. For such clients, encounter therapy

or a weekend marathon therapy have been found suddenly to open them up, produce more and more fresh material to work on and offer more enthusiasm for continued treatment. In experiential group therapy, the emotional stability of the therapist, control of countertransference, and the presence of a trained co-therapist are vital.

The individual entering an experiential or marathon group is generally instructed about his or her responsibilities 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 lifestyle, that there may be new and better ways of relating that one can learn. Sometimes a contract also may be drawn up with the clients in an experiential group therapy based on the changes persons desire to achieve. Also, emphasis is on the "here-and-now" rather than on the past.

Techniques in Experiential Group Therapy:

Encounter techniques vary with the inventiveness of the leader. Some of the techniques used are as follows:

- Members in a small group may be asked to "go around" and give their impressions of all the members – both, positive and negative.
- Members may be asked to draw anything that represents how they feel and also how they would like to feel by utilizing art materials (crayons, chalk, pastels, etc.). Later, the group associates with or discusses these productions.
- Two members may be asked to approach each other in front of the group and to communicate in nonverbal terms (i.e., touching, gestures, facial expressions, etc.). The group discusses the nature of communication.
- "warm-up" and other techniques described by Schutz (1967): i) Encourage the client to stand with the back to the therapist and to shut the eyes and fall straight back with trust that the therapist will surely prevent falling. This will help the person give up rigid controls and distrust of others. ii) Invite the clients to stretch out on a couch and to have them lifted by many hands and passed along, their bodies being stroked in the process.

Negative outcomes with experiential groups are also to be expected in two circumstances: i) when the superficial screening of the participants takes place, and ii) when a large number of untrained leaders contacting these groups have a few or no limits on the selection of techniques.

In experiential group therapy, factors such as close contact, the extended time period of interaction, the developing fatigue, and actual and implied pressure for change; all lead to the uniqueness of the experience. Motivation for change may be increased as the individual realizes the consequence of one's acts on the reactions of others.

6.2.5 Psychodrama and Role Play in Groups:

In 1925, Moreno (1934, 1946, 1966b) first introduced a useful group therapy method, called "psychodrama," created by him and it has later evolved into several clinical methods, including sociodrama, the axiodrama, role-playing, and the analytic psychodrama. Many of these have been incorporated into modern Gestalt and experiential therapy (i.e., encounter, and marathon therapy). Psychodrama is a valuable addition in the hands of a skilled therapist for helping clients work through resistance and translating their insights into action.

The initial tactic called the "warm-up" process in the group facilitates movement. Psychodrama is thus characterized by the three warm-up methods or processes as described below in brief:

1. "Cluster warm-up":

In this process, the director (the therapist) insists that the group remains silent) for a period. As tension increases, it will finally be broken by some member who complains about a problem, that is, 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. Then a "star" is chosen in a group, who is the person whose personality reflects the problem area most clearly.

2. "Chain of association warm-up":

In this warm-up method, an engrossing theme evolves when the group spontaneously brings up fears and associations. Here, the star chosen person is the one who is most concerned with the theme; and

3. "Directed warm-up":

This warm-up, as the term suggests, is initiated by the director. It is of two types. In the first directed warm-up method, the therapist, who knows the problems of the constituent members, announces the theme. On the other hand, in the second method called the "patient(client)-directed warm-up", the client announces to the group the subject/theme with which he or she would like to deal.

Thus through these three warm-up processes, the star is groomed for the roles to play with representatives of important people in the client's past and current life, selected from other group members ("auxiliaries") whose needs for insight preferably fit in with the parts they assume.

The director, on the other hand, facilitates the working together of the group on their problems while focusing on one person (the "protagonist"). Among the techniques used in this group therapy are:

- "Role Reversal": A protagonist and auxiliary reverse positions.

- "The Double": Another member seconds for and supports the protagonist;
- "The Soliloquy": It is characterized by a recitation by the protagonist of self-insights and projections; and
- "The Mirror": Auxiliary egos portray what the protagonist must feel.

In Psychodrama group therapy, the members are helped to break through blocks in their perceiving, feeling, and acting by forcing themselves to verbalize and act parts. Sometimes the therapist, as a director, decides which life situations from the clients' history are to be re-enacted in order to work at important conflictual foci.

Often, a technique is followed that is assumed by the "auxiliary egos". Auxiliary egos are the trained workers or former clients "standing in" for the client and spontaneously uttering ideas and thoughts that they believe the client may not yet be able to verbalize. They are best recruited from those persons present in the group who come from a sociocultural environment similar to that of the clients and portray the client's own internal figures, forcing the patient to face them in reality. This helps the client to bring his or her personal and collective drama to life and correct it (Moreno, 1966).

During psychodrama, the therapist as a director may remain silent or add questions and suggestions, when the clients re-enact the situation – the self role as well as other significant persons in their life, such as parents and siblings. Material elicited during psychodrama is utilized immediately in the presence of the "actor" client and the group "audience". An emotionally cathartic value of this technique also may help the clients understand problems revealed by their personal actions and thoughts as well as those reflected by other group members. The clients often get desensitized to inner fears, achieve hidden wishes, prepare for future contingencies, and otherwise help to resolve many deeper problems and conflicts as a result of venting feelings and fantasies in the role of the actor.

Different props, called "auxiliary chair" and "magic shop" are sometimes used in psychodrama group therapy. An auxiliary chair may represent an absentee personage. By using this prop, living or dead family members may be portrayed by several empty chairs around a table, where each chair in fantasy is being occupied by a different relative. On the other hand, in a magic shop, the shopkeeper distributes imaginary items to all group members, cherished by each in exchange for values and attitudes that are to be identified and surrendered by each member.

Role reversal is a useful technique in psychodrama. In this technique, two related individuals, for example, take the role of one another arguing how they imagine the other feels or portray the behaviour of the other. Here, a protagonist is involved emotionally with an absent person, who (latter) may be portrayed by an auxiliary ego. In rehearsal of future behaviour, which is an aspect of psychodrama, the protagonist will play out a

situation that necessitates the implementation of skills or the defeat of anxiety that is presently felt to be unmastered. Thus, verbalizing inner doubts and fears through psychodrama and attempting the task of overcoming them may facilitate it for clients through actions in real life. The controlled acting-out of fearsome strivings and attitudes helps for their clarification. In this technique, a protagonist, who is burdened, may be encouraged to swing away at imagined persons who obstruct. This offers the clients an opportunity for psychodramatic and sociocultural reintegration. Thus, the psychodrama technique has given rise to several role-playing methods that are being applied to education, industry, and other fields. Let us understand the psychodrama technique with the following example:

Example 6.1:

A group of four participants and a group leader may be observed by four observers who sit apart from and at the back of the participants. Initial interviews of 1 hour with each participant and observer are advantageous to determine motivations, expectations, and important psychopathological manifestations.

Preliminary mapping of the procedure considers group combinations, problems to be considered, objectives and desired modes of interaction. A short warm-up period is employed at the beginning of each session to establish rapport. Then the participants are assigned roles in a selected conflict situation. A discussion by the group of the issues involved with the description of possible alternative courses of action is followed by the leader's interpretation of why various participants reacted the way that they did.

