
UNIT 1 PSYCHOANALYSIS, PSYCHODYNAMIC AND PSYCHOTHERAPY

Structure

- 1.0 Introduction
- 1.1 Objectives
- 1.2 Psychotherapy
 - 1.2.1 Essentials of Psychotherapy
- 1.3 Psychoanalysis
 - 1.3.1 Phases in the Evolution of Psychoanalysis
 - 1.3.2 Brief History of Psychoanalysis
 - 1.3.3 The Work of a Psychoanalyst
 - 1.3.4 Goals of Psychoanalysis
- 1.4 Techniques in Psychoanalysis
 - 1.4.1 Maintaining the Analytical Framework
 - 1.4.2 Free Association
 - 1.4.3 Dream Analysis
 - 1.4.4 Interpretation
 - 1.4.5 Analysis and Interpretation of Resistance
 - 1.4.6 Analysis of Transference
 - 1.4.7 Counter Transference
- 1.5 Psychodynamic Therapies
 - 1.5.1 Freudian School
 - 1.5.2 Ego Psychology
 - 1.5.3 Object Relations Psychology
 - 1.5.4 Self Psychology
- 1.6 Differences between Psychodynamic Therapy and Psychoanalysis
- 1.7 Let Us Sum Up
- 1.8 Unit End Questions
- 1.9 Suggested Readings

1.0 INTRODUCTION

In this unit we will be dealing with psychotherapy, psychoanalysis and other related therapies. It provides a detailed account of psychoanalysis and presents the component factors in the same. We then discuss the essentials of Psychotherapy and point out its importance. Then we take up psychoanalysis and as the first step we elucidate the evolution of psychoanalysis and then follow it up by presenting a history of psychoanalysis. Then we take up the functions of a psychoanalyst and detail the same. This is followed by the goals of psychoanalysis and the techniques of psychoanalysis. The next section deals with the psychodynamic therapies and their significance. Then we point out the differences between Psychodynamic Therapy and Psychoanalysis

1.1 OBJECTIVES

After completing this unit, you will be able to:

- Discuss the concept of psychotherapy;
- Define psychoanalysis;
- Describe the goals of psychoanalysis;
- Identify the difference between psychodynamic therapy and psychoanalysis; and
- Explain the techniques like dream analysis and free association used by the psychotherapist.

1.2 PSYCHOTHERAPY

Psychotherapy consists of the whole range of psychologically based treatments by which trained practitioners help people who have psychological problems. Sometimes it is used in more restricted way. It refers to forms of treatment in which a psychotherapist and a client tackle client's problem through talking. Traditionally it focuses on serious problems associated with intra psychic, internal, and personal issues and conflicts. Characteristically, it emphasises the following issues:

- The past more than the present
- Insight more than change
- The detachment of the therapist
- The therapist's role as an expert

Psychotherapy is a systematic interaction between a therapist and a client that brings psychological principles to bear on influencing the client's thoughts, feelings, or behaviour to help that client overcome abnormal behaviour or adjust to problems in living. The interaction is between two or more individuals where one of them, called client or patient, is seeking help for a problem and the other participant, called therapist, provides necessary therapeutic help. The interaction is usually mediated by verbal means although facial expressions, bodily gestures and movement are also used. It usually involves a long term relationship that focuses on reconstructive change. Psychotherapies are procedures in which persons with mental disorders interact with a trained psychotherapist who helps them change certain behaviours, thoughts, or emotions so that they feel and function in a better way. It helps the patients to manage their symptoms better and function at their best in everyday life. It consists of a series of techniques for treating mental health, emotional and some psychiatric disorders and helps the individuals understand what helps them feel positive or anxious, as well as accepting their strong and weak points.

1.2.1 Essentials of Psychotherapy

- i) **Systematic Interaction:** Psychotherapy is a systematic interaction between a client and a therapist. The therapist structures the therapy process based upon a theoretical viewpoint and an understanding of the client's cultural and social background.

- ii) **Psychological Principles:** Psychotherapy is based on psychological theory and research in various areas such as personality, learning and abnormal behaviour.
- iii) **Thoughts, feelings and behaviours:** Psychotherapy influences clients' thoughts, feelings and behaviour.
- iv) **Psychological Disorders, adjustment problems and personal growth:** While psychotherapy is often used with people who have psychological disorders, it can also be used to help people with adjustment (loss of spouse, shyness) and personal growth.

Psychotherapy or talk therapy is currently used by psychologists and other professionals in different forms. It uses varied range of procedures and can be conducted with individuals as well as with groups. There are many different therapy styles and techniques including Psychodynamic Psychotherapy, Cognitive Behavioural Therapy (CBT), Group Therapy, and Couples Therapy. The unique elements of psychotherapy are that it varies according to different theoretical perspectives. The first organised system of psychotherapy which has a considerable influence in the field of Psychology was Psychoanalysis by Sigmund Freud.

1.3 PSYCHOANALYSIS

Psychoanalysis is a very significant perspective in the field of psychology. It is a method of analysing psychic phenomena and treating emotional disorders that involves treatment sessions during which the client or the patient is encouraged to talk freely about personal experiences and especially about early childhood and dreams. Psychoanalysis is both a theory of mental functioning and a specific type of psychological treatment philosophy. It is generally known as a theory of human behaviour.

It has three applications:

- i) a method of investigation of the mind;
- ii) a systematised set of theories about human behaviour;
- iii) a method of treatment of psychological or emotional illness.

Psychoanalysis was first devised in Vienna in the 1890s by Sigmund Freud. It involves analysing the root causes of behaviour and feelings by exploring the unconscious mind and the conscious mind's relation to it. It focuses on an individual's unconscious, deep-rooted thoughts that often stem from childhood.

Freud believed that Id, Ego and Super-Ego are three major parts of personality which represent desire, reason and conscience.

He was of the opinion that the root cause of all mental disorders is repressed desired in the unconscious mind.

This repression occurs due to non acceptance of Id impulses to ego or superego. These urges persist in the unconscious and individuals devote a considerable time to have a check on them and to keep them out of conscious part of the personality. People often use defense mechanisms to protect the ego from feeling of anxiety generated by these inner conflicts.

1.3.1 Phases in the Evolution of Psychoanalysis

Freud (1914b, 1927) described three phases in the evolution of Psychoanalysis.

The first phase

During first phase of psychoanalysis, Freud found that the central aspect of human mind was unconscious thoughts that could be accessed through dreams, fantasies, jokes, slip of tongues, hypnosis, free association, and so on.

The second phase

In the second phase, Freud discarded hypnosis and emphasised on free association. He found that clients voluntarily permitted the emergence of unconscious materials in free association. As Freud always wanted a unique theory so he developed his own specific techniques like Dream Analysis, Free Association and so on.

Third phase

During the third phase, he elaborated his dream analysis technique and described primary and secondary processes. Primary processes are governed by Id, the pleasure principle and are illogical. They can be found in dreams, poetry, myth and magic. Psychosis is the ultimate form of this process.

Secondary processes are governed by logic and are associated with the ego and reality principle.

At the end of the third phase of Psychoanalysis, other analysts such as Jung(1875-1961), Adler(1870-1937), Horney(1885-1952), Sullivan(1892-1949) and Erikson (1902-1992) modified Freud's psychoanalysis.

1.3.2 Brief History of Psychoanalysis

Psychoanalysis has also its roots in hypnosis. The first contributor was Franz Mesmer, who is known for inducing a mental state called Mesmerism. He has presented the idea of animal magnetism. He used magnets for the treatment of paralysis, later he claimed that he could treat paralysis without magnets by directing his own magnetic fluid to the patient's body.

Liebault and Bernheim introduced Mesmerism in the Nancy school, France. Jean Martin Charcot was a French Neurologist who used hypnosis to treat hysterical patients. In 1885 Charcot introduced Freud to hypnosis. Freud began developing his own theory of psychoanalysis under Charcot's influence. Josef Breuer introduced Freud to Cathartic method of treatment of hysteria.

Freud emphasised on unconscious drives. He used the term Psychoanalysis in *three distinct ways*: Firstly, it is a theory which describes the structure of the mind, the development of the personality, and psychopathology; secondly it is used as a technique to treat psychological difficulties; and thirdly it is a method of scientific investigation based on a clinical observation called case study.

Anna Freud (1895-1982) was especially instrumental in carrying on her father's tradition, particularly in her pioneering work on defense mechanisms.

Carl Jung, viewed by Freud as his heir apparent, separated away from Freud's inner circle. He had serious differences with Freud's theory of drives. He agreed with the importance of the unconscious but condemned Freud for his

overemphasising the sexual and aggressive drives. Jung emphasised on collective unconscious which was consistent with Freud's primitive universal fantasies. He laid emphasis on cultural symbols and believed that humans inherited a desire for higher religious fulfillment and self development.

Alfred Adler was the first disciple of Freud to disagree with the master. He developed individual psychology and emphasised on societal pressures which shape the personality and believed that behaviour is motivated by need to be superior.

Karen Horney disagreed with Freud's premise that women have penis envy rather felt that men on the other hand envied women. She believed that the basic anxiety results from disturbances in parent child relationships and in attempting to deal with basic anxiety, individuals develop a characteristic social orientation (dependent, submissive, inflated self concept, avoidant etc.).

Erik Erikson agreed with Freud that development occurred in stages but emphasised social as opposed to sexual development. He described that development occurs across the lifespan and believed that ego is relatively powerful part of personality that functions to establish and maintain a sense of identity (ego psychology).

Carl Rogers Client Centered therapy's core focus is on analyst's patient, empathetic, uncritical and receptive approach.

Otto Rank, a devoted follower of Freud, rejected theories of Oedipus complex. He related all neurotic anxieties to birth trauma. The central part of his theory was separation anxiety and believed that all forms of separation reactivated the primal anxiety of birth trauma.

Sándor Ferenczi, a close colleague of Freud's, is known as one of the most daring experimenters of the early psychoanalysts. He anticipated the humanistic movement in psychotherapy by emphasising that the analyst could not be a mere detached observer. He felt that the analyst must have an attitude of genuine caring in order to assist the patient's healing caused by past abuse and the analyst cannot be in the position of an authority because it creates a hierarchal relationship between the analyst and client.

He experimented with a technique called "mutual analysis," where he and the patient would take turns lying on the couch and free-associating but this technique did not work out.

Melanie Klein's work is an extension of Freud's work, but also a transformation of Freud's original insights through her unique interpretive perspectives. Klein was also profoundly influenced by Sandor Ferenczi, her own psychoanalyst. Working with children, Klein felt she had observed processes in pre-Oedipal children that were very similar to oedipal conflicts in older children. Throughout her career, she attempted to theoretically justify these observations.

In turn, Klein and her followers applied her practice and theory to work with psychotic adult patients. Klein's technique, in all cases, involved a method of using "deep" interpretations which she felt communicated directly to the unconscious of the client, thus by-passing ego defenses. The term "object relations" ultimately derived from Klein, since she felt that the infant introjects the 'whole' other with the onset of the depressive position during the ontogenesis of the self.

As a therapy, psychoanalysis is based on the concept that individuals are unaware of the many factors that cause their behaviour and emotions. These unconscious factors have the potential to produce unhappiness, which in turn is expressed through a score of distinguishable symptoms, including disturbing personality traits, difficulty in relating to others, or disturbances in self-esteem or general disposition (American Psychoanalytic Association, 1998).

1.3.3 The Work of a Psychoanalyst

- The psychoanalyst basically helps the person to tell his or her story by establishing a solid working alliance with the client.
- He gathers background information and history and then selects the problem or issue to be worked on.
- He tries to explore the precipitating events and deals with resistance shown by client.
- He then collaborates with the client to form a diagnosis and treatment plan and increase the client's awareness regarding defensiveness.
- The psychoanalytic process helps in exploring the client's transference and monitors the therapist's counter transference.
- Psychoanalyst helps in examining how the past is impacting the present.
- The psychoanalyst helps the client to behave more effectively.
- He provides feedback and confronts discrepancies, negotiates with the client regarding homework assignments.
- The psychoanalyst reminds the client of the termination date and end therapy as agreed upon with the client.
- The psychoanalyst schedules follow-up too as needed.

1.3.4 Goal of Psychoanalysis

The goal of psychoanalysis varies according to the client, but they focus mainly on personal adjustment, usually inducing a reorganisation of internal forces within the person.

The primary goal in most cases is to help client in achieving insight which can consciously make them aware of the psychodynamics that underlie their problems.

This awareness helps the clients to make adjustment to their current life situations. People repeatedly encounter and deal with repressed emotions, motives and conflicts.

The second major goal is to help client work through a developmental stage, not resolved in primary goal. If accomplished, clients become unstuck and are able to live more productively.

The final goal is to help clients cope with the demands of the society in which they live.

The goal of psychoanalysis is to enable the person to deal with the unconscious urges in a realistic and mature manner. But the question arises how to penetrate the unconscious mind.

The ways to penetrate take on a variety of forms varying from practitioner to practitioner. Freud suggested certain methods to achieve the aim or goal of psychoanalysis. Some of these methods include the following:

- Free association
- dreams or fantasies

clients can learn how to interpret deeply buried memories or experiences that may be causing them distress.

1.4 TECHNIQUES IN PSYCHOANALYSIS

The six basic techniques of psychoanalytic therapy are:

- 1) Maintaining the Analytic Framework,
- 2) Free Association,
- 3) Dream Analysis,
- 4) Interpretation,
- 5) Analysis of Resistance,
- 6) Analysis of Transference.

Each of the above is being discussed in detail below

1.4.1 Maintaining the Analytic Framework

This refers to a whole range of procedural and stylistic factors such as the analyst's relative anonymity, the regularity and consistency of meetings and in time conclusion of the sessions. The psychoanalytic process stresses upon to maintain a particular framework to accomplish the therapy's goal. The consistent framework itself works as a therapeutic factor.

