UNIT 1 INTRODUCTION TO BEHAVIOUR MODIFICATION AND COGNITIVE APPROACH IN COUNSELING

Structure

1.0 INTRODUCTION

Learning is an integral part of life. We learn and unlearn many things from our day to day experience. Since we learn things, we can also unlearn those things. The behavioural counseling approach is based on this assumption of learning and unlearning different aspects of behaviour. We tend to acquire and continue those behaviours that are approved, reinforced and rewarded; whereas behaviour that is not approved or considered undesirable tend to disappear. Thus the behavioural approach makes use of principles of reward, reinforcement and punishment to bring about desired changes in behaviour. However, this approach was mechanical in nature which assumed that human behaviour is governed by external stimuli only.

Human being is not so mechanical as to be regulated by the S – R (stimulus-response) mechanism. What about the thoughts, perception, feelings and beliefs of the human being? Hence it is not only the mechanical acquisition of physical responses, but the perception of the situation by the child also gets associated with physical responses. This led to the emergence of cognitive behavioural approach (Ellis, 1962; Beck, 1976; Meichenbaum,1977). According to this approach, thoughts, ideas, beliefs form an important part of behaviour which is learned. The behavioural view ignored

the subjective experiences of the individual. The individual was seen as passive human beings having no free will of their own. However, the cognitive behavioural approach considered thoughts, ideas, beliefs as important part of human behaviour.

Thus in this unit we are going to learn about the meaning of behaviour approach as well as cognitive approach to counseling. The procedure for each approach will be described and the different techniques under behavioural modification and cognitive approach will also be discussed. Finally the potentials and limitations of both behavioural and cognitive approaches to counseling will be delineated.

1.1 OBJECTIVES

After completing this unit, you will be able to:

- Define behaviour modification and cognitive approach in counseling;
- Explain the principles of behaviour modification;
- Describe the procedure of behaviour modification and cognitive therapy;
- Explain the different techniques of behaviour modification and cognitive therapy; and
- Analyse the potentials and limitations of both behaviour and cognitive therapy.

1.2 INTRODUCTION TO BEHAVIOUR MODIFICATION

Behaviour modification or behavioural counseling is a form of psychotherapy that is based on the learning theories of classical conditioning and operant conditioning. It applies these learning principles to bring about positive changes in behaviour and reduce or eliminate undesirable behaviour. Behaviour modification employs empirically tested behaviour change techniques to improve behaviour and/or reduce maladaptive/undesirable behaviour. It refers mainly to techniques for increasing adaptive behaviour through reinforcement and decreasing maladaptive behaviour through extinction or punishment.

The first use of the term behaviour modification appears to have been used by Thorndike in the year 1911. He talked about the Law of Effect where responses followed by satisfying state of affairs were strengthened whereas responses followed by dissatisfying state of affairs were decreased or discontinued. The learning theories of classical conditioning by Pavlov and operant conditioning by Skinner have further contributed to the development of behaviour modification approach to counseling. Classical conditioning proposes that our behaviour /responses are conditioned, i.e., there is an association between the stimulus which elicits the response and our response. When this association becomes strengthened on the basis of reward, conditioning happens and the behaviour is learned. This is the basic conditioning process. Operant conditioning is based on the law of effect. This conditioning consists of behaviour that is followed by consequences that are satisfying to the organism and so will be repeated. Behaviour that is followed by unpleasant consequences will be discouraged. For example, when a child throws temper tantrum, parents give in to his demand. As a result, the child learns that if he throws tantrums, his needs will be satisfied. Here parents attention and giving in to his demand is the reinforcer for the child and thus the child will repeat the same behaviour in the future.

1.2.1 Definition of Behaviour

First let us see what do we mean by behaviour? Behaviour is such a term which we use commonly and yet we may not be aware of its exact meaning. We talk about behaviour using the terms such as hard-working, kind, sociable, ungrateful, independent, selfish etc. However, if we analyse, these terms do not refer to the specific things we note in a person when for instance, we say hard-working or selfish. In general we may understand what selfish behaviour means or nervous behaviour means; but we may not know the person's nervousness refers to his nail-biting, or fidgeting, or pacing in the room? It is very essential that we talk about behaviour very specifically.