Repetition of the conflict situation with the same participants offers them an opportunity to try out new adaptive methods and tests their capacities for change. It also fosters reinforcement of a new mental set. At the end of the session, the group leader renders ego support in the form of praise for individual contributions and reassurance to lower any mobilized tension or anxiety.

Approximately six 1-hour group sessions are followed by individual consultation with each member to determine ongoing reactions. Another series of six group sessions, or more, may be indicated. These procedures, while effectively altering attitudes and promoting skills, may not bring significant changes in the basic personality structure.

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

After discussing various important aspects of group therapy/psychotherapy in two consecutive chapters, we will have a glance at some criticisms of group therapy/psychotherapy at the end of this chapter. Though group psychotherapy has contributed significantly to treating multiple individuals at the same time for the same problem faced by them, the quality of change in group psychotherapy is criticized for the following aspects:

- Changes in group psychotherapy are dramatic, for example, the attacking and aggressive person becomes quiet and considerate, the dominant individual shows abilities to be submissive, etc.
- These and other such effects will become apparent, sooner or later, as products of both group dynamics and the interpretive activities of the therapists and group members. However, whether a transfer of learning in the group will take place in the outside world and whether it is sufficient to influence a better life adaptation - is questionable.
- The role played in the group is different from the roles in other situations.
- The group expects one to behave in certain ways and one obliges. Thus, it often offers the individual protection from the harsh realities of the external world.
- Though one can "be oneself" in the group, defences may be checked in the therapist's office, and when leaving the therapist's office or the group during the post-session and alternate sessions. Because there are chances that one may reclaim the previous defences once the person leaves the group. This truly indicates that interpersonal change is not equivalent to intrapsychic change.
- Thus, the former changes during group therapy may merely reflect the acquisition of a new set of social roles that the individual is tied to and that enhance the repertoire of patterns.
- It is argued rightly that intrapsychic changes are possible if the person has the courage appreciably to test the changed assumptions and to apply new learning in the group to the other roles played in life.

These criticisms reflect that though group therapy offers the advantages of the group in healing various problems in life and offering some good benefits to the individuals, they still have some downsides, when it comes to transferring the skills acquired in the group to real-life situations.

6.3 SUMMARY

The present chapter imparted knowledge about the various special problems or situations that should be dealt with during group therapy and various group therapy approaches. Special problems during group therapy

include some tendencies of clients and situations, for example, the silent patients/clients, the monopolizer, habitual latecomer, etc. Such behaviours of the group or group members challenge the therapists' skills and further illustrate the need for therapists/counselors to learn effective leadership skills.

We briefly learned about different group therapy approaches, such as pre-intake groups and post-intake groups, and special age groups, such as children and older people. We also learned about the application of behaviour therapy, experiential therapy, and psychodrama and role-play in the group setting in detail. In behaviour therapy, we had a glance at some important operations in group behavioural treatment outlined by Goldstein and Wolpe (1971) which include feedback, modelling, behaviour rehearsal, desensitization, motivational stimulation and social reinforcement. We also looked at the conditions in treating various problems (i.e., habit disorders, lack of assertiveness, anxiety and insomnia-like symptoms, and phobia) in group therapy along with some behavioural techniques and exercises.

In experiential therapy, we learned about encounter group therapy, marathon group therapy, and different techniques used in experiential group therapy in considerable detail. In psychodrama and role play, we learned about "warm-up" processes before starting the actual group therapy sessions. We learned about different props used in psychodrama and role play, such as "auxiliary chair" and "magic shop"; and different techniques used, such as role reversal, rehearsal of future behaviour, and controlled acting-out. At the end of the chapter, we also looked at some criticisms regarding group therapy, despite its many advantages.

6.4 QUESTIONS

1. Discuss special problems during group therapy.
2. Discuss behaviour therapy in the context of group therapy.
3. Discuss experiential therapy in the context of group therapy.
4. Discuss psychodrama and role play in the context of group therapy.
5. Write short notes on:

a) Pre-intake and Post-intake groups

b) Special age groups for group therapy

c) Techniques in Experiential group therapy

d) "Warm-up" processes in psychodrama

e) Criticism of group therapy/psychotherapy.

6.5 REFERENCES

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7

INTERVENTIONS EMPHASIZING INTEGRATION, ECLECTIC SYSTEMS, MULTICULTURAL PERSPECTIVES – I

Unit Structure

7.0 OBJECTIVES

After reading this chapter students will be able

- To understand the Integrated and eclectic interventions
- To learn Effective Multicultural Counselling

7.1 INTRODUCTION

Apart from traditional therapies that we have learnt before, there is a growing popularity of two other approaches, viz., integrated and eclectic interventions Apart from that as the world has become one due to globalization and people are not hesitant to migrate to other countries in search of better life, multicultural counselling, has also become crucial part of effective counselling. In this chapter we will discuss each of these topics.

7.2 INTEGRATED AND ECLECTIC INTERVENTIONS

When a therapist chooses intervention techniques from various theories and combines them in one intervention program that is best suited to the specific needs of the client. It is called integrated intervention. It is free of theoretical orientations. Eclectic intervention, on the other hand, refers to combining, in a systematic manner, compatible features of various types of interventions, even if these interventions are from incompatible theoretical orientation and then combining them into a harmonious composite intervention.

7.2.1 Reasons for the Growth of Integrated and Eclectic Approach:

Integrated and eclectic therapies are growing in popularity for various reasons. Prochaska & Norcross (2007) has identified around 12 reasons as mentioned here -

1. Though a vast number of intervention techniques (more than 400 hundred identifiable techniques) have mushroomed up but none of them can individually capture the whole gamut of human experiences across the entire life span.

2. There is a growing trend of clients coming from variety of sociocultural backgrounds and having much more complex problems. To provide effective intervention, the therapists need to pay attention to sociocultural aspects of client's life instead of focusing on only internal factors within a person that may be causing the problems.

3. There is a growing realization that in spite of having variety of intervention systems, none of these systems are self-sufficient in successfully taking care of all problems of the clients.

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. Due to technology advancement, clinicians have ample opportunities to get educated and trained through case studies and other informative literature. This gives them a chance to study, observe, and gain experience in numerous intervention approaches.

6. Many state and national credentialing bodies has also made it mandatory for clinicians to be at least post graduate as well as to keep acquiring further credits through continuing education so that there is continued professional growth and development of new skills and ideas.

7. Many stake holders such as managed care organizations, governmental agencies, consumers, etc., are demanding accountability of the clinicians to provide effective and efficient intervention for each and every client by determine the most effective and efficient

treatment approach for each client, through planning and documenting their work for better transparency and accountability.

8. There are very strong empirical evidences indicating which treatment approaches have greater potential to successfully treat particular people, disorders, or problems (Seligman & Reichenberg, 2007).

9. Manuals giving details of empirically validated treatment plans for specific mental disorders are easily available in abundance.

10. Organizations such as the Society for the Exploration of Psychotherapy Integration have come up that focus on studying and promoting treatment integration.