1.4.2 Free Association

Freud and subsequent psychoanalysts widely used this technique as they considered that it provides important clues to the workings of the unconscious mind. They believed that mental events are meaningfully associated with one another and those clues to the contents of the unconscious can be found in the ongoing stream of thoughts, memories, images and feelings that we experience. It consists of the individual lying on a couch in a partly darkened room producing an uncensored, non-calculated account of what they are thinking and feeling during the session.

The nature of responses made during a free association session indicate the concerns and preoccupations of a person's unconscious as there is no censorship by the conscious mind, the Ego. Client reports immediately without censoring any feelings or thoughts. The client is encouraged to relax and freely recall childhood memories or emotional experiences. In this way, unconscious material enters the conscious mind, and the counselor interprets it. At times clients resist free association by blocking their thoughts or denying their importance. Psychoanalysts make the most of these moments by attempting to help clients work through their resistance.

1.4.3 Dream Analysis

Dream analysis is a particular tool of the psychoanalytic school of thought proposed by Freud and Jung, and is considered as the first scientific approach to the study

of dreams. It gives an important set of clues to the unconscious mind, because dreaming is thought to express levels of unconscious wish fulfillment expressive of the individual's deepest conflicts and desires.

Freud was of the opinion that we can give expressions to our desires and impulses that we are unable to express during our waking hours because they are unacceptable by the society. Thus we can gratify illicit sexual desires and thoughts which we generally repress during the day. In this clients report dreams to counselor on regular basis.

Freud believed that dreams were a main avenue to understanding the unconscious. He reported that in this way he gained important insight into the causes of client's problems. But Freud did not provide any specific and clear rule to interpret dreams and there was no way of determining whether that interpretation is right or wrong.

Counselor uses the free association and other techniques to bring unconscious material to the conscious. Clients are encouraged to remember dreams. The counselor analyses two aspects, viz., the manifest content and the other latent content.

1.4.4 Interpretation

Interpretation should consider part of all above mentioned techniques. It consists of the analyst's pointing out, explaining and teaching the client the meanings of behaviour that is manifested in dreams, free associations, and resistances. When interpreting, the counselor helps the client to understand the meaning of the past and present personal events.

Interpretation is grounded in therapist's assessment of the client's personality and of the factors in the client's past that contributed to his difficulties. Counselor points out, explains, and teaches the meanings of whatever is revealed. The therapist must be guided by a sense of client's readiness to consider it and it should be well timed.

Counselors must carefully time the use of interpretation for better understanding of unconscious influences and impulses. A general rule is that interpretation should be presented when the phenomena to be interpreted is close to conscious awareness.

Another rule is that interpretation should always start from the surface and go only as deep as the client is able to go. Also it is best to point out a resistance before interpreting the conflict that lies beneath it.

1.4.5 Analysis and Interpretation of Resistance

Anything which works against the progress of therapy and prevents the client to produce unconscious material is called Resistance. The client shows reluctance to bring unconscious material at the level of awareness. Freud viewed resistance as an unconscious dynamic that people used to defend against the anxiety and pain that would arise if they become aware of their repressed feelings. Resistance is a defense against anxiety that prevents clients and therapist from succeeding in their effort to gain insight into the dynamics of the unconscious. The therapist must respect the resistance of clients and assist them in working therapeutically with their defenses. If the therapist handles it properly It can be the most valuable tool to understand the client.

1.4.6 Analysis of Transference

Freud discovered and developed this psychoanalytic concept of transference which later on developed by many other analysts and professionals. The concept developed out of the inappropriate ending of a treatment. It is the client's response to a counselor as if the counselor were some significant figure in the client's past, usually a parent figure. Transference is a displacement of attitudes and feelings originally experienced in relationships with persons onto the analyst in the long past history of the patient.

It is a universal phenomenon. Patients are not aware at a conscious level of the displacement that has taken place. This allows the client to experience feelings that would otherwise be inaccessible. **This is ambivalent in nature which can be positive (affectionate) as well as negative (hostile) towards the analyst.** In positive transference, the patient has confidence in the doctor. If intense, the patient may over-idealise the doctor or develop sexual feelings toward the doctor. In negative transference, the patient may become resentful or angry toward the doctor if the patient's desires and expectations are not realised. This may lead to noncompliance Counter transference.

These phenomena increase emotionality and may thus alter judgment and behaviour in patients' relationships with their therapist (trans-ference) and therapist' relationships with their patients (counter-transference).

1.4.7 Counter Transference

This is an analyst's feelings that are thought to be related to what the patient is projecting onto the psychoanalyst. In this, feelings about a client and the reaction of the counselor towards the client who reminds the doctor of a close friend or relative may interfere with objectivity. The counselor encourages this transference and interprets positive or negative feelings expressed. Analysis of transference allows the client to achieve insight into the influence of the past. Analytically oriented therapists consider transference as the core of the therapeutic process as it aims in achieving awareness and personality change. It allows the clients to achieve insight into the influence of past on their present functioning and enables clients to work through old conflicts that are keeping them fixated and retarding their emotional growth. Through appropriate interpretation, clients become aware of their long standing inappropriate behaviours and gradually change some of them.

1.5 PSYCHODYNAMIC THERAPIES

Historically, psychodynamic therapies are based on the principles of psychoanalytic theory that mental disorders stem primarily from the kind of hidden conflicts first described by Freud. The term Psychoanalytic and psychodynamic have been used synonymously. Psychodynamic therapy or Psychoanalytic Psychotherapy is a general name for therapeutic approaches which try to get the patient to bring to the surface their true feelings, so that they can experience them and understand them. These therapies assume that the mental disorders occur because something has gone seriously wrong in the balance between these inner forces. These therapies assert that a person's behaviour is affected by his or her unconscious mind and past experiences. Both psychotherapeutic approaches derive from a set of principles

derived from psychoanalysis. Among these principles are the dynamic unconscious, transference, counter transference, resistance and psychic determinism.

Several different approaches to brief psychodynamic psychotherapy have evolved from psychoanalytic theory and have been clinically applied to a wide range of psychological disorders. There is a body of research that generally supports the efficacy of these approaches. Psychodynamic therapy is the oldest of the modern therapies. (Freud's psychoanalysis is a specific form and subset of psychodynamic therapy.) As such, it is based in a highly developed and multifaceted theory of human development and interaction.

There are four major schools of psychoanalytic theory, each of which has influenced psychodynamic therapy. The four schools are:

- Freudian,
- Ego Psychology,
- Object Relations, and
- Self Psychology.

1.5.1 Freudian School

Freudian psychology is based on the theories first formulated by Sigmund Freud. It is sometimes referred to as the drive or structural model. The essence of Freud's theory is that sexual and aggressive energies originating in the id or unconscious are modulated by the ego, which is a set of functions that moderates between the id and external reality. Defence mechanisms are constructions of the ego that operate to minimize pain and to maintain psychic equilibrium. The superego, formed during latency between age 5 and puberty, operates to control id drives through guilt.

1.5.2 Ego Psychology

Ego Psychology derives from Freudian psychology. It focuses upon enhancing and maintaining ego function in accordance with the demands of reality. Heinz Hartmann, the father of Ego Psychology, studied the ways in which the ego organises itself, adapts, and deploys ID drives. Ego Psychology stresses the individual's capacity for defence, adaptation, and reality testing. Heinz Hartmann-leader of ego therapy. It focuses on the ego's workings in creating defenses rather than focusing on the underlying id content. It engages the patient with less emphasis on uncovering hidden secrets but more on psychic structure-i.e. the relationships between the id, the ego, and superego (Mitchell and Black-1995)

1.5.3 Object Relations Psychology

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

1.5.4 Self Psychology

Self Psychology, founded by Heinz Kohut, observed that the self refers to a person's perception of his experience of his self, including the presence or lack of a sense of self-esteem. The self is perceived in relation to the establishment of boundaries and the differentiations of self from others (or the lack of boundaries and differentiations). Self Psychology emphasises empathy which is used to describe an intra-psychic process in the therapist by which an understanding of the patient, particularly an emotional understanding, a capacity to feel what the other is feeling, is enhanced.

Each of the four schools of psychoanalytic theory presents discrete theories of personality formation, psychopathology formation, and change; techniques by which to conduct therapy; and indications and contraindications for therapy.

Like Psychoanalysis, Psychodynamic Psychotherapy uses the basic assumption that everyone has an unconscious mind and that feelings held in the unconscious mind are often too painful to be faced. Thus we come up with defenses to protect us knowing about these painful feelings. Psychodynamic therapy assumes that these defenses have gone wrong and are causing more harm than good. It tries to unravel them, as once again, it is assumed that once you are aware of what is really going on in your mind the feelings will not be as painful. Several forms of therapy are based on these assumptions, but the most famous is Psychoanalysis developed by Freud.

1.6 DIFFERENCE BETWEEN PSYCHODYNAMIC THERAPY AND PSYCHOANALYSIS

Although similar to Psychoanalysis as it was derived from a similar background, Psychodynamic therapy is distinguished from psychoanalysis in several particulars, including the fact that psychodynamic therapy need not include all analytic techniques and is not conducted by psychoanalytically trained analysts. It tends to differ in the following ways:

Psychoanalysis

Focuses on repressed childhood conflicts, Id content, Ego activity.

- Brings conflict to conscious awareness to overcome neurosis.
- All adult problems can be traced back to childhood
- An Interaction of ego, superego, and id.
- Tends to affect a lot more of your personality.
- Conducted more frequently over a longer period of time.

Psychodynamic

- Less emphasis on sexual and aggressive drives.
- Less emphasis on unconscious information.
- More emphasis on past relationships.
- Offshoot of the psychoanalytic school.
- Interpretation is main tool.
- Mediator, a conscience and a devil.

- Has more specific goal e.g. sorting out a phobia.
- Conducted over a shorter period of time with less frequency than psychoanalysis

1.7 LET US SUM UP

Psychotherapy is procedures in which persons with psychological problems and mental disorders interact with a trained psychotherapist who helps them change certain behaviours, thoughts and emotions so that they feel and function better. The outcome of psychotherapy depends upon the client, the therapist and the techniques used by the therapist. Many forms of psychotherapy exist, ranging from the techniques used by Freud through modern techniques base on learning and cognitions.

Psychoanalysis is a form of psychotherapy focuses on helping individuals gain insight into their hidden inner conflicts and repressed wishes. The goal of Freudian psychoanalysis is to achieve insight into the unconscious dynamics that underlie their behaviour disorders so that they can deal adaptively with their current environment. The chief means for promoting insight is the interpretation of the client's free associations, dream content, resistance and transference reactions. Psychodynamic therapists view maladaptive behaviours as symptoms of an underlying conflict that needs to be resolved if behaviour is to be changed.

1.8 UNIT END QUESTIONS

- 1) What is Psychotherapy? What are its essentials?
- 2) What is Psychoanalysis? Discuss the phases in its evolution.
- 3) Discuss the role of Dream analysis in Psychoanalysis.
- 4) Explain the techniques used by Psychoanalysts.
- 5) What are Psychodynamic therapies? How are they different from Psychoanalysis?
- 6) Discuss the schools of psychoanalysis which have influenced Psychodynamics.

1.9 SUGGESTED READINGS

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UNIT 2 BEHAVIOURAL THERAPY, COGNITIVE BEHAVIOUR THERAPY AND APPROACHES TO COUNSELLING

Structure

- 2.0 Introduction
- 2.1 Objectives
- 2.2 Behaviour Therapy
 - 2.2.1 History
 - 2.2.2 Systematic Desensitisation
 - 2.2.3 Exposure: An extinction Approach
 - 2.2.4 Aversion Therapy
 - 2.2.5 Operant Conditioning Treatments
- 2.3 Cognitive Behavioural Therapy (CBT)
 - 2.3.1 Brief History
 - 2.3.2 ABC Model of CBT
 - 2.3.3 Goals of CBT
 - 2.3.4 Techniques/ Principles Used in CBT
 - 2.3.5 Levels of Cognition
 - 2.3.6 Techniques Used in CBT
 - 2.3.7 Hierarchical Structure of A-B-C
- 2.4 Let Us Sum Up
- 2.5 Unit End Questions
- 2.6 Suggested Readings

2.0 INTRODUCTION

This unit deals with behaviour therapy cognitive behaviour therapy and related issues. We start with Behaviour Therapy, how it started and with what purpose and proceed to give some of the techniques related to behaviour therapy. The techniques such as systematic desensitisation, exposure, flooding, and aversion therapy are all discussed in this unit. Then we take up operant conditioning techniques under which we discuss the positive reinforcement, participant modeling and assertiveness training etc. This is then followed by cognitive behaviour therapy in which we discuss its history, present the ABC model of CBT and describe the techniques of CBT in detail. We then present the hierarchical structure of ABC model of cognitive behaviour therapy and elucidate the principles underlying cognitive therapies.

2.1 OBJECTIVES

After completing this unit, you will be able to:

- Define behaviour therapy;
- Describe classical conditioning procedures in behaviour therapy;

- Explain cognitive-behavioural therapy (CBT) and its principles;
- Describe A-B-C Model of CBT;
- Identify the difference between behaviour therapy and cognitive-behavioural therapy (CBT); and
- Explain the techniques involved in CBT.

2.2 BEHAVIOUR THERAPY

Behavioural psychology, or behaviourism, arose in the early 20th century in reaction to the method of introspection that dominated psychology at the time. John B. Watson, the father of behaviourism, had initially studied animal psychology. In the 1960s, behaviour approaches emerged as a dramatic departure from the assumptions and methods that characterised psychoanalytic and humanistic therapies. They argued that psychology should concern itself only with publicly observable phenomena i.e., overt behaviour. According to Behaviouristic thinking, as mental content is not publicly observable, thus it cannot be subjected to rigorous scientific inquiry.

The new practitioners of behaviour therapy denied the importance of inner dynamics, instead they insisted that

- 1) maladaptive behaviours are not merely symptoms of underlying problems but rather are problems;
- 2) problem behaviours are learned on the same ways normal behaviours are; and
- 3) maladaptive behaviours can be unlearned by applying principles derived from research on classical conditioning, operant conditioning and modeling.

Consequently, behaviourists developed a focus on overt behaviours and their environmental influences.