Essentially, behaviour is anything that a person says or does. Behaviour modifiers generally talk very precisely about the behaviour. This helps in focusing on the particular aspect of behaviour which need to be changed. Behaviour also need to be described either as behavioural deficits or behavioural excesses. Behavioural deficit refers to something lacking, e.g., the child is not able to mix and interact with his classmates; the child has not learned how to eat in a proper manner in a restaurant; the teacher is not able to manage her anger if some child disturbs her class; the manager does not know how to conduct himself in a board meeting. Behavioural excesses refer to behaviour which is out of control, for example, a child showing tantrums; an adult engaged in continuous smoking or drinking; a child eating candies and toffees frequently; or seeing television continuously.

Thus there is a deviation of behaviour, either lack or excess of behaviour, which causes the problem and need to be addressed. Behaviour modification helps in changing these problem behaviours and establishing the appropriate behaviour. However, one thing to be noted here is that identification of behavioural lack or behavioural excess should always consider the context, the culture and the ethics of the persons involved. Although some behaviour like self injurious behaviour is always inappropriate no matter what the context is.

1.2.2 Meaning of Behaviour Modification

Thus Behaviour modification can be described as an approach to psychotherapy which is based on learning theory and aims to address the client's problems through techniques designed to reinforce desired and eliminate undesired behaviours. The behaviour modification approach involves the development and encouragement of desirable behaviours and removal and reduction of undesirable behaviours by methods based on the learning and reinforcement principles.

In simple terms, behaviour modification assumes that behaviours can be acquired/ learned and can also be unlearned. Hence if the child has learned any negative behaviour, it can also be unlearend and new desirable behaviour can be learned. Thus the relationship between observable stimuli and response is important; and reward and punishmnet can be used to control and regulate this relationship between stimulus and response.

Thus according to Skinner, greater or lesser reinforcement can be used to modify behaviour. For example, Rajan , a 5 year old boy always pushes other children in front of him and has not learned to stand in a line and wait for his turn. Behaviour modification in this case will help the child to change his behaviour by the use of reward and learn to be disciplined while standing in a line.

1.2.3 Principles of Behaviour Modification

Behaviour modification principles and practices are used to assist individuals with developing new, desirable behaviours while eliminating behaviours that are no longer useful. Reinforcement and punishment are the main principles of behaviour modification. Reinforcement strengthens a behaviour, while punishment weakens a behaviour. Both can be either positive or negative.

Positive reinforcement describes desirable behaviour rewarded with a pleasant stimulus, while negative reinforcement describes desirable behaviour rewarded with the removal of a negative stimulus.

Positive punishment occurs when an undesirable behaviour results in the addition of a negative stimulus, while negative punishment occurs when an undesirable behaviour results in the removal of a pleasant stimulus. For example, a rat accustomed to receiving food when pressing the lever, no longer receives food when pressing the lever. The rat has experienced negative punishment. However, positive punishment is not much used, because when misused, more aversive punishment can lead to affective/emotional disorders. The difference between positive and negative reinforcement is that in positive reinforcement, a response/behaviour produces a stimulus (positive reinforcer), whereas in negative reinforcement a response removes the occurrence of a negative stimulus. Examples of positive reinforcers are food, money, recognition; whereas negative reinforcement leads to the learning of avoidance and escape responses. For instance, when we ignore the child when he throws a tantrum, it is a negative reinforcement.

Thus positive reinforcement as well as negative reinforcement both tend to increase or strengthen behaviour. However, negative punishment , decrease or weaken the undesirable behaviour. When the child misbehaves and given time out (removal of the pleasant stimulus, for example, being with friends), it leads to decrease the undesirable behaviour of the child.

The principles of operant conditioning which are used for the behaviour modification also applies a schedule of reinforcement to bring about the desired results. Target behaviours are reinforced as soon as they occur, while negative behaviours are discouraged. Reward and punishment tools are also used to strengthen new behaviours. In effect, these tools work to redirect a person's motivations toward the desired outcome.