11. There are many models available now that give directions for logical and therapeutically sound integration of treatment approaches.

12. Even therapists have become more aware to the fact that common factors among various intervention programs such as therapeutic alliance, are as important for the success of the treatment as are specific strategies.

7.2.2 Nature of Integrated and Eclectic Approaches:

Initially by using the term eclectic orientation, clinicians meant that they have taken techniques from more than one intervention approaches. While some of the clinicians using eclectic approach were very clear about the reason for drawing from various theoretical approaches and combining them into one intervention program, others did it in illogical, muddled and disjointed manner. Eysenck (1970) called it lazy eclecticism, a sign of non-professionalism and ignorance.

Types of Eclectic and Integrated Approaches

There are four identified types of eclecticism –

1. **Atheoretical eclecticism** – refers to having a combination intervention without any predominant theory of change as a base. If a clinician does not have logical base for combination intervention, there can be problems of clients being confused and doubting a clinician's competency, clients being demotivated and non-cooperative and problem of treatment failure.

2. **Common factors eclecticism** is based on the premise that there are some common elements that promote growth and bring change in a client. These elements are communicating support, empathy, and unconditional positive regard.

3. **Technical eclecticism** – is an organized mixture of interventions. These parts of interventions are taken from different treatment systems purely on empirically tested research basis and may or may not be based on the theories or philosophies related to those

interventions. However, this approach is criticised as it is not a rational model for human development and growth.

4. **Theoretical integration** – it gives a conceptual structure for combining two or more treatment approaches to understand clients in a better way and to provide effective treatment. Instead of paying much attention to technical aspects, it pays attention to theoretical base.

7.2.3 Integrating Treatment Systems:

Many clinicians follow their own logic for making a combined intervention program instead of systematically integrating the compatible theories.

Mostly theories are combined on the basis of (1) cognitive and behavioural treatment systems, (2) humanistic and cognitive approaches, and (3) psychoanalytic and cognitive approaches (Prochaska & Norcross, 2009).

Characteristics of Sound Integrated and Eclectic Approaches:

Sound eclecticism has the following characteristics:

i) They build on the strengths of existing theories,

ii) They create a logical and orderly combination of theories to make a unified whole.

iii) They work on fundamental principal 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.

7.2.4 Formulating an Integrated and Eclectic Treatment System:

While designing an integrated or eclectic treatment system, clinicians need to pay attention to many questions, such as:

1. The theory under consideration is based on which model of human development?

2. How this treatment approach will promote the most beneficial change in the client?

3. During interview which informational inputs should be focused on?

4. What is the take of this approach on the past influencing present and how the clinician should deal with past experiences and difficulties, faced by the client, while designing intervention program have of the influence of the past on the present?

5. What is the role of insight in bringing change, and how the insight can be improved during the treatment?

6. Do emotions play any role in bringing about a change and how can intervention program help a client to identify, express and modify his emotions.

7. Which dysfunctional cognitions are contributing to current problems and how they can be modified to help a client to deal with his problems.

8. Which self-destructive and unhelpful behaviours are leading to problems and how they can be modified to bring change.

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?

11. Can this approach be used for people coming from multicultural backgrounds?

12. What is the place of diagnosis and treatment planning in this approach?

13. What are the overall goals of treatment?

14. Which types of therapeutic alliances and client-clinician interactions are most likely to be productive?

15. To use this approach, which clinical skills are essential?

16. Which other interventions and strategies can match with this treatment system?

17. What modifications are needed in using this approach while dealing with individuals, Families, or Group?

18. What will be the duration of this treatment?

19. What are the parameters for determining when to conclude the treatment and to measure its effectiveness?

20. Is this treatment system has sufficient empirical evidence in favour of it? What other information is required to enhance its value?

7.2.5 Skill Development: Treatment Planning:

Treatment planning helps in four ways (Seligman, 2004a):

Treatment planning serves the following four purposes (Seligman, 2004a):

i) A treatment plan that has strong empirical evidence and has been carefully designed is more likely to succeed.

ii) If the goals of the treatment and the ways of achieving those goals are specified, it is easier for the clinician as well as the client to assess whether progress is made towards achieving the goal and if the progress is not there, what changes should be incorporated. Treatment plan is not considered as a finished product to be used, instead it is considered as a work in progress.

iii) If the treatment is planned carefully, both client and the clinician will have realistic expectations from the plan and will be hopeful about its success.

iv) Making treatment plan is essential especially in case of integrated or eclectic approaches used by the clinician. Such a treatment plan will draw techniques from various theories and combine them into a cohesive whole one piece that will address all the concerns of the client.

A comprehensive treatment planning includes 12 steps:

i) Diagnosis: First of all the clinician must make 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: After determining the diagnosis, both client and clinician must together determine and write down the objectives of the treatment that takes care of the diagnoses and problems presented by the client.

iii) Assessments: Very often clinicians use assessment tools to ensure that they are making accurate diagnoses and establishing worthwhile and viable objectives, to measure progress.

iv) Clinician: One also needs to look what type of clinician are more likely to work more effectively with a given client. This refers to the match between client and clinician characteristics or attributes.

v) Location of treatment: While planning the treatment, it is also important to determine whether the treatment should be inpatient, outpatient, or an alternative such as a day treatment program.

vi) Interventions: The clinician needs to state which treatment approach will be used (e.g., cognitive therapy, solution-focused brief therapy, Gestalt therapy).

vii) Emphasis: None of the clinicians work in identical manner. Each one has his/her own style. Their styles differ from each other as well as from client to client too.

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

ix) **Timing:** The treatment plan also needs to specify 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, counsellors, and social workers often work along 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.

7.2.6 Benefits of Integrated and Eclectic Approaches:

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

1. Integrated and Eclectic interventions are more flexible than other treatment process. They allow clinicians to make client specific intervention plans to ensure a well fitted treatment for client.

2. Integrated and Eclectic interventions allow clinicians to be sensitive to clients' culture and context while planning their integrated intervention programs and this shows their multicultural competence. This approach is highly successful with clients belonging to non-dominant cultures.

3. Clinicians using this approach can cater to a wider spectrum of people and problems than those working with single theoretical orientation.

4. This approach permits clinicians to design intervention according to their own beliefs about human growth and development, personality and also to work as per their natural style.

5. It allows Clinicians to be a practitioner as well as researcher and based on their experiences in using various orientations in a scientific manner they can design programs that have face validity as well as strategies that they have proven to be successful with other clients.

7.2.7 Challenges of Eclectic and Integrated Approaches:

It is easier for a counsellor to use any one specific theory for intervention than to use an eclectic or integrated theoretical orientation for intervention. Use of single specific theoretical orientation requires expertise in a limited area while use of integrated or eclectic theoretical orientation requires expertise in number of intervention systems for an effective treatment plan for a particular client. It is next to impossible for any clinician to develop expertise in all therapeutic approaches, to treat all kinds of clients, and for

all kinds of problems. Clinicians who want to use eclectic or integrated orientation need to delineate the scope of their practice.

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.