Behaviour therapy involves changing the behaviour of clients to reduce dysfunction and to improve quality of life. Behaviour therapy includes a methodology, referred to as *behaviour analysis*, for the strategic selection of behaviours to change, and a technology to bring about behaviour change, such as modifying antecedents or consequences or giving instructions. Behaviour therapy represents clinical applications of the principles developed in learning theory.

2.2.1 History

Around 1920s, the application of learning principles to the treatment of behavioural disorders began to appear, but it had little effect on the mainstream of psychiatry and clinical psychology. Behaviour therapy emerged as a systematic and comprehensive approach to psychiatric (behavioural) disorders in 1960s. Joseph Wolpe and his colleagues used pavlovian techniques to produce and eliminate neuroses in cats. From this research, Wolpe developed systematic desensitisation. At about the same time, Eysenck and Shapiro stressed the importance of an experimental approach in understanding and treating individual patients, using modern learning theory. A Harvard psychologist B. F. Skinner also inspired the origin of behaviour therapy. Skinner's students began to apply his operant conditioning technology, developed in animal conditioning laboratories, to human beings in clinical settings.

Classical conditioning procedures have been used in two major ways.

- i) First, they have been used to reduce or de condition anxiety responses.
- ii) Second, they have been used in attempts to condition aversive stimuli.

His most commonly used classical conditioning procedures are:

- Systematic Desensitisation,
- Exposure therapy, and
- Aversion therapy.

Let us take up each of these and discuss.

2.2.2 Systematic Desensitisation

In 1958 Joseph Wolpe introduced Systematic Desensitisation, This is actually learning based treatment for anxiety disorders. Wolpe viewed anxiety as a classical conditioned response. His goal was to eliminate anxiety by using a procedure called Counterconditioning. In this, a new response that is incompatible with anxiety is produced. For example relaxed state which is incompatible with anxiety state. This relaxed state is conditioned to the anxiety arousing conditioned stimulus (CS), like for instance fear of a closed room or fear of heights etc.

It is based on the behavioural principle of Counterconditioning, whereby a person overcomes maladaptive anxiety elicited by a situation or an object by approaching the feared situation gradually, in a psychophysiological state that inhibits anxiety.

In systematic desensitisation, patients attain a state of complete relaxation and are then exposed to the stimulus that elicits the anxiety response.

The negative reaction of anxiety is inhibited by the relaxed state, a process called *reciprocal inhibition*.

Instead of using actual situations or objects that elicit fear, patients and therapists prepare a graded list or hierarchy of anxiety provoking scenes associated with a patient's fears. The learned relaxation state and the anxiety provoking scenes are systematically paired in treatment. Thus, systematic desensitisation consists of three steps:

- Hierarchy construction
- Relaxation training
- Desensitisation of the fear evoking stimulus.

Step 1: Hierarchy Construction

When constructing a hierarchy, clinicians determine all the conditions that elicit anxiety, and then patients create a hierarchy list of 10 to 12 scenes that produce anxiety and these are then put in order of increasing anxiety. In the box below is given an example of a hierarchy construction used in the systematic desensitisation treatment of a Test Anxious College Student.

Scene: Hierarchy of Anxiety Arousing Scenes

Hearing about someone else who has a test (**Least anxiety provoking**)
Instructor announcing that a test will be given in three weeks
Instructor reminding class that there will be a test in two weeks
Overhearing classmates talk about studying for the test, which will occur in one week
Instructor reminding class of what it will be tested on in two days
Leaving class the day before exam
Studying the night before test
Getting up morning of the test
Walking toward the building where the exam will be given
Walking into the exam room
Instructor walking into the room with the test
Tests being distributed
Reading the test questions
Watching others finishing the test
Seeing a question I can not answer
Instructor waiting for me to finish the test (**High anxiety provoking**)

Step 2: Relaxation Training

Relaxation training can help people control their physiological responses in stressful situations. These techniques produce physiological effects opposite to those of anxiety, that is slow heart rate, increased peripheral blood flow, and neuromuscular stability.

A variety of relaxation methods have been developed. Most methods use progressive relaxation, also known as somatic relaxation training, developed by the psychiatrist Edmund Jacobson.

It provides a means of voluntarily reducing or preventing high level of arousal. Patients relax major muscle groups in a fixed order, beginning with the small muscle groups of the feet and working towards shoulders, neck, face and head etc. Moving from lowest extremities to the head is called cephalocaudal. Ofcourse one can also start with head muscles, face muscles and move down to neck etc. and then on to the extremities.

Some clinicians use hypnosis to facilitate relaxation or use tape-recorded exercise to allow patients to practice relaxation on their own.

Mental imagery is a relaxation method in which patients are instructed to imagine themselves in a place associated with pleasant relaxed memories.

Such images allow patients to enter a relaxed state or experience. The physiological changes that take place during relaxation are the opposite of those induced by the stress responses that are part of many emotions.

Muscle tension, respiration rate, heart rate, blood pressure, and skin conductance decrease. Relaxation increases respiratory heart rate variability, which is an index of parasympathetic tone. In the box below relaxation step by step are given

With its focus on full, cleansing breaths, deep breathing is a simple, yet powerful, relaxation technique. It's easy to learn, can be practiced almost anywhere, and provides a quick way to get your stress levels in check. Deep breathing is the cornerstone of many other relaxation practices, too, and can be combined with other relaxing elements such as aromatherapy and music. All you really need is a few minutes and a place to stretch out.

How to practice deep breathing

The key to deep breathing is to breathe deeply from the abdomen, getting as much fresh air as possible in your lungs. When you take deep breaths from the abdomen, rather than shallow breaths from your upper chest, you inhale more oxygen. The more oxygen you get, the less tense, short of breath, and anxious you feel. So the next time you feel stressed, take a minute to slow down and breathe deeply:

- Sit comfortably with your back straight. Put one hand on your chest and the other on your stomach.
- Breathe in through your nose. The hand on your stomach should rise. The hand on your chest should move very little.
- Exhale through your mouth, pushing out as much air as you can while contracting your abdominal muscles. The hand on your stomach should move in as you exhale, but your other hand should move very little.
- Continue to breathe in through your nose and out through your mouth. Try to inhale enough so that your lower abdomen rises and falls. Count slowly as you exhale.

If you have a hard time breathing from your abdomen while sitting up, try lying on the floor. Put a small book on your stomach, and try to breathe so that the book rises as you inhale and falls as you exhale.

Progressive muscle relaxation for stress relief

Progressive muscle relaxation is another effective and widely used strategy for stress relief. It involves a two-step process in which you systematically tense and relax different muscle groups in the body.

With regular practice, progressive muscle relaxation gives you an intimate familiarity with what tension—as well as complete relaxation—feels like in different parts of the body. This awareness helps you spot and counteract the first signs of the muscular tension that accompanies stress. And as your body relaxes, so will your mind. You can combine deep breathing with progressive muscle relaxation for an additional level of relief from stress.

Progressive Muscle Relaxation Sequence

- Right foot
- Left foot
- Right calf
- Left calf
- Right thigh

- Left thigh
- Hips and buttocks
- Stomach
- Chest
- Back
- Right arm and hand
- Left arm and hand
- Neck and shoulders
- Face

Most progressive muscle relaxation practitioners start at the feet and work their way up to the face. For a sequence of muscle groups to follow, see the box to the right:

- Loosen your clothing, take off your shoes, and get comfortable.
- Take a few minutes to relax, breathing in and out in slow, deep breaths.
- When you're relaxed and ready to start, shift your attention to your right foot. Take a moment to focus on the way it feels.
- Slowly tense the muscles in your right foot, squeezing as tightly as you can. Hold for a count of 10.
- Relax your right foot. Focus on the tension flowing away and the way your foot feels as it becomes limp and loose.
- Stay in this relaxed state for a moment, breathing deeply and slowly.
- When you're ready, shift your attention to your left foot. Follow the same sequence of muscle tension and release.
- Move slowly up through your body — legs, abdomen, back, neck, face — contracting and relaxing the muscle groups as you go.

Step 3: Desensitisation of the Anxiety Provoking Stimulus

In the final step, called *desensitisation*, the patient proceeds systematically through the list from the least, to the most, anxiety provoking scene while in a deeply relaxed state. In fact they vividly imagine the situation as is given in the list and as they imagine and as they are in the relaxed state, the scene even if evokes anxiety the anxiety does not bother the individual. In case it does, then the patient is made to relax once again all the more and the same scene is imagined, until the anxiety is no more evoked when visualising the concerned anxiety provoking situation. Once the patient is totally relaxed even under the anxiety provoking situation, the patient is asked to move to the next item in the list that is anxiety provoking. The same process as above is repeated until the situation no more evokes anxiety. Then the patient moves on to the third item in the list and so on. The rate at which the clients progress through the list is determined by their responses to the stimuli. When patients can vividly imagine the most anxiety provoking scene of the hierarchy with equanimity, they experience little anxiety in the corresponding real life situation.

2.2.3 Exposure: An Extinction Approach

From a behavioural point of view, phobias and other fears result from classically conditioned emotional responses. The conditioning experience is assumed to involve a pairing of the phobic object (fear of heights let us say) with an aversive unconditioned stimulus (UCS). For example, if a person has a fear of heights, then put him at a height (UCS) where he has no way to come down except with the help of a ladder that you may provide him later. As a result, the phobic stimulus (Height) becomes a conditioned stimulus (CS) that elicits the conditioned response (CR) of anxiety. Continuously staying exposed to the aversive stimulus (heights) in course of time brings down the anxiety and the extreme negative reaction. As this process of exposure is repeated again and again, the patient does not react negatively or with fear when exposed to heights.

Thus, according to this formulation, the most direct way to reduce the fear is through a process of classical extinction of the anxiety response. The client may be exposed to real life stimuli or asked to imagine scenes involving the stimuli. These stimuli will evoke considerable anxiety, but the anxiety will be extinguished in time if the person remains in the presence of the fear evoking stimulus (heights) and the UCS (anxiety) does not occur.

Some critics of exposure treatment are concerned that the intense anxiety evoked by the treatment may worsen the problem or cause clients to flee from the treatment. But experimental research has proved this technique a very effective treatment for extinguishing anxiety in both animals and humans.

Advances in computer technology have made it possible to present environmental cues in Virtual Reality (VR) for exposure treatment. Virtual reality involves the use of computer technology to create highly realistic virtual environments that stimulate virtual actual experience so vividly that they evoke many of the same reactions that a comparable real world environment would. Beneficial effects have been reported with virtual reality exposure of patients with height phobia, fear of flying, spider phobia, and claustrophobia. Much experimental work is being done in the field.

2.2.4 Aversion Therapy

For some clients, the therapeutic goal is not to reduce anxiety but actually to condition anxiety to a particular stimulus that triggers deviant behaviour. In aversion therapy, the therapist pairs a stimulus (drinking alcohol) that is attractive to the client (the CS) with a noxious UCS (vomiting due to an injection given immediately before taking alcohol) in an attempt to condition an aversion to the CS (alcohol). When a noxious stimulus (vomiting as punishment) is presented immediately after a specific behavioural response, theoretically, the response is eventually inhibited and extinguished. Many types of noxious stimuli are used which include for instance, electric shocks, substances that induce vomiting, corporal punishment, and social disapproval. The negative stimulus is paired with the behaviour, which is thereby suppressed. The unwanted behaviour may disappear after a series of such sequences. Aversion therapy has been used for alcohol abuse, paraphilias (child molesters), and other behaviours with impulsive or compulsive qualities, but this therapy is controversial for many reasons. For example, punishment does not always lead to the expected decreased response and can sometimes be positively reinforcing.

2.2.5 Operant Conditioning Treatments

The term behaviour modification refers to treatment techniques that apply operant conditioning procedures in an attempt to increase or decrease a specific behaviour like positive reinforcement, extinction, negative reinforcement, or punishment.

- i) **Positive Reinforcement:** When a behavioural response is followed by a generally rewarding event, such as food, avoidance of pain, or praise, it tends to be strengthened and to occur more frequently than before the reward. This principle has been applied in a variety of situations. In the inpatient hospital wards, patients with mental disorder receive a reward for performing a desired behaviour, such as tokens that they can use to purchase luxury items or certain privileges. The process, known as token economy, has successfully altered undesirable behaviours to desirable behaviours.
- ii) **Flooding:** Flooding, sometimes called *implosion*, is similar to graded exposure in that it involves exposing the patient to the feared object in vivo; however, there is no hierarchy. It is based on the premise that escaping from an anxiety provoking experience reinforces the anxiety through conditioning. Thus, clinicians can extinguish the anxiety and prevent the conditioned avoidance behaviour by not allowing patients to escape the situation.

In a variant, called *imaginal flooding*, the feared object or situation is confronted only in the imagination, not in real life.

Many patients refuse flooding because of the psychological discomfort involved.

It is also contraindicated when intense anxiety would be hazardous to a patient (e.g., those with heart disease or fragile psychological adaptation). The technique works best with specific phobias.

- iii) **Participant Modeling:** In participant modeling, patients learn a new behaviour by imitation, primarily by observation, without having to perform the behaviour until they feel ready. Learning by watching others' behaviour is also called Observational learning.

Just as irrational fears can be acquired by learning, they can be unlearned by observing a fearless model confront the feared object. The technique has been useful with phobic children who are placed with other children of their own age and sex who approach the feared object or situation.

With adults, a therapist may describe the feared activity in a calm manner that a patient can identify.

Or, the therapist may act out the process of mastering the feared activity with a patient.

Sometimes, a hierarchy of activities is established, with the least anxiety provoking activity being dealt with first. The participant modeling technique has been used successfully with agoraphobia by having a therapist accompany a patient into the feared situation. In a variant of the procedure, called *behaviour rehearsal*, real life problems are acted out under a therapist's observation or direction.

- iv) **Assertiveness Training:** Assertive behaviour enables a person to act in his or her own best interest, to stand up for herself or himself without undue anxiety, to express honest feelings comfortably, and to exercise personal rights without denying the rights of others.