Further, a behaviour, or habit, is framed by what happens before and what happens after the behaviour is carried out. The principle of extinction is also made use of which works by removing or changing what happens after the behaviour takes place. In effect, the incentive or reward that motivates a person to carry out a certain behaviour is taken away. When this happens over and over again, the motivation to indulge in a certain behaviour begins to fade. Eventually the behaviour itself becomes extinct for lack of incentive.

Self Assessment Questions

1) Explain the meaning of 'behaviour'.

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2) What do you understand by the term behaviour modification?

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3) Describe the principles of behaviour modification.

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4) Fill in the blanks with the following alternatives:

(Deficits, reinforcement, undesirable, unlearned)

a) Behaviour modification involves the reduction of _____ behaviours.

b) Behaviour modification makes use of the principle of _____to bring desirable changes in behaviour.

c) The basic premise of behaviour modification is that 'if a behaviour is learned, it can be _____.'

d) Behaviour is described in terms of behavioural excesses and behavioural _____.

1.2.4 Steps/Procedure of Behaviour Modification

The goal of behaviour modification is always to bring about a change in the behaviour. The change may be in terms of:

- a newly developed behaviour
- increase or strengthening of a behaviour
- maintaining a behaviour at a particular rate or pattern of occurrence
- decrease or change in a behaviour

Deciding the goal is only one part of the entire procedure for behaviour modification. First of all we need to analyse the problem behaviour through a process of behavioural assessment. Behavioural assessment helps us to understand the problem in its different aspects, in different contexts and across different settings/situations. The problem is studied in detail:

Frequency – how often the behaviour occurs, e.g., how many times the child has used abusive language in a class duration

Duration – how long the problem behaviour lasts, e.g., the child goes on talking abusive language or uses it for a while only

Intensity – how severe is the behaviour, e.g., the child uses extreme abusive language or mild abusive language

Thus baseline data forms an important step in the behaviour modification plan. Specific information about the behaviour is collected . The ABC model of behavioural analysis, also called functional analysis is used. The ABC model refers to

- A antecedent it: describes what happens just before the occurrence of the behaviour
- B behaviour: it describes the client's behaviour
- C consequence: it describes the consequence, i.e. what happens after the behaviour

Antecedents help in understanding the problem in detail, what precipitates the problem, when it occurs, at what setting it occurs, who are present, what type of event/ situation usually leads to the behaviour/ problem in question. Behaviour refers to the behaviour shown or demonstrated. Consequences determine the client's behaviour. Consequences refer to what does the behaviour lead to- how do parents, teachers, peer respond to the child's behaviour – this determines whether the behaviour will continue or be modified or decrease or increase.

In other words, the ABC model can be described as follows: What comes directly before the behaviour?", "What does the behaviour look like?", and "What comes directly after the behaviour?" respectively. Once enough observations are made, the data are analysed and patterns are identified. If there are consistent antecedents and/or consequences, an intervention should target those to increase or decrease the target behaviour. If the behaviour pattern shows a particular antecedent or trigger, then intervention can be to avoid that trigger as far as possible and to learn a new behaviour in the presence of the trigger. If a problem behaviour occurs because it achieves some purpose, then there is a requirement to teach an alternative behaviour which will achieve the same purpose without creating any problem.

The functional assessment helps in understanding the behaviour . This facilitates in planning the appropriate intervention technique. The following steps can be delineated in the behavioural assessment process:

The problem behaviour is described in detail with example of its occurrence.

- All the antecedent factors are also elaborated.
- The consequences are noted down.
- The goals are specified.
- Accordingly the target response is stated in precise terms.
- The particular intervention to be used is finalised and implemented.
- Follow up and evaluation is done. If the intervention did not bring in the desired result, then we again go back to the first step of analysing the problem in detail in terms of the antecedent factors and then deciding on the intervention strategies to be adopted.