They must carefully design a client specific treatment plan for each client to make sure that various discordant parts of treatment merge seamlessly as whole into a chosen intervention. The intervention should not appear as a mere collection of divergent parts, it should be a coherent composite unit of intervention, that is well planned and has firm moorings in strong theoretical and empirical evidence.

7.3 EFFECTIVE MULTICULTURAL COUNSELLING

While interacting with the clients, counsellors trained in traditional theories such as psychoanalytical, behaviouristic and even humanistic theory pay attention to the client himself and overlook his social cultural background. There are two reasons for it –

a.) the counsellor himself belongs to western culture which emphasizes on individualism. Even the traditional theories tend to overlook or underplay the social cultural factors and look at individual as an island.

b.) There has been over emphasis on positivistic, scientific view point which demands objectivity and evidence for every thing happening to around us. It emphasizes on generalizations. Consequently, instead of treating every client as a unique person with his own web patterns of personal and sociocultural contributors, counsellors look for similarities.

However, in real life, none of us are islands. By nature, human beings are known to be social animals or species who survive and thrive in group or community. A child is born in a cultural environment. One cannot discount the fact that culture dominates an individual's each and every aspect of life, as culture is multidimensional and dynamic.

Christopher went to the extent of saying that culture structures our thought process, emotions and behavioural tendencies and also determines the moral framework in which actions will take place. It sets the parameter for an individual to decide what should be considered normal or aberrant, good or bad, what one should strive for and what should be avoided. Human beings determine their self-identity and evaluate their self-worth on the basis of their membership in a group that they take pride of. In fact,

culture gives definition of what it means to be a human. Even in individualistic cultures, if we look beneath the surface, 'we' is more important than 'I'. In such a scenario, a counsellor will commit a folly if he ignores the culture of a client.

Multiculturalism:

There are as many cultures as many societies exist within a country and across the countries. Even within the same society, culture differs based on gender, class, age, sexual orientation, disability, etc. For instance, J. Sommers-Flanagan & Sommers-Flanagan(1997) suggested that children have different culture than adolescents and adolescents have different culture than adults. Multiculturalism refers to combination of cultures across various cultures in different societies as well as to intracultural differences within the same society. Psychologists who study the similarities or universalities across cultures are known as transculturalists. Multiculturalists acknowledge the fact that there are various different cultures existing in different societies and there can be different cultural layers within a culture too.

Multiculturalism is not just an academic exercise of understanding and acknowledging various cultures, but its objective is to achieve social justice too for everyone. One of its basic tenet is to ensure that no group is oppressed and every group has equal opportunity. It opposes any idea or behavior that is against the principle of social justice - D.W. Sue et al. (1999).

As mentioned before, previously three schools of thought- psychoanalysis, behaviourism and humanistic theories dominated the field of psychotherapy, but now theories of multiculturalism are accepted as the fourth force that influences psychotherapy. Some psychologists have argued that all counselling is multicultural oriented and there is no need to have separate theories of multiculturalism. This argument ensures that existing injustices through cultural norms are not challenged and oppression that is going on for ages together continues. But there are other psychologists who propagated that knowing the fact that culture is a strong instrument to deny social justice, multiculturalism needs to be redefined to ensure that discrimination based on race, religion, gender, sexual orientation, class, etc. can be prevented. Now let us look at what is multicultural counselling.

What Is Multicultural Counseling?

Derald Wing Sue (2008) defined multicultural counselling 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."

Since multiculturalism is comparatively a new field, its definition is also still evolving. Let us look at the historical development of this field.

7.3.1 Historical Context:

Traditionally, psychological theories have been developed by white men. These theories contain the views and interventions that are presented through the white males' perspectives. It is the dominant culture of privileged white males who decided what is normal or abnormal, what is good or bad for all people in the world. The concept of multiculturalism originated from the realization that application of these traditional theories of psychotherapy had disastrous outcomes when they were applied to the psychological functioning of people from other cultures than western cultures, white males who did not come from upper or middle socioeconomic class, non-males or were in the category of non-white males.

It was gradually realized that there are other diverse world views too apart from the world view of these privileged white upper-class males from western culture. The definition of normality and abnormality, good or bad, differs from culture to culture and is equally legitimate. The generalized assumptions made by white male culture about the definition of normality, intelligence level of non-whites and females reeked of racism, classism, ageism, and sexism. These racist statements at that period of history were ironically passed off as being sensitive to multiculturalism.

For example, in a popular periodical, Southern Literary Messenger published in 1843, it was submitted that it is poor White race that suffers immensely from slavery practice, while African American thrive from this practice of slavery. It claimed that black people are happy to be slaves and do not want to be free and white people go through tremendous suffering to keep these black people as slaves.

In 1851, a doctor S. A. Cartwright announced that he has discovered two new diseases, which takes place only in Africans. The first disease was labelled as drapetomania and the second disease was called dysaethesia. Dysaethesia makes Africans disobedient and disrespectful while drapetomania leads to a strong urge to run away.

Freud too claimed that compared to men, women are psychologically, morally and biologically inferior, and they can't be cured for this inherent weakness.

Terman (1916) who first authored the Stanford-Binet Intelligence Scale, was convinced that there are racial differences in intelligence and children of different race should be put in separate classes. He went to the extreme of saying that people from other races than white should not be allowed to reproduce and increase their numbers.

Even in recent times, DSM III included ego-dystonic homosexuality as a disorder and the acceptance of homosexuality is very much influenced by the culture.

There are many such examples in history that show that dominant cultures not only focus on, and define differences as inferiorities or mental disorders, especially if these differences are irritants for the majority cultural people. Growing resentment and opposition to such bigotries led to rise of emphasis on multiculturalism.

Now, The American Psychological Association as well as the American Counseling Association have divisions devoted to minority-ethnic issues; diversity issues; gay, lesbian, and bisexual issues; and social justice concerns. Since 1994, The American Psychiatric Association's DSM also has sections titled "Specific Culture and Gender Features" for each psychiatric diagnosis (Mezzich et al., 1999). Yet, we can say that multicultural counselling is in its infancy.

7.3.2 Theoretical Principles:

Multicultural theories illuminate the importance of culture, while dealing with the issues of psychological functioning, psychological distress, and psychological well-being in mental health area (D. W. Sue, Bingham, Porche-Burke, & Vasquez, 1999).

Culture by nature is multidimensional and dynamic. Psychologists are still debating about what should be included in the definition of multiculturalism. Therefore, there is no consensus among psychologists on what should be the distinct principles of multicultural theories. Yet, on the basis of certain commonalities in the theories, certain guidelines can be offered as principles for general multicultural theory. These principles are:

Principle 1:

All human beings are born and brought up in a specific culture (or set of cultures). This culture influences our entire existence, in terms of our cognition, affect and behavior. Belonging to a specific culture can either enhance or reduce the life opportunities for a person. For example, as discussed in historical context, a white person born in middle- or upper-class family and being a member of dominant western culture will have many subtle advantages and entitlements, purely on the basis of his membership in that culture. People in dominant culture take these privileges for granted and remain unaware of them, unless and until these privileges are contrasted with people from another less dominant culture. So, the first principle is that we all are shaped by our membership of certain culture and subcultures and cultural experiences. Depending upon the membership, we will be either privileged ones or suffering from various limitations.