Two types of situations frequently call for assertive behaviours:

- setting limits on pushy friends or relatives and
- commercial situations, such as countering a sales pitch or being persistent when returning defective merchandise.

Early assertiveness training programs tended to define specific behaviours as assertive or nonassertive.

- v) **Social Skills Training:** Social skills training have been found to be efficacious for depression and schizophrenics. These training programs cover skills in the following areas:

- conversation,
- conflict management,
- assertiveness,
- community living,
- friendship and dating,
- work and vocation, and
- medication management.

Each of these skills has several components. For example, assertiveness skills include the following:

- making requests,
- refusing requests,
- making complaints,
- responding to complaints,
- expressing unpleasant feelings,
- asking for information,
- making apologies,
- expressing fear, and
- refusing alcohol and street drugs.

Each component involves specific steps.

2.3 COGNITIVE BEHAVIOURAL THERAPY (CBT)

In 1960s, Cognitive revolution in Psychology occurred and by 1970 many behaviour therapists influenced by it began to call it Cognitive Behavioural therapy. Cognitive behavioural therapy (CBT) is an amalgam of two therapies: cognitive therapy (CT) and behavioural therapy. The term “cognitive behavioural therapy” is a very general term for a classification of therapies with similarities.

2.3.1 Brief History

CBT is a form of psychotherapy that emphasises the important role of thinking in how we feel and what we do. It does not exist as a distinct therapeutic technique. Beck and Ellis are two names associated with Cognitive Behavioural Therapy.

Albert Ellis's system, originated in the early 1950s, developed Rational Emotive Therapy (RET), the first discrete therapeutic approach to CBT. Aaron T. Beck, inspired by Albert Ellis, developed **cognitive therapy** in the 1960s.

Ellis developed and popularised the ABC model of emotions, and later modified the model to the A-B-C-D-E approach.

In the 1990's Ellis renamed his approach Rational Emotive Behaviour Therapy. Behavioural therapy focuses on a person's actions and aims to change unhealthy behaviour patterns.

In the 1960's, Aaron Beck, M.D. developed his approach called Cognitive Therapy. CT focuses on a person's thoughts and beliefs, and how they influence a person's mood and actions, and aims to change a person's thinking to be more adaptive and healthy. Aaron Beck proposed the basic principles of CBT which can be applied to variety of psychiatric and medical problems. It focuses on identifying and changing maladaptive patterns of information processing and related behaviours. CBT methods are rooted in a psychological understanding of symptoms. It shares three fundamental propositions:

- 1) Cognitive activity affects behaviour
- 2) Cognitive activity may be altered and monitored
- 3) Desired behaviour change may be effective through cognitive change

Beck's approach became *known for its effective* treatment of depression.

Cognitive behavioural approach is based on the assumption that anxiety, depression, and negative emotions develop from maladaptive thought processes.

2.3.2 ABC Model of CBT

This model records a sequence of events in terms of:

- A – Activating Event (described as a ‘Trigger’)
- B – Beliefs (e.g. the thoughts that occur when the Activating Event happens)
- C – Consequences (how you feel and behave when you have those Beliefs)

This ABC technique of irrational belief has proven as the major tool in cognitive therapy. The main aim of this technique is to focus around the causes that develop irrational belief and has to be recorded during the therapy.

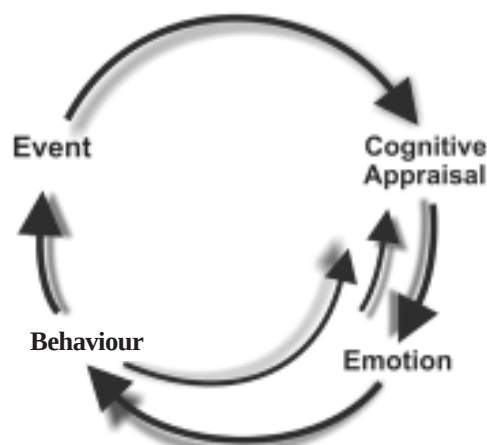


Fig.1: Basic Cognitive Behaviour Model

Source: From Wright JH. Basco MR. Thase ME: Learning Cognitive-Behaviour Therapy: An Illustrated Guide. Washington, DC. American Psychiatric Publishing. 2006, p 5

CBT helps a person focus on his or her current problems and how to solve them. Both patient and therapist need to be actively involved in this process. The therapist helps the patient learn how to identify distorted or unhelpful thinking patterns, recognise and change inaccurate beliefs, relate to others in more positive ways, and change behaviours accordingly. There are several approaches to cognitive behavioural therapy, including the following:

- 1) Rational Emotive Behaviour Therapy,
- 2) Rational Behaviour Therapy,
- 3) Rational Living Therapy,
- 4) Cognitive Therapy, and
- 5) Dialectic Behaviour Therapy.

2.3.3 Goals of CBT

CBT focuses on A *Here and Now* orientation.

The goals of CBT are:

- To challenge the thoughts about a particular situation by identifying the cognitive traps
- To help the patient to identify less threatening alternative and
- To test out these alternatives in the real world.
- It also aims to leave clients at the completion of therapy with the freedom to choose their emotions, behaviours and lifestyle (within physical, social and economic restraints).
- To Finally effect profound and lasting change in the underlying belief system of the client, rather than simply eliminating the presenting symptoms.
- To make the client equipped with self help techniques that enable coping in the longterm future

2.3.4 Techniques/Principles of CBT

CBT is based on several principles. These are:

- It is brief and time-limited
- It is structured, directive, and problem-oriented
- It is based on the cognitive-behavioural model of emotional disorders.
- It is a collaborative effort between the CBT practitioner and the client seeking treatment and requires a sound therapeutic relationship. They work together to try to understand the person's difficulties and what may be contributing to them.
- The sessions of CBT are typically one hour in length.
- The clients are guided to discover new ways of thinking for themselves with specific questions.
- It is often based on an education model.

- It relies on the inductive method, a scientific approach using logic and reasoning.
- It uses between-session practice as a central feature (for people to put into practice what they have learned). New behaviours are initially tested in safe situations (for example, the practitioner's office).
- It focuses on the present. The past cannot be changed, but the way we think about the past can be changed

2.3.5 Levels of Cognition

Three major levels of cognition, relevant to the practice of CBT, were identified by Beck and his colleagues. These are (i) Full consciousness, (ii) Automatic Thoughts, and (iii) Schemas.

- Consciousness is a state in which rational decisions are made with full awareness.
- Automatic thoughts are more autonomous, often private cognitions that flow rapidly in the stream of everyday thinking and may not be carefully assessed for accuracy or relevance.
- Schemas, the deepest level of cognition, are fundamental rules for information processing which are shaped by developmental influences and other life experiences. Schemas that play a major role in regulating self worth and behavioural coping strategies are a frequent target of CBT.

Examples of automatic thoughts and maladaptive schemas

Automatic Thoughts	Maladaptive schemas
I should be doing better in life	I must be perfect to be accepted
I have let him / her down	I am a fake
I always keep messing things up	If I choose to do something, I must succeed.
I cannot handle it	I am unlovable
It is too much for me	No matter what I do, I won't succeed
I don't have much of a future	The world is too frightening for me
Things are out of control	Others cannot be trusted
I feel like giving up	I must always be in control
I will never be able to get this done	I am stupid
Something bad is sure to happen	Other people will take advantage of me.

(Source: Wright et al (2011))

2.3.6 Techniques Used in CBT

The CBT techniques, described below, are useful in eradicating certain problems in a time bound manner which stem from maladaptive thoughts and behaviours. The techniques are given in the following section:

- i) **Cognitive Rehearsal:** In this technique, the therapist asks the patient to recall a problematic situation of the past. The therapist and patient both work together to find out the solution to the problem.
- ii) **Validity Testing:** This is one of the first cognitive therapy techniques. Every disorder or disease must have supporting evidence and the therapist asks the patient, to defend his feelings, thoughts and beliefs, with objective evidence. The faulty nature or invalidity of the beliefs of the patient is exposed if he is unable to produce any kind of objective evidence.
- iii) **Writing in a diary / Journal:** It is the practice of maintaining a diary to keep an account of the situations that arise in day to day life. This is a detailed diary, which notes every emotion, thought and belief. The therapist and the patient, later, collectively assess the diary/ journal, to analyse how they actually affect the behaviour of the individual..
- iv) **Guided Discovery:** The purpose of this technique is to enable the patient realise his cognitive distortions. The patient becomes aware of his cognitive distortions through a series of questions and answers.
- v) **Systematic Positive Reinforcement:** Cognition can be changed over a period of time, by positive encouragements and small rewards. It is one of the cognitive behavioural therapy techniques in which positive behaviours of a person are rewarded with a positive reinforcement.

A reward system is established for the reinforcement of certain positive behaviours. Just like positive reinforcement, withholding the reinforcement is also equally important. It helps in eradicating a maladaptive behaviour.
- vi) **Aversive Conditioning:** This technique makes use of dissuasion for lessening the appeal of a maladaptive behaviour. The patient is exposed to an unpleasant stimulus while engaging him in a particular behaviour or thought for which he has to be treated, thus, the unpleasant stimulus gets associated with such thoughts/behaviours and then the patient exhibits an aversive behaviour towards them.
- vii) **Modeling:** In Modeling, the patient makes use of the behaviour of the therapist as a model in order to solve his/her problems. The therapist performs role playing exercises which are aimed at responding in an appropriate way to overcome difficult situations.
- viii) **Homework:** The therapist gives a set of assignments to patients as homework. The patient take notes during the session, reviews the audiotapes of a particular session or reads article/books that are related to the therapy.

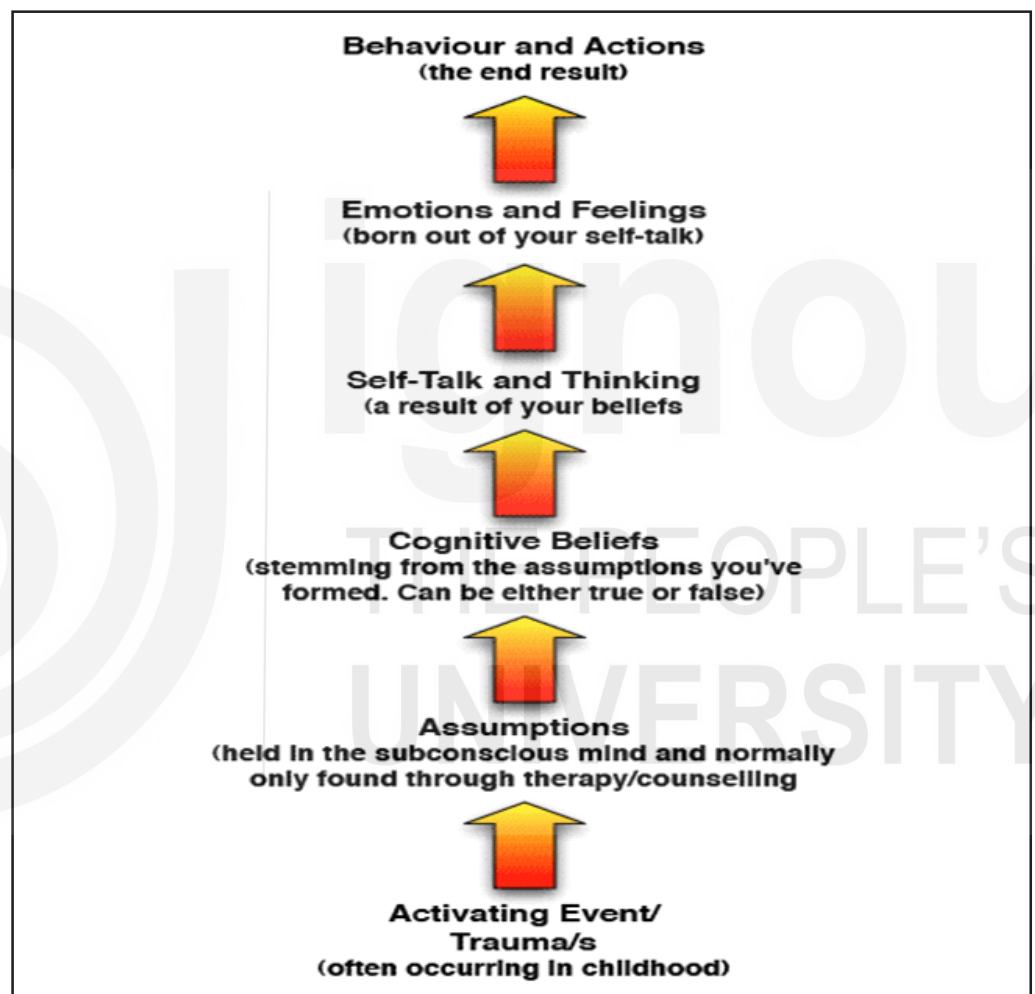
2.3.7 Hierarchical Structure of A-B-C

People experience events in their life. These events lead to assumptions (right or wrong) being made about that event. Once the assumption has been made, it gets placed into our subconscious mind. This assumption then generates beliefs or conclusions. These beliefs can either be true/accurate or false/inaccurate.

From these beliefs comes our thinking and self talk. From our thinking and self talk comes our feelings and emotions. Finally, our feelings and emotions give rise

to our behaviour and actions. The following diagram displays the way in which one wrong assumption can give birth to many beliefs, which in turn gives birth to many more self talk, emotional and behavioural issues.

Looking at this hierarchy structure, true change, that is life long and effective, can only happen if the core assumptions are uncovered and dealt with. The assumption is the base level which determines everything else in the hierarchy. If change was attempted by only addressing the behavioural level, sooner or later the emotions and self talk would cause that change to be negated. Will power can not override the internal feelings below the behavioural level. If change was attempted at the emotions and feelings level, then changed behaviour will follow, but at some point internal self talk, beliefs and assumptions will be too much to bear and cause the emotions then actions to revert back.



Thus Cognitive therapy involves getting down to the beliefs level.

Down at this level, lasting change can begin to occur.

Change in the belief system results in change in all the levels above it.