Principle 2:

People differentiate between groups of people and keep mentally segregating them on the basis of race, religion, sex, sexual orientation, ethnicity, physical and mental disabilities, and socioeconomic status.

Principle 3:

A multiculturalist viewpoint emphasizes that members of different culture must have a better understanding of different cultural groups and must also aim to treat all human beings equally irrespective of their cultural identities, and practice the principle of social justice. Being habituated to a particular culture, it is not easy for counsellors to practice this principle.

Theory of Personality:

Multicultural counsellors believe that basically the concept of personality is a culture-bound concept as many aspects of intra- and interpersonal functioning differ on the basis of culture.

Individualistic versus Collectivist Orientation

Whenever multiculturalism issue is raised, it basically refers to the characteristics and pros and cons of Western culture in comparison with Eastern and Asian cultures. Western culture is known to be individualistic culture while Eastern and Asian cultures are known to be collectivist cultures.

Characteristics of Individualistic cultures –

- There is lot of emphasis on personal freedom of the individuals.
- It propagates that one's own interests are more important than the interests of the group and one should first take care of his own interests. Being independent and protecting one's autonomy is the supreme goal of every individual's life. Being independent is also considered to be a highly desirable virtue.
- An individual's self-identity and personality are separate from family and culture.
- Individuals derive their self-worth from accomplishment of their personal goals and not group goals.

Characteristics of Collectivist cultures –

- It emphasizes on shared group values and norms.
- An individual's self- identity and the personality are not independent, rather they are shaped by group memberships.
- The needs and values of the group should be more important for a person than his own personal needs.
- Members of collectivist culture assess their own worth on the basis of achievement of group goals commonly held by all group members.

Problems with Individualistic Culture – Limitless individual freedom without any consideration and respect for common goals can be dangerous. An imbalance is created if there is an emphasis on only

personal rights without any consideration for personal responsibilities towards others. If the freedom is defined in terms of having no restrictions on choices and no personal burden of responsibilities is seen as unfair, it becomes a sure recipe for psychological and social disorders and disaster for the society itself.

A counsellor coming from an individualistic culture finds it very difficult to understand collectivist cultural values and personality traits and is not able to honour them in the counselling process.

Acculturation and the Infamous Melting Pot:

Acculturation is also known as ethnocultural orientation. At individual level, acculturation refers to "a process of giving up one's traditional cultural values and behaviors while taking on the values and behaviors of the dominant social structure" (Atkinson, Lowe, & Mathews, 1995, p. 131).

Garrett and Pichette (2000) have identified five cultural orientation types within American Indian populations,. These are -

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 either traditional Indian culture or mainstream society. He may speak both languages.

3. **Bicultural.** The individual is relatively comfortable and well versed in both sets of cultural values.

4. **Assimilated.** The individual is aligned more toward the mainstream social culture and is not much interested in traditional tribal practices.

5. **Pantraditional.** The individual has seen as well as may be adopted mainstream values but has deliberately decided and put in the efforts to return to traditional values.

a.) Role of Acculturation in Personality Development:

For many decades, America was known to be a melting pot. It meant that people coming from diverse cultures to America, eventually adopt the main stream culture of America, that is, white male culture. In other words, the contention was that gradually over one or two generation, the minority group members will give up their native cultural ways, which are inferior to white male culture and will adopt the superior white male culture. For example, Michel Jackson left his black culture and tried to be a white man.

However, a decade back, it dawned upon psychologists that in melting pot, the cultures remain identifiable, minority cultures don't disappear in dominant culture. They coexist with dominant culture. As people of one culture, mingle and marry people of another culture, their cultural and

racial identity remains a unique mixture of different cultures, at individual level.

Counsellors realize that the personality of a person belonging to minority community and living in dominant culture will be very different from a person belonging to dominant culture. The problems of identity and family relationships and functioning become a significant problem for individuals belonging to second generation of a minority group. The members of second generation (e.g. Michel Jackson) adopt the values and norms of dominant culture that interferes with their family relationships and with their identity.

Swartz-Kulstad and Martin (1999) identified five different contextual factors that significantly contribute to 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:

According to multicultural theory, cultural and social factors play a significant role in psychopathology of a person. Multicultural practitioners are hesitant and take their own time, to label a deviant behavior as pathological. They first try to understand that deviant behavior in the cultural context of the client and his family.

7.3.3 The Practice of Multicultural Counselling:

Das (1995) said that multicultural counsellors must keep in mind the following points:

- The behaviour, values, and beliefs of all human beings are determined by their culture. Culture has significant influence on both – the client and the counsellor.
- People belonging to minority culture have difficulty in getting mental health services for two reasons – a.) most of the mental health services cater to dominant culture and do not understand the ethos of minority culture, b.) most of the counsellors belong to dominant culture and are not sensitized to other cultural variations as well as have very stem narrow attitudes.
- If the definition of culture is broadened to include not just the race, nationality and ethnicity, but also gender, age, social class, sexual orientation, and disability, then it is safe to say that essentially, all counselling types are multicultural counselling.
- While in dominant cultures, individuals seek help due to personal problems, in minority cultures, individuals seeking help face problems due to sociocultural pressures and stressors.

- Though, a counsellor need not focus on cultural values and conflicts originating from those cultural values, but he should be sensitive to the fact that cultural factors contribute significantly to a client's personal conflicts. Therefore, it is important to be aware of client's cultural values and practices, even if client asserts that his present problems have nothing to do with his culture.

Preparing Yourself to Do Therapy from a Multicultural Perspective:

To be culturally competent, all multicultural mental health professionals must have following multicultural competencies as per guidelines issued by The American Counselling Association -

1. Awareness and Acceptance:

Mental health professionals must be aware of their own cultural background and experiences. They should be able to effectively communicate what it means to be a member of their culture. They must increasingly become aware of their own biases and fears about others' race, gender, sexual orientation, poverty, and/or religious beliefs, etc. and accept others' cultural practices and beliefs as equally valid and worthy.

2. Knowledge:

They must realize that they need to seek specific knowledge about the cultures of their clients. They must gather information about socio-political history, challenges faced by the culture at present, and basic cultural beliefs, values, and practices of their clients.

3. Skills:

They must realize that sometimes they can give more effective intervention if they tweak or alter standardized techniques and strategies as per the needs of clients from diverse cultures. They should also develop the competency of recognizing their own inadequacy of dealing with clients of certain cultures, and should refer those cases to other professionals.

Pederson (2000) suggested that it is essential for a counsellor to keep checking and rechecking throughout his life his own beliefs and assumptions about other culture members.

Preparing Your Client for Multicultural Therapy:

At the beginning of establishing therapeutic relationship with the client, a counsellor has to decide, when he should bring up the topic of differences in their culture. If this topic is brought up too early in the sessions, the client gets the impression that counsellor is trying to say that his culture is superior to client's culture or that counsellor is finding the causes of client's problems in his culture rather than personal life context. So, a counsellor has to decide when and how to highlight the issue of culture with the client. On the other hand, if a prospective counsellor is a member of a minority culture and is training to be a mental health professional in

the dominant culture, he experiences unique challenges in preparing his clients from a multicultural perspective. He has to deal with an unspoken question of the client, whether this counsellor (who is from different culture) will understand me enough to help me.