The only problem is that the underlying assumption that caused the false belief and then conflict is still lurking.

It means that if the assumption itself is incorrect/wrong/false, then it will generate other false beliefs.

What can occur in therapy then is that false belief upon false belief are traced, faced and replaced, but there always seems to be more.

The ONLY way to achieve true freedom from the shackles is to uncover the core assumption at the base level.

Once you find this and confront it, the false beliefs take care of themselves and no new ones are created, your self talk changes, your emotions and feelings turn positive and your actions follow suit.

2.4 LET US SUM UP

Behaviour therapy has been used successfully for a variety of disorders and can be easily taught. It requires less time than other therapies and is less expensive to administer. Although useful for circumscribed behavioural symptoms, the method cannot be used to treat global areas of dysfunction (e.g., neurotic conflicts, personality disorders).

Controversy continues between behaviourists and psychoanalysts, which is epitomised by Eysenck's statement: "Learning theory regards neurotic symptoms as simply learned habits; there is no neurosis underlying the symptoms, but merely the symptom itself. Get rid of the symptom and you have eliminated the neurosis."

Analytically-oriented theorists have criticized behaviour therapy by noting that simple symptom removal can lead to symptom substitution: When symptoms are not viewed as consequences of inner conflicts and the core cause of the symptoms is not addressed or altered, the result is the production of new symptoms. Whether this occurs remains open to question, however.

Whereas CBT is based on the concept that mental disorders are associated with characteristic alterations in cognitive and behavioural functioning and that this pathology can be modified with pragmatic problem-focused techniques. CBT is well established as a treatment for depression, anxiety disorders, and eating disorders. There is growing evidence that it can play an effective role in the clinical management of a large range of other disorders, including schizophrenia, bipolar disorder, and axis II conditions.

2.5 UNIT END QUESTIONS

- 1) What is Behaviour Therapy? Give a brief outline of its history.
- 2) What is modeling, and how it can be used in treating psychological problems?
- 3) Write a note on Exposure as an extinction approach.
- 4) Construct a hierarchy of fear arousing situation of any animal.
- 5) Define CBT and discuss the levels of cognitions.
- 6) According to CBT, What is the primary cause of mental disorders?
- 7) Explain the hierarchical structure of A-B-C model of CBT.

2.6 SUGGESTED READINGS

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UNIT 3 DRAMA AND ART THERAPY IN COUNSELING

Structure

- 3.0 Introduction
- 3.1 Objectives
- 3.2 Drama Therapy
 - 3.2.1 Five Stage Theory
 - 3.2.2 Drama Therapy Techniques
 - 3.2.3 Applications of Drama Therapy
- 3.3 Art Therapy
 - 3.3.1 Basic Approaches
 - 3.3.2 Steps in Art Therapy
 - 3.3.3 Art Therapy Techniques
- 3.4 Let Us Sum Up
- 3.5 Unit End Questions
- 3.6 Suggested Readings

3.0 INTRODUCTION

Counseling is both an art and a science. It is scientific in its development of theoretical approaches to working with individuals and groups. It is artistic in the way in which it uses timing and emphasis to implement certain methods with particular individuals. For effective counseling, art and science must work together for the welfare of client as well as counselor. Artistic methods and therapies can be important and useful for the growth of counseling profession because it may promote new insight. The creative arts have a significant contribution to make to counseling theory and practice. Creative arts refers to art forms including visual representations like painting, drawing and sculpture, literary expressions, drama and music, that help the individuals become more aware of themselves or others. In counseling, creative arts are defined as arts that are employed in therapeutic settings to help facilitate relationships between counselors and clients. Various art forms have been employed in counseling. The most widely used are: Visual Art, Psychodrama, Poetry, Dance and Music. This unit will discuss art and drama therapy.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Discuss the concept of drama therapy;
- Define art therapy;
- Explain the steps involved in the process of art therapy;
- Describe five stage theory; and
- Explain art and drama therapy techniques.

3.2 DRAMA THERAPY

Drama therapy is defined by the National Association for Drama Therapy as “the systematic and intentional use of drama/theater processes, products, and associations to achieve the therapeutic goals of symptom relief, emotional and physical integration and personal growth.”

The word ‘drama’ comes from ancient Greek and means quite literally “things done” (Harrison, 1913).

Drama therapy uses action techniques, particularly role play, drama games, improvisation, puppetry, masks, and theatrical performance, in the service of behaviour change and personal growth.

It is an active approach that helps the client tell his or her story to solve a problem, achieve a catharsis, extend the depth and breadth of inner experience, understand the meaning of images, and strengthen the ability to observe personal roles while increasing flexibility between roles.

The result is an active, experiential process that draws on the person’s capacity for play, utilising it as a central means of accessing and expressing feelings, gaining insight, practicing successful approaches to difficult situations. It has its roots in religion, theatre, education, social action, and mental health/therapy

Early humans began to make art that is, paintings, sculpture, music, dance, and drama about 45,000 years ago. The origins of the arts and religion seem to be intertwined because the arts naturally provided effective symbolic ways to express abstract religious ideas. Dance and drama, in particular, were extremely useful in rites to create sympathetic and contagious magic as well as to embody myths and rituals.

The first written theoretical account of drama therapy can be found in connection with Greek theatre. In his *Poetics*, Aristotle says the function of tragedy is to induce catharsis which is a release of deep feelings (specifically pity and fear) to purge the senses and the souls of the spectators (Aristotle, trans. 1954). According to Aristotle, the purpose of drama is not primarily for education or entertainment, but to release harmful emotions in an individual which in turn will lead to harmony and healing to the individual as well as in the community (Boal, 1985).

Drama therapy applies techniques from theatre to the process of psychotherapeutic healing. It emerged as a field in the late 1970’s from hospitals and community programs where it was first used with clients to produce plays and later was integrated with improvisation and process drama methods. The focus in drama therapy is on helping individuals grow and heal by taking on and practicing new roles. While much drama therapy aims at helping people who are in therapy, drama therapists have extended their applications beyond clinical contexts to enrich the lives of at risk individuals, to prevent problems, and to enhance wellness of healthy people. Many of the skills for such extensions require a measure of training psychological training as well as a strong basis in theatre.

Just as psychotherapy treats people who have difficulties with their thoughts, emotions and behaviour, drama therapy uses drama processes (games, improvisation, storytelling, role play) and products (puppets, masks, plays/

performances) to help people understand their thoughts and emotions better or to improve their behaviour.

The drama therapist is trained in four general areas:

- i) drama/theatre,
- ii) general and abnormal psychology,
- iii) psychotherapy, and
- iv) drama therapy.

The drama therapist's role is to facilitate the client's experience in a way that keeps the client emotionally and physically safe while the client benefits from the dramatic process. Depending on the goals and needs of the client, the drama therapist chooses a method that will achieve the desired combination of understanding, emotional release, and learning of new behaviour.

Some methods, such as drama games, improvisation, role play, developmental transformations, sociodrama and psychodrama are very process oriented and unscripted. The work is done within the therapy session and not presented to an audience.

Other methods, such as Playback Theatre, Theatre of the Oppressed, and the performance of plays are more formal and presentational, involving an audience. Puppets, masks, and rituals can be used as part of performance or as process techniques within a therapy session.

Certain techniques like drama games, role play, etc. involve fictional work. The client pretends to be a character different from him or herself. This can expand the client's role repertoire.

Other techniques, such as Psychodrama, Therapeutic Spiral Model, Playback Theatre, Theatre of the Oppressed and autobiographical performances, allow the client to explore his or her life directly. Clients need to have good ego strength to be able to do this kind of non-fiction work because it requires an honest, searching look at oneself.

3.2.1 Five Stage Theory

Renee Emunah (1994) has identified five stages through which most drama therapy groups progress. Her five stage theory parallels established wisdom from group dynamics on how successful groups form and grow.

- 1) The first stage is Dramatic Play where the group gets to know each other and the therapist through playing together develop trust, group cohesion, and basic relationship skills.
- 2) The second stage is the Scene Work Stage where they continue playing. The focus remains on developing dramatic skills which they will need as they continue in treatment. As they grow older and begin school, they are encouraged to develop their abstract reasoning skills and use them in their learning.
- 3) Stage Three focuses on Role Play, exploring issues through fictional means. Perhaps the group acts out a generic family conflict or a familiar character from a fairy tale or legend that goes through a crisis or challenge shared by group members. When the group is ready, they can move on to the next stage.

- 4) Stage Four: Culminating Enactments, where personal issues are acted out directly through psychodrama or autobiographical performance.
- 5) The final stage is Dramatic Ritual, which usually involves closure to the work of the group. This might be the sharing of a public performance that has been created by the group or the sharing of a private ritual within the group

3.2.2 Drama Therapy Techniques

Drama therapy techniques differ from therapist to therapist or from session to session, but certain concepts are common to all forms.

- 1) **Use of Metaphor:** The first is the use of metaphor through action. Behaviours, problems, and emotions can be represented metaphorically, allowing for symbolic understanding. An emotion can be represented with a metaphorical image: anger displayed as a volcano, an exploding bomb, or a smoldering fire. These images can be dramatised which allow the client to gain more insight into the qualities of the emotion and how it functions positively or negatively in his/her life.
- 2) **Concrete embodiment:** This technique allows the abstract to become concrete through the client's body. Embodiment allows clients to "experience" or "re-experience" in order to learn, to practice new behaviours, or to experiment with how to change old behaviours. Playing a role quite different from oneself often feels more comfortable than playing oneself directly.
- 3) **Dramatic Projection:** This technique is akin to concrete embodiment and employs metaphor. It is the ability to take an idea or an emotion that is within the client and project it outside to be shown or acted out in the drama therapy session.
- 4) A client's difficulty asking for help (an internal problem) can be dramatised in a scene with other members of the group, with puppets, or through masks, so the problem becomes an external problem which can be seen, played with, and shared by the therapist and the group.
- 5) **Creation of transitional space:** The creation of Transitional Space is an important component in many therapeutic and learning environments, but it is essential in drama therapy. Transitional space is the imaginary world that is created when we play or imagine together in a safe, trusting situation.
- 6) It is a timeless space in which anything we can imagine can exist. It is created jointly by the therapist and the clients playing together and believing in the possibility that anything can happen.
- 7) **Incorporating other Arts:** Drama therapy is like a crossroad, where all the arts come together and are allowed to work together. Drama therapists use music, movement, song, dance, poetry, writing, drawing, sculpture, mask making, puppetry, and other arts with their drama therapy activities. Drama therapists are required to have training in the other creative arts therapies and why many drama therapists have credentials in one of the other arts therapy modalities.

3.2.3 Applications of Drama Therapy

Drama therapy is primarily conducted in groups, but can be used in individual, couples, or family counseling. It can be found in a wide variety of settings with many different kinds of clients. Any kind of therapy group that uses talk therapy can use drama therapy. For some groups, the action methods of drama therapy are more effective. Drama therapy ignores the excuses and denial, getting right to the behaviour.

Other types of groups for instance, nonverbal clients or children who are not good candidates for verbal therapy can often participate successfully in drama because they can not verbalize rather show how they feel. It is practiced in clinical settings, residential settings, correctional facilities, educational situations, corporations and businesses, community action settings, and social and recreational centers.

3.3 ART THERAPY

Art therapy is a modality emerged from the interacting of art, creativity and psychotherapy. It uses art media to express internal images, feelings, thoughts and sensations in a concrete form. It provides the opportunity for non verbal expression and communication, which can assist in improving the client's functional abilities and resolving emotional issues. The use of art as therapy implies that the creative process can be a means both of reconciling emotional conflicts and of fostering self awareness and personal growth.

The use of art can be traced all throughout history, from prehistoric eras to the present, but art therapy first received significant attention due to the theories of Freud and Jung (Wadeson, 1980). These psychologists believed in the importance of symbolism, which is very prominent in art forms.

Art therapy has continued to evolve and became a recognised profession in the 1960's. According to Wadeson (1980), "the creation of the American Journal of Art Therapy and the establishment of the American Art Therapy Association" were responsible for art therapy's rise to a recognised profession and therapeutic intervention.

Art therapy is based on the idea that the creative process of art making is healing and life enhancing and is a form of nonverbal communication of thoughts and feelings (American Art Therapy Association, 1996). It is the therapeutic use of art making, within a professional relationship, by people who experience illness, trauma, or challenges in living, and by people who seek personal development.

Through creating art and reflecting on the art products and processes, people can increase awareness of self and others, cope with symptoms, stress, and traumatic experiences; enhance cognitive abilities; and enjoy the life affirming pleasures of making art. It is used to encourage personal growth, increase self understanding, and to assist in emotional reparation and has been employed in a variety of settings with children, adults, families and groups.

It is a modality that can help individuals of all ages create meaning and achieve insight, find relief from overwhelming emotions, resolve conflict and problems, enrich daily life and achieve an increased sense of well-being (Malchiodi, 1998).

Art therapy is a mental health profession that uses the creative process of art making to improve and enhance the physical, mental and emotional well being of individuals of all ages. It is based on the belief that the creative process involved in artistic self-expression helps people to resolve conflicts and problems, develop interpersonal skills, manage behaviour, reduce stress, increase self-esteem and self-awareness, and achieve insight.

Art therapy integrates the fields of human development, visual art (drawing, painting, sculpture, and other art forms), and the creative process with models of counseling and psychotherapy. It is used with children, adolescents, adults, groups, and families to assess and treat anxiety, depression, and other mental and emotional problems; physical, cognitive, and neurological problems; and psychosocial difficulties related to medical illness. Art therapy programs are found in a number of settings including hospitals, clinics, public and community agencies, educational institutions, businesses, and private practices.

Art therapists are master's level professionals who hold a degree in art therapy or a related field. Educational requirements or syllabus include theories of art therapy, counseling, and psychotherapy, ethics and standards of practice, assessment and evaluation, individual, group, and family techniques, human and creative development, multicultural issues research methods, and practicum experiences in clinical, community, and/or other settings. Art therapists are skilled in the application of a variety of art modalities (drawing, painting, sculpture, and other media) for assessment and treatment. Art therapy combines traditional psychotherapeutic theories and techniques with an understanding of the psychological aspects of the creative process, especially the affective properties of the different art materials.