Assessment Issues and Procedures:

The American Counseling Association and the American Psychological Association have specific ethical guidelines for multicultural assessment

Assessing members of other culture requires lot of awareness of cultural differences, sensitivity to others' culture, and training and experience in assessment.

The counsellor has to decide the therapeutic goals and method of assessment needed for the client's problems, keeping in mind the culture of the client. The idea of good health and good life differs from culture to culture and counsellor should be sensitive to what is considered good life and health from client's cultural perspective. He must be able to assess cultural specific as well as more general dysfunctional behavior or problem of the client.

The counsellor has to be alert to any biases or prejudice that may involuntarily take place in assessment of the client. He must be cautious about not over diagnosing or underdiagnosing or misdiagnosing the problems of clients.

Before starting the assessment of the client, the therapist must judge the client as a cultural being and then choose a culture-specific tests constructed in the client 's native language, check the norms given for interpretation and then administer the test in client's preferred language. Later, the therapist must interpret the results and give feedback to the client appropriate according to his culture.

Specific Therapy Techniques:

Multicultural counselling emphasizes relationship with the client, keeping in mind his cultural background, instead of emphasizing standardized techniques. Depending upon the ethnicity and culture of the client, the technique to be used is decided.

S. Sue (1998) has detailed three specific skills for cross-cultural therapeutic competency. These skills are:

Scientific mindedness: Therapists with scientific mindedness will formulate tentative hypotheses about their clients instead of making premature conclusions based on their prejudices.

Dynamic sizing: Therapists knows when to generalize and be inclusive in attributing the client's problems to his culture, and when to individualize and be exclusive in attributing the client's problems to his own self.

Culture-specific expertise: Therapists must have knowledge of their own culture as well as knowledge of the client's culture, and use intercultural sensitivity in an effective manner.

7.3.4 Non-Western Theories and Techniques:

Since most of the theories in psychology have originated from western countries, it is not surprising that western cultural ideas and values have infiltrated the thought process and knowledge bodies of the countries, on the other side of the globe too. Consequently, the biases inherent in western culture such as assigning premier position to masculinist, individualistic, essentialist, and rationalist worldviews, creating an imbalance. Most of the time, psychologists trained in these western culture-based theories and therapies are not even aware of their own biases and their tendency to ignore or look down upon the experiences that do not fit in western cultural values. Very naively these psychologists believe that empirical evidence presented by studies carried out in west, represent the universal truth. The life experiences, needs, desires, frustrations, pain, etc. experienced by people in the western countries are universal and therefore the interventions applicable to them can be used for people from other cultures too. But this is far from truth. Of late, there is a growing realization that people from other cultures do differ in their needs, motives, emotions, thought process, etc. In some way people are same all over the world, and yet in some other ways they are distinct from each other. Psychologists, first of all, must have a deeper understanding of their own culture and they should also have deep understanding of other cultures too, to which their clients belong. Having a deeper understanding of others' culture will sensitize the psychologists at the biases inherent in their own culture and in their own interaction with the client.

Instead of depending on evidence based universal truths, they will start appreciating that psychological distress is a multidimensional phenomenon. The causes and cures of psychological distress can be due to philosophical-ethical, religious spiritual, ancestral-familial, and even political considerations. For example, let us look at Buddhism, an eastern psychological theory with philosophical moorings.

Buddhism:

Of late Buddhism and one of its main principles - mindfulness, have become very popular among western counsellors. So, let us see what is Buddhism and how it helps in counselling. Though there are Buddhist temples, rituals and monks that give it a religious flavour but, Buddhism does not believe in God or some higher power, rather it is an umbrella appellation which covers various diverse practices. To that extent, it can be termed as a non-theistic religion and applied philosophy.

Four Noble Truths taught by Buddha, are:

1. All Human beings are suffering in some way or the other, irrespective of their geographical location, caste, colour, creed, religion, social and economic status, nationality, etc.

2. This suffering originates from human beings' desires, craving, greed, attachments with worldly things. Desires or cravings, attachments and ignorance are the root cause of human sufferings.

3. It is possible to overcome these sufferings through enlightment, through realization and acceptance that there is nothing permanent in life and to attain peace, one should detach oneself from impermanent things or people.

4. If one follows the Eightfold Path, he will be able to overcome suffering and live without attachments.

These Eightfold paths are not hierarchical steps. Morgan (1996, pp. 57–58) categorized these Eightfold paths into three categories - wisdom, morality, meditation.

Wisdom:

Right understanding/ Right View:

Perceive the world as it really is, without having any delusions. Understand that sufferings are the outcome, the cause is in our mind. Understand that in this world and in our lives, nothing is permanent, neither objects, nor people and nor situations. Desire to have permanency in life is the cause of sufferings. It leads to fear of losing what one has and craving for something that one does not have.

Right thought/ Right Intention:

One should be unselfish and compassionate in thoughts. This will purify his mind and heart and will lead to unselfish or detached acts that are full of compassion.

Morality:

- **Right speech** – one should be disciplined and not indulge in lying and gossiping or talking in such a way that will lead to ill feelings, hatred or hostilities.

- **Right action -** One should not indulge in taking life, stealing, committing sexual misconduct, and taking stimulants and intoxicants.

- **Right livelihood** – One should take up a meaningful job or adopt a way of life that does not cause harm or injustice to other beings.

Meditation:

- **Right effort –** refers to developing mental discipline that does not allow evil thoughts or actions to rise, if such evil thoughts or actions is already taking place, put in a conscious effort to stop it and , and encourages what is good.

- **Right mindfulness –** this refers to paying full attention to what is happening in the body, speech, and mind.

- **Right concentration –** this refers to training the mind in meditation stages.

Meditation and Mindfulness:

Meditation is nothing but seeking mindfulness by emptying one 's mind. Mark Epstein (1998) very aptly differentiated the concept of emptiness in western philosophy and in Buddhism. In Buddhism, emptiness refers to "an understanding of one's true nature, an intuition of the absence of inherent identity in people or in things", while in western philosophy emptiness refers to "a tortured feeling of distress, and absence of vitality, a sense of being not quite real enough, of disconnection." Mark Epstein (1998) (p. 13).

Empirical research studies have found meditation and mindfulness to be effective in treating addictions and pain. It has been successful in advancing the holistic health of HIV and AIDS patients, and in the treatment of people having borderline personality disorder.

Spiritual Psychotherapy: Spirituality and Counselling:

In Eastern and Asian culture spirituality is considered to be an integral part of all human beings' psyche and life. On the other hand, people from western culture find it hard to accept the superiority of spirituality over logical positivistic view. One of the criticisms against interventions based on traditional theories such as psychoanalytic, behavioural, and humanistic-approaches, is that they treat the patients but cut off those patients from their spirituality.

So far very little empirical work has been done to assess the link between spirituality and counseling and psychotherapy.

Karasu (1999) believed that spiritual psychotherapy is very effective. It emphasizes on individual differences and interventions have to be tailor made to fit each client individually. No two clients can be treated in the same way. In other words, there cannot be any standardized steps or methods that can be documented in operational manuals. It does not assume any causes and does not make any predictions that needs to be validated empirically. It does not believe that anything needs to be validated with objective evidences, instead it believes that effectiveness of interventions are influenced by belief and faith.

7.4 SUMMARY

In this unit we have studied integrated and eclectic interventions, reasons for the growth of integrated and eclectic approach, nature of integrated and eclectic approaches, integrating treatment systems, formulating an integrated and eclectic treatment system, skill development: treatment planning, benefits of integrated and eclectic approaches, challenges of eclectic and integrated approaches, effective multicultural counselling, historical context, theoretical principles, the practice of multicultural counselling and non-western theories and techniques in brief.

7.5 QUESTIONS

Q. 1 Discuss in brief skill development treatment planning

Q. 2 Write detail note on effective multicultural counselling

Q. 3 Short Notes

a) Reasons for the Growth of Integrated and Eclectic Approach

b) Benefits of Integrated and Eclectic Approaches

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8

INTERVENTIONS EMPHASIZING INTEGRATION, ECLECTIC SYSTEMS, MULTICULTURAL PERSPECTIVES - II

Unit Structure

8.0 OBJECTIVES

After reading this unit students will understand:

- Psychoanalytical, Adlerian, Person-Centered, Behaviour Therapy from Multicultural Perspective

8.1 INTRODUCTION

In the previous unit we have dwelled in detail on multicultural counselling. Now let us look at some of the strengths and weaknesses of Psychoanalytic therapy, Adlerian Therapy, Person-Centred Therapy, and Behaviour Therapy in counselling practice from multicultural perspective:

8.2 PSYCHOANALYTICAL, ADLERIAN, PERSON CENTERED, BEHAVIOUR THERAPY FROM MULTICULTURAL PERSPECTIVE

8.2.1 Psychoanalytic Therapy from Multicultural Perspective

Strengths from a Diversity Perspective

1. With little bit of modification of the techniques used in psychoanalytic therapy, it can be successfully adapted to cater to clients from diverse cultural backgrounds.

2. Irrespective of the cultural background, one thing common among all people is that all of them have dealt with developmental crisis that

take place in various stages of development. With the help of therapist, the client can re-examines the crucial events that took place at every developmental stages of his life and evaluate how these events have adversely or favourably affected his life.

3. Psychotherapists go through intensive training. This enables them and be alert to their own sources of countertransference, including their biases, prejudices, and racial or ethnic stereotypes.

Shortcomings from a Diversity Perspective:

1. Traditional psychoanalytic approaches are costly, and for many people, the cost of treatment is beyond their means.

2. Psychoanalytic therapy is generally seen as being based on upper- and middle-class values. All clients do not share these values.

3. Most psychoanalytic approaches have ambiguity as an ingrained part of the therapy. This can result in ineffectiveness of the therapy, especially if clients due to their cultural values expect direction from an expert. For example, many Asian American clients may prefer directive, problem-oriented approach to counselling and may not continue therapy if a nondirective or unstructured approach is employed.

4. Intrapsychic analysis may be in direct conflict with some client's social framework and environmental perspective.

5. Psychoanalytic therapy is more concerned with long term personality reconstruction than with short term problem solving.

6. Atkinson et.al. (1993) was of the opinion that therapists must look at the possibility of any external sources contributing to clients' problems, especially if clients have been in an oppressive environment.

7. The psychoanalytic approach fails to sufficiently take care of social, cultural, and political factors that may have contributed to an individual 's problem. If the therapist does not keep a balance between the external and internal causes of clients' problems, he may erroneously believe that client is responsible for his present problems. The therapist can avoid committing such an error of judgement by adopting the non-judgemental attitude propagated by the psychoanalytic theory.

8. Psychoanalytic approach may not be suitable for low-income clients. Clients from low income group have typical needs that are different from high income clients. For instance, low income clients approaches a counsellor only when there is a crisis situation and they want either an immediate solution or some guidance about how to solve their problems., Their most dominant immediate problem may be related with their existential needs, such as need for housing, employment and child care. They will benefit more from the therapy

only after these existential need related problems are taken care of. A psychotherapist cannot successfully cater to low income clients, if he/she has classist attitudes and is neither willing nor has the ability or resources to help them with their existential needs first, on a free of charge basis.

9. In such a situation, Smith suggested that instead of using psychoanalytic therapy, the therapist should use other therapeutic techniques such as psychoeducation, counseling, preventive psychology or community psychology, especially if he/she does not want to give any free service to the client.

8.2.2 Adlerian Therapy from Multicultural Perspective:

Strengths From a Diversity Perspective:

1. Carlson and Englar-Carlson (2008) were of the opinion that the best part of Adlerian theory is that it acknowledges the influence of culture, social class, racism, spirituality, religion, family and gender on the behavior of individuals. That is why his ideas are well accepted across all countries, by people living in present era.

2. Broad concepts such as age, ethnicity, lifestyle, sexual/affectional orientations, and gender differences are facilitated to come to the fore in Adlerian therapy. At the beginning of present century, Adler was one of the very few psychologists to promote the idea of equality for women, even though he did not deny that men and women differ in various areas.

3. The Adlerian approach is known as Individual Psychology, but it concentrates on individual in his/her social context. The clients are motivated to look at themselves and describe themselves within their social environments. As Arciniega and Newlon (2003) noted that Adlerian therapy looks at the role of the family, client's contribution to the community, and encourages the sense of belonging, socially oriented values, cooperation and collective spirit. It ignores competitive and individualistic values. Adlerian approach states that culture gives a chance to a person to look at himself, others around him and the world in general in many different dimensions, which is much more wholistic and realistic.

4. Adlerian therapy is very flexible. Instead of trying to fit clients into any established models, the therapeutic process is customized and rooted within a client's culture and worldview. Adlerian counsellors are not tied to any specific procedures, but adopt their techniques according to each client's needs and sociocultural background. When the client realizes that counsellor is sensitive to their cultural values, they also show more willingness to explore and amend their lifestyles, if necessary. Thus, Adlerian therapy is malleable to cultural values that accentuate community.

Shortcomings from a Diversity Perspective:

1. Keeping in sync with Western cultural models, the Adlerian approach considers self as autonomous and therefore the focal point for change and responsibility. This is in contrast to Eastern or Asiatic cultural models where self is just a part of broader social picture. In other words, it lacks the multicultural approach.

2. Though this approach pays due attention to birth order and family configuration, yet it is not representative of all types of families because it is seeped into Western culture and assumes family to be a nuclear family. People living in joint families or raised in extended families can't relate with its concepts.

3. This approach can't benefit clients who do not want to explore past childhood experiences, early memories, family experiences, and dreams.

4. This approach is of little use for clients who do not understand that it is important to analyze past and present lifestyle to decide the remedial measures for current problems.