3.3.1 Basic Approaches

There are two basic ways in which an art therapist can approach the idea of art therapy. The first is to be process intensive. In this approach the art therapist, uses art as a means to help his/her patient(s) to discover something about him or herself. Art is used as a catharsis, an emotional journey to which self-actualisation and discovery are the end result. Edith Kramer was the first person to champion this school of thought. Kramer emphasised the healing qualities of art making, and was concerned with artistic quality.

The second approach is not to be so concerned with the process of making the art, but with what the person is consciously or unconsciously expressing through their art. Margaret Naumburg believed that this was the best way to utilise art therapy. In this way, the art therapist uses art as a window into the subconscious of the patient, and from there can attempt to figure out the underlying problems that the patient may be suffering from. It can be risky to look into art too closely, but in the case of children, who may not have the words to express how they are feeling; it is very beneficial to use art as a mode of expression.

3.3.2 Steps in Art Therapy

- 1) **Assessment:** Assessment often comes at the beginning of art therapy, and usually happens during the first session that the therapist has with the client. Assessment is used by the therapist to find out what the client is going through, and to gain any other information that he or she may wish to find out about

the client. It is important to be very up-front at this time with the client, being very clear that the session is not treatment oriented, but is for assessment purposes. Assessment at the beginning of therapy is an important first step because it is at this point that the therapist will decide if art therapy is a good option for the client or if it would be a waste of time.

- 2) **Treatment in the Beginning:** During the first session, the first thing for the therapist is to establish a good rapport with the client because it allows for the development of trust in the relationship. It is also essential for the art therapist to better grasp the framework from which the client is operating.

After establishing a rapport with the client and getting a grasp on the client's vantage point, the art therapist can introduce art therapy to the client by giving back-round information about art therapy, and answering any questions that the client may have. At this point, the therapist may suggest doing some artwork.

This first piece of art that the client creates is a very important one because it sets the tone for the rest of the session. Because many people have art anxiety in these beginning sessions, it is important that the therapist makes the client feel as comfortable as possible. This could be done by saying to the client that they should not worry about artistic accomplishment, but rather self-expression. Another important aspect of this first artistic work is the reaction of the therapist to it.

After this first session, it is important for the art therapist to begin developing treatment goals, as well as to reflect on what initial reactions the therapist may have after the first meeting.

- 3) **Mid-phase of treatment:** It is hard to know when the treatment has moved from the beginning portion to the mid phase but there are a couple of key differences which are given below:

- when the trust between the client and therapist has been established, and
- the focus of the sessions becomes more goal oriented, that do mark the mid-phase.

In the mid phase of treatment the therapist first establishes direction and boundaries, both personal and professional. There are many different techniques that are used in art therapy and knowing which one to use at what time is one of the art therapist's toughest jobs. Because each case is unique and each client is different, the art therapist must custom fit the art therapy for each individual client.

- 4) **Termination:** The termination of art therapy is initiated abruptly and clearly. Either the art therapist or the client can initiate the termination of the art therapy. Termination is generally decided upon when the therapist or the client realises that the therapy is finite. It is a very important part of the therapy process. The way in which therapy is brought to a close is crucial to the outcome of the treatment. If termination is handled incorrectly, the client or patient may regress as the end of therapy approaches.

The therapist should prepare the patient well in advance. This can be done by bringing up the issue of termination, focusing on its importance and discussing and interpreting feelings and behaviours due to the pending ending of the sessions. This is a difficult tightrope for the therapist to walk because focusing on the end often brings to mind other separations that client may have suffered.

When nearing the end of the therapy, the client and therapist should begin relooking at the art that the client has created throughout the sessions and talking about the progress that the client has made. It is also a good idea to use art in these last few sessions to help express feeling about the termination of the therapy sessions. The therapist often will join the client on these works of art.

The termination of the art therapy brings up a very practical question as well, what should be done with the art that the client created during the course of the sessions? This is a tricky question, but ultimately it is one that should be answered by the client. They could keep the art as a form of remembrance to the journey they went through, or give it to the therapist to show the importance of the therapeutic bond that they reached.

These are of course not the only two options that the client has, but two of the most common ones.

3.3.3 Art Therapy Techniques

The following are some techniques that art therapists use:

- 1) **Exploration Tasks:** An exploration task can be quite liberating. The goal is to encourage the patient/client to let go of conscious thoughts and controls, and to have them express themselves as freely and spontaneously as possible. In this way, exploration tasks are very much akin to verbal free associations. Exploration tasks are generally used in the beginning sessions of art therapy. Some examples of exploration tasks are:

- a) *Scribble Technique /Automatic Drawing*

In this, the patient/client is asked to relax and begin to make draw free lines or scribbles on paper. In some cases the patient/client will be instructed not to remove his or her pen from the paper until the exercise is over. Automatic drawing provides an excellent way for the patient/client to let down their guards and thus is a good starting point for therapy.

- b) *Free Drawing*

In free drawing all the choices are up to the patient/client. The patient/client is told to express him or herself freely, and not to worry about planning the picture. This technique is useful because the images that the patient/client creates are often mirrors into the person's present problems, strengths and weaknesses. Often at the end of free drawing, the patient/client is asked to share and explain what they drew about.

- c) *Drawing Completion*

In the drawing completion technique, a patient/client is given one or more pieces of paper that already have a few lines or simple shapes on them. These shapes or lines act as a starting point for the art therapy artist, and they are to be incorporated into a larger picture. Because of the wide individual responses

to the same stimuli, this is an excellent technique for a group discussion topic. Kinget developed this approach for therapeutic purposes.

- 2) **Rapport-Building:** Rapport-building exercises are used in both individual and group art therapy settings. The basic idea behind rapport building exercises is to reduce the amount of isolation that the patients/clients may feel while they are creating their art. This includes isolation from the other patients/clients in the group, and the distance they feel between themselves and the therapist. Some examples of Rapport-Building are:

a) *Conversational Drawing*

In conversational drawing, the group is broken up into pairs. The two people who are assigned to work together are seated across from one another. The only way of communication is with shapes, colours and lines. In this way, the pair is not only communicating, but sharing at the same time. This is a good way from patients to get to know one another a little better.

b) *Painting Completion by the Group*

In painting completion by the group, each member of the group is asked to name one thing, an object, feeling or event, and then depict it. From here, one or more of the group members begin adding to the collage, trying to improve upon what is already there. This technique better enables people to become aware of how it feels when they make something and have someone else “put upon you anything they want to.” The patients/clients are encouraged to share what they are feeling about someone else adding to their work.

c) *Painting with an Observer*

In painting with an observer, one member of a pair tells the other one whatever comes to into his or her minds as he or she watches the other one paint. The painter can respond to what the other one is saying as he or she sees fit during their painting. This exercise promotes discussion of feelings of dependency and autonomy, as well as acceptance issues.

- 3) **Expression of Inner Feelings:** These techniques are designed to help the patient/client get in touch with inner feelings, desires and fantasies and to make visual representations of them. This is done in the hope that the patient will become increasingly aware of him or herself. The therapist will then attempt to help the patient/client deal with these feelings, and move in a direction toward a solution. An example of expression of inner feelings technique is called “three wishes”.

a) *Three Wishes*

In the three wishes technique, the patient or client is asked to paint or portray three or more wishes. Responses tend to be of desires for things, personal security and so on. Responses to this exercise reflect maturity level, degree of egocentricity and so on. Discussion that follows this exercise focuses on the strength of the wish and whether or not these goals/wishes are attainable.

- 4) **Self Perception:** The self perception technique is aimed at moving a client toward a more complete awareness of personal needs and body image. Some examples of this technique are as follows:

Immediate States -Here the patient/client selects one or more of statements “I am”, “I feel”, “I have”, or “I do” to paint about.

a) *Self-Portraits*

Self-portraits can vary from being realistic, done with or without a mirror to abstract. A variation of this technique is to give a time limit to the painter, such as one minute. In this way, the artist is forced to quickly decide what important feature about themselves they wish to draw.

b) *Draw Yourself as an Animal*

Here the patient/client is asked to draw themselves as any kind of animal, or as the animal that they see themselves as most similar to. This is a good group building technique because the discussions are usually funny as well as revealing.

- 5) **Interpersonal Relations:** The interpersonal relations technique is designed to make the patient/client more aware of others, and how others may perceive him or her. Some examples of this technique are as follows:

a) *Portraits of Groups Members*

Here group members are asked to depict each other. This exercise helps group members to more fully clarify their feelings toward each other.

b) *Group Mural*

Here the group works cooperatively on a large project. The choice in subject matter and materials may be left to the group or predetermined by the therapist. This exercise promotes cooperation, group unity, fitting in individually to a larger whole and self expression in a larger group setting.

- 6) **The Individual's Place in the World:** This technique is designed to help the patient/client to see where he or she fits into the world, and hopefully accept and deal with this realisation. Some examples of this technique are as follows:

a) *House-Tree-Person*

Here the patient/client is asked to depict a house, tree and a person in one picture. The patient/client is faced with the task of how to relate the human figure to the other two common environmental features.

b) *Collage and Assemblage*

Here the patient/client is allowed to create a personal world out of any materials that he or she may desire. The therapist may predetermine themes, or the patient/client may work until themes begin to appear by themselves.

It is important to keep in mind that although there are many techniques available to the art therapist and all of them are valid, no one technique should dominate. This is because the techniques discussed here are only loose guidelines that the art therapist should take into consideration. More important than these guidelines are that the approaches that the art therapist chooses to take are well designed and thought out to meet the specific demands and needs of the individual or group.

3.4 LET US SUM UP

Art and Drama therapies have benefited all areas of health care system. According to the American Art Therapy Association, Inc.'s professional definition of Art Therapy, Art Therapy is a human service profession that utilises art media, images, the creative art process and patient/client responses to the created products as reflections of an individual's development, abilities, personality, interests, concerns and conflicts. Defining art therapy is a daunting task because it is an evolving science, and because it is hard to come up with a definition that fully encompasses what art therapy is, but it doesn't mean that it is any less beneficial as a form of therapy. Art therapy is not just a stepping stone to a verbal exchange, and should not be treated in this way. The art therapist should be very careful of over or under reliance on the verbal amplifications of the art by the client or patient.

One of the great advantages of art therapy is it fosters use of both sides of the brain. The nonverbal art expression is primarily a right brain process; the writing is coming from the left-brain language centers.

Drama therapy is the systematic and intentional use of drama and theatre processes to achieve the therapeutic goals of symptom relief and personal growth. It is an active, experiential approach that facilitates the client's ability to solve problems, set goals, express feelings appropriately, achieve catharsis, improve interpersonal skills and relationships, and strengthen the ability to perform personal life roles. It increases flexibility between roles. Dance therapy is proving especially beneficial for the elderly to increase their range of mobility.

3.5 UNIT END QUESTIONS

- 1) What is art therapy?
- 2) Define drama therapy.
- 3) Explain the steps used in art therapy.
- 4) What is rapport building?
- 5) Illustrate with examples the exploration technique of art therapy.
- 6) Discuss Renee Emunah's stages in drama therapy.
- 7) What do you mean by Dramatic projection?

3.6 SUGGESTED READINGS

Judith A. Rubin (2001): *Approaches to Art Therapy: Theory and Technique*. Publisher: Bruner- Routledge

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UNIT 4 OTHER THERAPIES (PERSONS CENTER COUNSELING AND SOLUTION FOCUS COUNSELING)

Structure

- 4.0 Introduction
- 4.1 Objectives
- 4.2 Person Centered Counselling
 - 4.2.1 Basic Assumptions of Person Centered Counselling
 - 4.2.2 Core Conditions
 - 4.2.3 Process of Therapy
 - 4.2.4 Techniques Used In Person Centered Therapy
- 4.3 Solution Focused Counseling
 - 4.3.1 Basic Assumptions
 - 4.3.2 Therapeutic Process
 - 4.3.3 Therapeutic Goals of Solution Focused Brief Therapy (SFBT)
 - 4.3.4 Steps in Solution Focused Brief Therapy
 - 4.3.5 Solution Focused Tasks
 - 4.3.6 Solution Focused Techniques
- 4.4 Different Questioning Techniques
 - 4.4.1 The Miracle Questions (MQ)
 - 4.4.2 Scaling Questions
 - 4.4.3 Exception Seeking Questions
 - 4.4.4 Coping Questions
 - 4.4.5 Problem Free Talk
- 4.5 Let Us Sum Up
- 4.6 Unit End Questions
- 4.7 Suggested Readings

4.0 INTRODUCTION

In this unit we will be dealing with person centered counseling and solution focused therapy. We start with person centered counselling in which we discuss the basic assumptions of person centered counseling followed by the core conditions needed for person centered counseling. Then we give a detailed account of the counseling process of person centered counseling. Then we elucidate the many techniques that are part of person centered counseling. This is followed by a detailed account of solution focused counselling . Here we put forward the basic assumptions of solution focused counseling, followed by the therapeutic process involved in the same. The next section presents the therapeutic goals of solution focused therapy and the various steps involved in the therapeutic process. The section also talks about the various tasks of solution focused therapy and the various techniques in carrying out the therapy. This therapy has certain typical questioning techniques which are then presented that involves miracle questioning, scaling question, coping question etc.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Define person center counseling;
- Discuss the core conditions needed for person center counseling;
- Explain the assumptions and techniques of person center counseling;
- Describe the assumptions and therapeutic process in solution focus counseling;
- Identify the therapeutic goals of solution focus counseling; and
- Explain the techniques used in solution focus counseling.

4.2 PERSON CENTERED COUNSELLING

Person centered counseling, formerly known as client centered counseling and nondirective counseling, is a treatment approach developed by Carl Rogers in the 1940s. It has provided the basis for many more recent counseling approaches. The principle of person centered counseling is the idea that if the counselor can provide clients with a genuine relationship in which they feel understood, accepted, and valued, their self esteem will be enhanced and they will increasingly be able to draw on their own resources to help themselves. This humanistic approach views each person as unique and able to strive towards self actualisation and achievement of his or her full potential. This model has certain qualities:

- 1) Person oriented.
- 2) Advocates a holistic view of people as well as a belief in the human potential.
- 3) Emphasises the person's experience, perceptions, agenda, and goals.
- 4) Promotes a therapeutic alliance in which the counselor communicates empathy, acceptance, genuineness and congruence.
- 5) Focuses on life long development, self esteem, self awareness, and self actualisation.
- 6) Emphasises feelings and emotions.
- 7) Encourages concreteness and specificity as well as exploration.

4.2.1 Basic Assumptions of Person Centered Counseling

The basic assumptions of person centered counseling are as follows:

- 1) Human beings are growth oriented and tend towards self actualisation. This natural process of development towards higher stages of moral, emotional and behaviour evolution can be facilitated by professional helpers who are able to stimulate the inherent capacity for progress in clients who are temporarily faltering.
- 2) Every individual exists in a continually changing world of experience of which he is the center (Rogers, 1951). This proposition emphasises the central importance of the individual and the subjective nature of personal experience.
- 3) An important vehicle for change is the therapeutic relationship that exudes qualities of trust, openness, acceptance, permissiveness and warmth. The

degree to which the counselor is able to create this nurturing atmosphere will influence the client's possibility for growth.

- 4) The legitimate focus of counseling content is on affect and the exploration of feelings. Both interpersonal relationships and self-conception may be improved by becoming aware of feelings about oneself and others by learning to express these emotions in sensitive and self-enhancing ways.
- 5) The universal goals of counseling are to help people to be more free, intentional, ethical, and human. This means that time is spent in sessions helping clients to examine their values and personal characteristics so that that may become more humane and caring in their relationship with self and others.
- 6) The client has the primary responsibility for the course of treatment. Thus a goal is shared by the client and the counselor; they both share a mutual understanding of the client's world.
- 7) Human beings are intrinsically good and trustworthy. They will intrinsically move, in a deliberate way, towards goals that are satisfying and socially responsible. Irresponsible or socially undesirable behaviour emerges from defensiveness that alienates human beings from their own nature.

4.2.2 Core Conditions

Carl Rogers has considered three main core conditions that are essential for effective counseling. These are:

- 1) **Unconditional Positive Regard:** This means that the counselor accepts the client unconditionally and non-judgmentally. The client is free to explore all thoughts and feelings, positive or negative, without fear of rejection. The therapist must show a positive approval of how they are feeling. It helps in building up or restoring the client's unconditional positive self-regard (Iberg, 1996). The client is free to explore and to express without having to do anything in particular or meet any particular standards of behaviour to 'earn' positive regard from the counselor.
- 2) **Congruence:** Congruence or genuineness, involves letting the other person know "where you are" emotionally (Rogers, 1980). It means that the counselor is authentic and genuine, and transparent to the client. There is no air of authority or hidden knowledge, and the client does not have to speculate about what the counselor is 'really like'. Congruence can be either positive or negative, and the therapist must express their feelings to be as genuine as possible. It is so important for the therapist to become congruent with their client so that a trusting relationship can be created in which the client can let the therapist into their lives. It is a very crucial factor in establishing trust.
- 3) **Empathy:** Rogers defines empathy as "to sense the client's private world as if it were your own, but without ever losing the "as if" quality" (Rogers, 1992). Empathic understanding means that the counselor accurately understands the client's thoughts, feelings, and meanings from the client's own perspective. When the counselor perceives what the world is like from the client's point of view, it not only views its value, but also accepts the client as it is. A good counselor needs to show empathy during therapy, to be able to understand and accurately be aware of the problems that the client is conveying.

4.2.3 Process of Therapy

Rogerian counseling involves the counselor's entry into the person's unique phenomenological world. Phenomenological world means it is the study of the development of human consciousness and self awareness as a preface to philosophy or a part of philosophical world. In mirroring this world, the counselor does not disagree or point out contradictions. Neither does the counsellor attempts to delve into the unconscious. Rogers describes counseling as a process of freeing a person and removing obstacles so that normal growth and development can proceed and the person can become more independent and self directed.

During counseling, the client can move from rigidly self perceiving to fluidity. Certain conditions are necessary for this process. A 'growth promoting climate' requires the counselor to be congruent, have unconditional positive regard for the person as well as show empathic understanding. Congruence on the part of the counselor refers to the counsellor's ability to be completely genuine whatever the self of the moment. The counsellor is not expected to be a completely congruent person all the time, as such perfection is impossible.

The client and the counsellor will work towards the outcome, the product. But there is also something else going on, that is the process of counseling which affects the healing. This is the time the client spends with his counsellor, and during the period the process takes place and between the client and counsellor many issues are sorted out. The message that the client should be getting from this safe stranger in this secure place is an assurance that the client is worth taking seriously, and that the concerns of the client are real ones.

Here the therapist sees the strength in the client, and is optimistic about the client's future when the latter does not believe that he or she has any future. And yet the client believes that the counsellor is sincere and has some insights. So the client begins to realise that he is able to see in the therapist someone he or she dimly recognises from way back before the client was so worried about. In other words the client is a little more confident, a little surer of the direction in which he or she is proceeding.

Rogers believed that the most important factor in successful therapy was not the therapist's skill or training, but rather his or her attitude. Three interrelated attitudes on the part of the therapist are central to the success of person centered therapy: (i) congruence (ii) unconditional positive regard and (iii) empathy. Congruence refers to the therapist's openness and genuineness. In other words, the willingness of the therapist to relate to clients without hiding behind a professional facade. Therapists who function in this way have all their feelings available to them in therapy sessions and may share significant emotional reactions with their clients.

Congruence does not mean, however, that therapists disclose their own personal problems to clients in therapy sessions or shift the focus of therapy to themselves in any other way.

Unconditional positive regard means that the therapist accepts the client totally for who he or she is without evaluating or censoring, and without disapproving of particular feelings, actions, or characteristics. The therapist communicates this attitude to the client by a willingness to listen without interrupting, judging, or giving advice. This attitude of positive regard creates a nonthreatening context in

which the client feels free to explore and share painful, hostile, defensive, or abnormal feelings without worrying about personal rejection by the therapist.

The third necessary component of a therapist's attitude is empathy ("accurate empathetic understanding"). The therapist tries to appreciate the client's situation from the client's point of view, showing an emotional understanding of and sensitivity to the client's feelings throughout the therapy session. In other systems of therapy, empathy with the client would be considered a preliminary step to enabling the therapeutic work to proceed; but in person-centered therapy, it actually constitutes a major portion of the therapeutic work itself.

A primary way of conveying this empathy is by active listening that shows careful and perceptive attention to what the client is saying. In addition to standard techniques, such as eye contact, that are common to any good listener, person-centered therapists employ a special method called reflection, which consists of paraphrasing and/or summarising what a client has just said.

This technique shows that the therapist is listening carefully and accurately, and gives clients an added opportunity to examine their own thoughts and feelings as they hear them repeated by another person. Generally, clients respond by elaborating further on the thoughts they have just expressed.

According to Rogers, when these three attitudes (congruence, unconditional positive regard, and empathy) are conveyed by a therapist, clients can freely express themselves without having to worry about what the therapist thinks of them. The therapist does not attempt to change the client's thinking in any way.

Even negative expressions are validated as legitimate experiences. Because of this nondirective approach, clients can explore the issues that are most important to them—not those considered important by the therapist. Based on the principle of self-actualisation, this undirected, uncensored self exploration allows clients to eventually recognise alternative ways of thinking that will promote personal growth. The therapist merely facilitates self actualisation by providing a climate in which clients can freely engage in focused, in-depth self-exploration.

Thus the process of therapy is:

- 1) Client's communications about externals and not self
- 2) Client describes feelings but not recognise or "own" them personally
- 3) Client talks about self as an object in terms of past experiences
- 4) Client experiences feelings in present-just describes them with distrust and fear
- 5) Client experiences and expresses feelings freely in present-feelings bubble up
- 6) Client accepts own feelings in immediacy and richness
- 7) Client trusts new experiences and relates to others openly and freely

4.2.4 Techniques Used in Person Centered Therapy

It is not technique-oriented. This approach is simply to restate what the client just said or the technique of reflection of feelings. The therapeutic relationship is the primary agent of growth in the client. Therapist's presence is being completely engaged in the relationship with clients. The best source of knowledge about the client is the individual client. Caring confrontations can be beneficial. The general techniques used in this therapy are:

1) **Listening:** Active listening involves summarising the person's emotions back to them, asking questions to help them express what they feel or believe or asking questions to achieve a better understanding of what they are saying. The feeling of being valued as a human being creates the sense of safe space for their deeper internal explorations. In listening the counselor:

- Invites the client to describe his/her reasons for coming to talk.
- Allow the client time to respond – this behaviour is called as attending or active listening.
- Helps create true intimacy between the counselor and the client – trust, comfortable with each other.
- Tells the client that you are interested in him/ her, wants to listen to him, and will try to understand both the spoken and the unspoken message in the communication.

2) **Accepting**

- The counselor accepts the client unconditionally for who he/she is- Unconditional Positive regard.
- Being professional, the counselor is not prejudice towards the client.

3) **Respecting**

- The counselor respects the client's view of his/her life.
- Helps the client towards a greater degree of independence and integration of the individual with respect towards his/her multicultural background.

4) **Understanding**

- The counselor understands the client's feeling sensitively and accurately.
- Empathetic understanding help the counselor sense client's feeling as if they were his/her own without becoming lost in those feelings.

Empathetic understanding helps the counselor to reflect the client's experiences.

5) **Responding**

- The counselor responds to the client's story.
- Also responds to seek clarification about the client's feelings and thoughts.
- Respond by giving advices and suggestions that can help for the client's personal growth.

Roger's Person Centered Counseling technique has certain strengths. It is a Phenomenological approach which focuses on empathy, unconditional positive regard and acceptance. It helps in increasing self-understanding. It is very genuine and reflective. But it has certain weaknesses too. In this technique, client is not challenged and not all clients are able to find their own answers. It is too simple and undirected. As such it has no interventions/techniques. Despite its limitations, still it has been used widely as it focuses on inner and subjective experience.

4.3 SOLUTION FOCUSED COUNSELING

Solution focused Counseling developed by Steve De Shazer, Insoo Berg, Eve Lipchek and Michele Weiner-Davis, is post Modern approach that emphasises the client's strengths and focuses on solutions. It is also known as Solution focused brief therapy (SFBT) or Brief Therapy (BT). The emphasis of SFBT is to focus on what is working in client's lives in contrast to the traditional models of therapy that tend to be problem- focused. These therapists assist clients in paying attention to the exceptions to their problem patterns. They promote hope by helping client discovering exceptions, times when the problem is less intrusive in their lives (Metcalf, 2001). SFBT looks at the positive side of problems and what works. It believes that all people are free to make choices.

It is a competency based model, which minimizes emphasis on past failings and problems, and instead focuses on clients' strengths and previous successes. There is a focus on working from the client's understandings of her/his concern/situation and what the client might want different. Differing from skill-building and behaviour therapy interventions, this model assumes that solution behaviours already exist for clients. Clients' solutions are not necessarily directly related to any identified problem by either the client or the therapist. It can be used in a variety of settings with a variety of problems.

Solution-focussed therapy focuses on people's strength, competence, and possibilities instead of their deficits, weaknesses and limitations (O'Hanlon & Weiner Davis 1989).

The solution focussed approach builds upon clients' resources. It aims to help clients achieve their preferred outcomes by evoking and co-constructing solutions to their problems (O'Connell, 2001).

Solution Focussed Brief Therapy differs from traditional treatment in that traditional treatment focuses on exploring problematic feelings, cognitions, behaviours, and/or interaction, providing interpretations, confrontation, and client education (Corey, 1985). In contrast, SFBT helps clients develop a desired vision of the future wherein the problem is solved, and explore and amplify related client exceptions, strengths, and resources to co-construct a client-specific pathway to making the vision a reality. Thus each client finds his or her own way to a solution based on his or her emerging definitions of goals, strategies, strengths, and resources.

4.3.1 Basic Assumptions

Different therapists have described assumptions in different ways:

Walter and Peller (1992, 2000) described SFT as a model that explains how people change and how they can reach their goals. They gave following basic assumptions:

- Individuals who come to therapy do have the capability of behaving effectively, even though this effectiveness may be temporarily blocked by negative cognitions. Problem focused thinking prevents people from recognising effective ways they have dealt with problems.

- There are advantages to a positive focus on solutions and on the future. If clients can reorient themselves in the direction of their strengths using solution talk. There is a good chance that a therapy can be brief.
- There are exceptions to every problem. By talking these exceptions, clients can get control over what had seemed to be an insurmountable problem. The climate of these exceptions allows the possibility of creating solutions. Rapid changes are possible when clients identify exceptions to their problems.
- Clients often present only one side of themselves. This therapy invites clients to examine another side of the story they are presenting.
- Small changes pave the way for larger changes. Small changes are all that are needed to resolve problems that clients bring to therapy.
- Clients want to change, have the capacity to change and are doing their best to make changes happen. Therapist should adopt a cooperative stance with clients rather than devising strategies to control resistive patterns. With therapist's cooperation, resistance does not occur.
- Clients can be trusted in their intentions to solve their problems. There are no right solutions to specific problems that can be applied to all people. Each individual is unique and so, too is each solution.

O'Hanlon & Weiner Davis (1989): They provided several powerful assumptions as the foundation of solution-focused therapy:

- Individuals who come to therapy have strengths, resources, and the ability to resolve the challenges they face in life.
- Change is always possible and is always happening.
- The counselor's job is to help clients identify the change that is happening and to help them bring about even more change.
- Most problems do not require a great deal of gathering of historical information to resolve them.
- The resolution of a problem does not require knowing what caused it.
- Small changes lead to more changes.
- With rare exceptions, clients are the most qualified people to identify the goal of therapy. (Exceptions include illegal goals [e.g., child abuse] and clearly unrealistic goals.)
- Change and problem resolution can happen quickly.
- There's always more than one way to look at a situation

General Assumptions

- Clients are their own experts who know what is best for them.
- The therapist accepts the client's view of reality.
- Therapy is collaborative and cooperative.
- Uses the resources available to the client.