5. Clients from certain culture may consider counsellor to be an expert, just like a medical doctor, who has solutions for all their problems. The Adlerian approach, on the other hand, believes that counsellor does not have and is not expected to provide solutions to the client. He is merely supposed to suggest or teach the client in a collaborative manner, the alternative ways to deal with his life problems.

6. Some clients have cultural beliefs that family matters should not be disclosed to outsiders. Moreover, many clients are not willing to disclose everything about their lives to the counsellor. They reveal only those areas of their lives, that they think is connected with their present problem. In other words, they decide what is connected or cause of their present problems.

8.2.3 Person-Centred Therapy from Multicultural Perspective:

Strength from a Diversity Perspective:

1. Person-centered therapy is one of the most suitable approach, especially in the field of human relations, for people from varied cultural backgrounds. It is immensely popular in various Western and Eastern countries. It is used not only for counselling purpose, but also for education, reducing political and racial conflicts, and for cross-cultural communication. Various countries have embraced this approach and tweaked it as per their cultural norms. There has been worldwide acceptance of Roger's approach. His work is now available in more than 12 languages, in more than 30 countries.

2. Though person centered approach acknowledges diversity of cultures across the world, the therapist does not make any assumptions about the client and does not initiate the sessions with any prejudice. The

therapist is empathetic, open, believes that every client is unique and respects the values of the client. So this approach is very apt for people from diverse cultural backgrounds.

3. The intervention is customized as per the uniqueness and needs of the clients. The counsellor does not assume the position of an expert who knows what is best for the client and dispenses solutions for all problems of the clients. Instead, counsellor takes up the position of a fellow explorer and collaboratively explores the phenomenological world of the client and keeps verifying from the client about the accuracy of his perceptions about the client's problems.

4. Motivational interviewing technique originates from person centered approach. It is very successfully used across different gender, age, ethnicity, and sexual orientation populations, as it is a very culturally sensitive approach and well suitable for multicultural counselling.

Shortcomings from a Diversity Perspective:

1. One of the disadvantages of this approach is that it is too flexible and unstructured. Many clients come to mental health clinics as outpatients or approach a counsellor only when they are in crisis and are unable to handle their day to day life problems. They require more structured, task-oriented intervention for their problems. They get disappointed when the counsellor does not give them a structured intervention and they may discontinue the sessions.

2. The basic principles of person centered approach such as empathy, congruence and non-directiveness are not suitable for clients from some of the specific cultural back grounds. For instance, clients from some cultures are not at ease with therapist openly expressing empathy and self-disclosure. These clients are comfortable if the therapist expresses empathy indirectly by using task – focused methods of intervention and acknowledging their need for maintaining the distance. In such cases, core practices of person centered cannot be applied in actual practice.

3. Person centered approach assumes that self-awareness, freedom, autonomy, self-acceptance, inner-directedness, and self-actualization are universal innate characteristics of human beings. Any hurdle in satisfaction of these needs leads to problems. But this assumption is reflection of individualistic, western culture bias and may not be true for collectivistic cultures like Asian cultures.

In Asian cultures, people are driven by societal expectations. They view giving importance to one's own personal interests and needs, as being selfish. Such people are least concerned about self-actualization, they are motivated by close, harmonious interpersonal relations with others and being useful to community. They derive their identity from their role and responsibilities in their families and not from the self as is true for western culture. In such a scenario, it will be counterproductive for a therapist to

suggest ways of improving her self-actualization at the exclusion of her social context.

4. The therapist has to be sensitive to the fact that clients come not only from diverse cultural backgrounds, but even clients from any one specific cultural background too have individual differences. So, the core principles of person centered approach can not be uniformly applied to all individuals. The therapeutic style has to be tailor made according to the needs of the clients.

8.2.4 Behaviour Therapy from Multicultural Perspective:

Strengths from a Diversity Perspective:

1. Some clients of a particular ethnicity are reluctant to share their feelings and personal problems due to their cultural values. Behavioural therapy is useful for such clients as this therapy does not insist on clients to go through catharsis. It assumes that all problems of the client can be overcome by just changing the specific behaviors.

2. Irrespective of cultural values, it emphasizes on the specific tasks and actions to be carried out. It does not look at the past history of the client but concentrates on the present problem and what should be the done to solve those problems. So, it is problem solution-oriented therapy. People from any culture can benefit from such an approach.

3. This therapy focuses on the techniques for learning the new behavior and ensuring that such behavior is maintained. So, the clients who are interested to know what exactly should be the concrete remedial plan of action and specific behavior to overcome their problems benefit from this therapy.

4. While dealing with clients who are discriminated in the society due to their caste, colour, creed, religion, etc., this therapy does take into consideration their social and cultural environment while setting up the therapeutic goals.

5. In present times, the behavioural approach does not target to merely treat the behavioural problems, but also assesses the life conditions of the client that may have triggered the current behavioural problems and also evaluates whether it is possible to change the problem behavior and if it is possible, whether client's overall life situation will improve due to this behaviour change.

6. While dealing with clients from different background or culture, the therapist assesses the problem situation through functional analysis. Through functional analysis, the therapist determines whether any cultural factors are responsible for the present behavioural problem, the impact of this behavioural problem on the client himself and to his sociocultural environment. Then he also looks at any resources within the client's sociocultural environment that may help in bringing the change and the consequences of this change on others in his

surroundings. While such an assessment is applaudable, it can be devastating if the counsellor is not trained, knowledgeable, or sensitive to cultural values of the client. So the therapist must be aware of the cultural parameters that determine the normality of behavior and the importance of spirituality in the client's life

Shortcomings from a Diversity Perspective:

1. There is not much empirical evidence about how behavior therapy can be maximally beneficial to people from different cultures. It is well proven that sociocultural variables such as race, gender, ethnicity, and sexual orientation have significant impact on the techniques to be used and the end result of the therapy. Behavioural therapists need to pay take these factors into consideration while using therapy and also to ensure that social justice is not violated during the therapy.

2. Behavioural counsellors pay attention to problems that are within a person and do not pay attention to sociocultural environmental factors that significantly influence a client's life. Resultantly, clients do not get much benefit from this therapy.

3. While deciding about the goals of the therapy with the client, the counsellor should be aware of and consider the cultural and interpersonal aspects of the client's problems. The counsellor must inform the client about the possible changes that can take place in his environment. As the client learns and uses new social skills at home and outside home, other people in his surrounding environment may also change their reactions, it may be for good or it may create new problems. If his changed behavior gives rise to new problems, he should be able to discuss them with the counsellor.

8.3 SUMMARY

In this unit we studied psychoanalytic therapy from multicultural perspective, Adlerian therapy from multicultural perspective, Person-Centred therapy from multicultural perspective and behaviour therapy from multicultural perspective.

8.4 QUESTIONS

1. Discuss Psychoanalytic Therapy from Multicultural Perspective
2. Explain Adlerian Therapy from Multicultural Perspective
3. Write in detail on Person-Centred Therapy from Multicultural Perspective
4. Write brief note on Behaviour Therapy from Multicultural Perspective

8.5 REFERENCES

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