- Goals are specific, behavioural and obtainable.
- Problems are reframed in a more positive way.
- Focus on what is right and what is working.
- Goals are always set in positive terms.
- People are highly susceptible and dependent.
- Don't ask a client to do something that he or she has not succeeded at before.
- Avoid analysing the problem.
- Be a survivor not a victim.

4.3.2 Therapeutic Process

Solution focused brief therapy (SFBT). “What SFBT does is that instead of digging somewhere deep it mainly focuses on client strengths and resiliencies examining previous solutions and exceptions to the problem, and then, through a series of interventions, encouraging clients to do more of those behaviours”. In this case it is important what are the effective therapeutic principles implemented in SFBT. It is important to mention that principle is ‘a set of rules that guides the therapy’, than a technique is ‘a specific procedure to get a specific result’. So principles are something what will be followed during all the therapy than technique is something used to achieve a well defined goal at a certain time. These might be distinguished as the main principles of Solution Focused Therapy:

Principle 1: Start where the client is, or adapt to the stage in which the client finds himself

There can be three different types of people who end up in front of the ones offering professional health:

- A Complainant – a person who does not have a clear request for help (a drinking housewife who says that no way she can cope without drinking as long as her husband works long hours and she has to take care of home on her own)
- A Visitor – the one sent to seek for help by the doctors, friends, relatives
- A Buyer – a person who actively seeks for help on his own (contacts a therapist about the drinking problems on his own and not influenced by anyone)

In scientific literature these mentioned types of people seeking for help can also be defined as three stages which change during the process of relationship between the therapist and the client. It is very important that therapist would correctly identify at what stage is the person seeking for help than he first contacts him. In this case therapist can use correct principles to move a client along the stages and get the result more effective. A client can very easily turn from a Visitor to Complainant and then a Buyer.

Principle 2: Use and enhance the client's competence

Every person has abilities and coping strategies prior to any therapeutic intervention. Therefore, the therapeutic process should consist of bringing forward and implementing solutions that are already present in clients and their systems.

Therapy works better if the solution suggested by the therapist is based on the natural healing processes of the patient, in this way all the best competences of the client can be used.

Principle 3: Defining clear goals and obtaining the client's collaboration

Solution focused approach gives a very important meaning to the clear definition of the goal which a person coping with various problems should achieve. Client needs to define the goal using the details and concrete examples regarding how his life should be rather than how he has been coping with this problem or is at the certain stage of the therapy.

Principle 4: Change client's perception and experience

Promoting corrective emotional experience is another basic principle in SFBT. Corrective emotional experience refers to 'exposing the patient under more favourable circumstances to emotional situation which he could not handle in the past under less favorable circumstances' (Alexander, French & al., 1946). Nowadays this principle is considered as an efficient. It is described as an ability to create experiences where the client has the opportunity to learn something new is an essential ingredient in brief therapy.

Principle 5: Solution oriented language

Solution focused approach helps the clients to discover their own solutions and expects the therapist to adopt a trusting and respectful attitude. In the solution focused therapy it is very important that a therapist adopts the language of the patient: words, intonation, speed of talking and reflex. This, firstly, will build the trust and secondly, will help to communicate. In solution focused approach therapy the one who knows the solution is patient himself, just a therapist needs to help out while bringing that solution to the day light, while being supportive and respectful. There should not be any confrontation, denials, only the suggestions and alternatives.

Principle 6: Restore and enhance hope and positive expectation

Hope and positive expectation have a strong influence on final outcome of any therapy. Solution focused approach in therapy seeks of the ways to enhance hope, as a willing to improve into the healing process. Positive expectations in solution focused approach is something that stimulates the patient to focus more on the healing process.

To sum up: solution focused approach in therapy is a process during which the clear goals are defined by the patient and a therapist is the one trying to engage the best of patient's skills and competences in order to achieve these goals. Also This is the kind of therapy which focuses only on the positive factors: hope, healing, improvement, goals and dismisses the negative things: problems and fails. In this case therapist is like a silent advisor who never is to persuasive and instead of telling the patient what to do only suggests alternatives in the way patient thinks it was actually his idea.

Solution focused counseling assumes a collaborative approach with clients in contrast to the educative stance that is associated with most traditional models of therapy. If clients are involved in the process from beginning to end, the therapy will be successful. Collaborative and cooperative relationships are more important

than hierarchical relationship in therapy. Walter & Peller described four steps that characterise the process of SFBT:

- 1) Find out what clients want rather than searching for what they do not want.
- 2) Do not look for pathology and do not attempt to reduce it by giving them a diagnostic label. Instead look for what clients are doing that is already working and encourage them to continue in that direction.
- 3) If what clients are doing is not working encourage them to experiment something different.

Principle 4: Keep therapy brief by approaching each session as if it were the last and only session.

SFBT is an approach that focuses on how clients change, rather than one which focuses on diagnosing and treating problems. As such, it uses a language of change. The signature questions used in solution-focused interviews are intended to set up a therapeutic process where in practitioners listen for and absorb clients' words and meanings, then formulate and ask the next question by connecting to clients' key words and phrases. Therapists then continue to listen and absorb as clients again answer from their frames of reference, and once again formulate and ask the next question by similarly connecting to the client's responses. It is through this continuing process of listening, absorbing, connecting, and client responding that practitioners and clients together co-construct new and altered meanings that build toward solutions.

4.3.3 Therapeutic Goals of SFBT

The solution focused therapist believes that people have the ability to define meaningful goals and that they have the resources required to solve their problems. Each client is unique and constructs unique goals for better future. The therapists focus on small, realistic and achievable changes that can lead to additional positive outcomes. Modest goals are viewed as the beginning of the change. SBF therapists use similar words, pace and tone in the same language as of the clients. Clients must feel that their concerns are heard and understood before they can formulate meaningful personal goals. Walter and Peller (1992) emphasised the importance of assisting the clients in creating their well defined goals that are:

- 1) Stated positively in the client's language;
- 2) Are process or action oriented;
- 3) are structured in here and now;
- 4) are attainable, concrete and specific;
- 5) are controlled by the client.

O'Hanlon & Weiner- Davis (2003) offers several forms of goals: Changing the viewing of a situation or a frame of reference, changing the doing of problematic situation, and tapping client strength and resources.

4.3.4 Steps in SFBT

The structure of solution building differs greatly from traditional approaches to problem solving as can be seen in brief description of steps involved (De Jing & Berg, 2008):

- 1) Clients are given opportunity to describe their problems. The therapist listens respectfully and carefully as clients answer the therapist's question, "How can I be useful to you"?
- 2) The therapist works with clients in developing well- formed goals as possible. The question is posed, "What will be different in your life when your problems are solved"?
- 3) The therapist asks clients about those times when they were problem free. Clients are assisted in exploring these exceptions, with special emphasis on what they did to make these events happen.
- 4) At the end of each solution building conversation, the therapist offers clients summary feedback, provides encouragement and suggests what clients might observe or do before the next session to further solve their problem.
- 5) The therapist and the client evaluate the progress being made in reaching satisfactory solutions by using a rating scale. Clients are asked what needs to be done before they see their problem as being solved and also what their next step will be.

4.3.5 Solution Focused Tasks

Molnar and de Shazer (1987) discussed a list of five tasks and corresponding rationales. These tasks represent a simple attempt to realise the objectives of solution-focused counseling.

Task 1: The client is told and asked, "Between now and the next time, I would like you to observe, so that you can tell me next time, about those times when you are able to make it (the goal) happen."

Rationale: This task is given if the client is able to construct a problem and goal, and identify and amplify exceptions.

Task 2: The client is told and asked, "Between now and the next time, I would like you to pay attention to and make note of what you do when you are able to effectively cope with or deal with the problem."

Rationale: This task is given if the client is able to construct a problem and goal and identify exceptions, but is unable to amplify exceptions.

Task 3: The client is told and asked, "Between now and the next time, I would like you to observe, so that you can tell me next time, what happens in your life (relationship, family, work situation) that you want to continue to have happen."

Rationale: This task is given if the client is able to construct a problem and goal, and potential exceptions, but is unable to identify exceptions.

Task 4: The client is told and asked, "Try to avoid making any drastic changes. If anything, think about what you will be doing differently when things are improved."

Rationale: This task is given if the client is able to construct a problem, but is unable to construct a goal.

Task 5: The client is told and asked, "The situation is very volatile. Between now and the next time, attempt to think about why the situation is not worse."

Rationale: This task is given if the client is in severe crisis.

4.3.6 Solution Focused Techniques

- 1) **Mapping the Influences of the Problem:** This technique, developed by Michael White, refers to a line of questioning aimed at helping the client understand how the problem has influenced his or her life. When mapping the influences of the problem, counselors ask how the problem has affected various aspects of the client's life, including relationships, work, and daily functioning, e.g. in the problem of depression, the counselor might ask the client to identify ways in which depression has affected aspects of their life. The purpose of this technique is to use the influences as a basis from which to later identify exceptions.
- 2) **Scaling:** In this clients are asked to rate their subjective experiences, such as how they feel, how they deal with their problems, and so forth on a scale from 0 to 10. Molnar and de Shazer (1987) developed a reverse scale which can be effective. Scaling techniques are useful for clients who find it difficult to discern exceptions and notice differences. The therapist asks the clients to keep a written record of their ratings. Then, review the ratings with your client, and focus on the client's best days and highlight the other information that was recorded as these are exceptions that can be amplified.
- 3) **Journaling:** Journaling, also known as the structured log, is a useful exercise for clients who are unable to identify exceptions or unable to develop goals at all. The client might be asked to keep track of times when the problem does not happen or when the goal happens. The client is asked to describe in detail what they did, how they coped, what was different, and so forth. The structured log often leads to helping the client identify exceptions and set more attainable and realistic goals.
- 4) **What is Better?:** De Shazer (1994) proposed a simple question that counselors can use during follow-up sessions aimed at identifying exceptions: "What's better? Starting off the next session with the variations in question like "What's better?" or "What's new?" or "What's up?" or "What do you want to talk about?" can get you and the client in a solution- focused direction from the start. These types of questions might help in identifying exceptions that were missed in prior sessions or raise new problems and exceptions.
- 5) **The Surprise Task:** When working with couples and families, the surprise task can serve to identify positive outcomes that might otherwise not have been produced in counseling. In this task, one family member is instructed to surprise another family member on two occasions. The other family member is instructed to observe for times when the other surprises them.
- 6) **Strategic Eclecticism:** Solution focussed counseling allows for the compatible application of diverse theories and techniques within its own clinical theory. Eclecticism can be understood in terms of a strategic approach. The term strategic refers to an effort on the part of counselors to tailor conceptualisations and interventions to account for the uniqueness of each client, thereby facilitating the change process in an effective manner and often in a brief period of time.

4.4 DIFFERENT QUESTIONING TECHNIQUES

4.4.1 The Miracle Question (MQ)

This is powerful in generating the first small steps of ‘solution states’ by helping clients to describe small and realistic steps they can take as soon as the next day involves asking the client to imagine how their future would look in an ideal world, with particular attention to the absence of the problem that brought them to therapy in the first place.

4.4.2 Scaling Questions

These are used to monitor change in the client, who rates their position on a scale, usually ranging from one (the worst scenario) to ten (the best scenario). **Scaling questions (SQ)** can be used when there is not enough time to use the Miracle Question. It is used in many ways, including with children and clients who are not verbal or who have impaired verbal skills. Careful exploration enables clients to identify resources that enable movement along the scale towards their rating of a better future.

4.4.3 Exception Seeking Questions

These assume that there are always times when the problem is less acute, and investigate what enables this to be so. The client can then use this knowledge to improve their situation and gain confidence in their own autonomy.

4.4.4 Coping Questions

These are used to elicit examples of times when the client coped with even the direst of situations, so that a problem-focused narrative can be challenged and transformed into a more positive and solution focused alternative. This question is a powerful reminder that all clients engage in many useful things even in times of overwhelming difficulties. Coping questions such as, “How have you managed to carry on?”; “How have you managed to prevent things from becoming worse?” open up a different way of looking at client’s resiliency and determination.

4.4.5 Problem-Free Talk

This focuses on areas outside of the problem and enables both therapist and client to establish an atmosphere in which the strengths and positive qualities of the latter is emphasised and drawn upon to help improve other areas of life e.g. Hobbies and social activities.

4.5 LET US SUM UP

Rogers has developed a person centered approach to create an environment at which clients are able to hash out their problems in a self directed way. The therapist is merely a listener, there to make the client feel that what they are feeling is ordinary. Rogers states it, “people are essentially trustworthy, that they have a vast potential for understanding themselves and resolving their own problems without direct intervention on the therapists part, and that they are capable of self directed growth.

Brief solution-focused counseling (BSFC) offers great promise to practitioners seeking an efficient and research-supported approach to school problems and the young people who experience them. The BSFC approach presented in this article is derived from four decades of psychotherapy outcome research on the essential ingredients or “common factors” of therapeutic change—client, relationship, hope, and model-technique factors. Outcome research can be translated into practical strategies for resolving problems including the “ambassador approach” to client–practitioner relationships, the strategic use of language, and the emphasis on client strengths and resources.

4.6 UNIT END QUESTIONS

- 1) Define Person Centered Counseling.
- 2) What do you understand by Congruence?
- 3) Describe the general techniques involved in Person Centered Counseling.
- 4) What is Solution-Focused Brief Therapy? Write down its steps.
- 5) Describe O’Hanlon & Weiner Davis basic assumptions.
- 6) Explain mapping the Influences technique of SFBT. Also discuss different questioning techniques.

4.7 SUGGESTED READINGS

Gerald Corey (2009): *Theory and Practice of Counseling and Psychotherapy*. Publisher: Thompson Brooks.

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