For instance, the problem is the aggressive behaviour of the child in the playground. Examples of occurrence of the aggressive behaviour by the child in the playground is cited. When did it occur, how did it start, what was the duration and intensity etc. The consequences: how did the teacher react to the aggressive behaviour of the child, how did other classmates present reacted , and any other consequence, may be punishment by the principal of the school are also noted. Analysis of the antecedent and consequences of the problem then leads to the setting of goals. The goal may be to reduce the aggressive behaviour of the child. To achieve this goal, the target response, i.e. the response which need to be changed are specified. In this case, the target responses may be reduction in hitting behaviour, using abusive language, overcoming getting angry very quick. Thereafter, the appropriate intervention technique to be used are decided and implemented.

1.2.5 Techniques of Behaviour Modification

Behaviour modification uses different techniques to modify a person's behaviour. It's based on the use of a reward system that targets specific behaviours. Rewards are used to reshape a person's motivations so old habits are eliminated and new, more beneficial habits are formed.

Three techniques of behaviour modification are (i) systematic desensitisation, (ii) aversive conditioning and (iii) token economy. Other techniques include (iv) extinction and (v) biofeedback. The three techniques are given in detail in the following paragraphs.

i) Systematic Desensitisation

Systematic desensitisation is a behaviour modification practice used to eliminate fears or undesirable emotions. It is based on the classical conditioning principles of pairing anxiety provoking stimulus/event with a relaxation response. Exposure to the fear-producing stimuli while focusing on relaxation techniques eventually leads to the fear-inducing stimuli resulting in the relaxation response, rather than fear. The assumption here is that relaxation and anxiety cannot go together. If we bring in relaxation, then anxiety has to go. Thus systematic desensitisation uses the principle of counter conditioning, which counters the anxiety connected with a particular behaviour or situation by inducing a relaxed response to it instead. This method is often used in the treatment of people who are afraid of flying. Another example of this practice will be removing the fear of public speaking. This is done by gradually exposing the person to the experience of public speaking. Speaking in front of the family or a small group of friends may be the first step. The person then gradually works up to speaking in front of a larger group of strangers or associates.

Systematic desensitisation involves the following steps:

Step 1: Constructing an anxiety hierarchy

The first and most important requirement is to construct/prepare a list of all the situation/events/objects that evoke fear or anxiety in the client. This has to be arranged in a hierarchical order from lowest anxiety provoking stimulus to the highest anxiety provoking stimulus. The degree to which each item produces anxiety is measured in terms of Subjective Unit of Distress (SUD).There should usually be 5-10 SUD difference between each item in the hierarchy. An example of an anxiety hierarchy in case of a person who has fear of speaking in the public is as follows. Rahul is a newly recruited manager of the company and he has to attend a conference of the managers from the region and represent his company's policies and progresses. But Rahul is very anxious about this . Systematic desensitisation can be used to help Rahul overcome his anxiety. First of all the counselor can help Rahul construct an anxiety hierarchy. The list may be as follows:

Two weeks before the conference, reading the brochure for the conference of the managers

Ten days before the conference, discussing with senior managers about things to be presented in the conference.

Eight days before the conference, discussing with the colleagues about the conference.

Six days before the conference, preparing notes on the things to be presented.

Four days before the conference, rehearsing the things to be presented

One day before the conference, keeping the materials ready that need to be taken to the conference.

The night before the conference day

Morning of the conference, getting ready for the conference

Arriving at the conference venue

Meeting other managers from other companies

Rahul's turn comes to present his company's case

Step 2: Training in relaxation

This consists of helping the client achieve a relaxed state of body and mind. Different kinds of relaxation techniques are available. Jacobson's progressive muscular relaxation is commonly used, though it requires training and takes longer time. Among other relaxation methods are 'Shavasana', meditation, 'pranayama' and so on. The main thing here is that the client should find it comfortable and achieve the desired state, i.e., relaxation. Jacobson's relaxation technique is based on the premise that muscular tension and relaxation are incompatible. It involves creating muscular tension in each part of the body and then relaxing it. This practice of alternatively tensing and the relaxing the group of muscles one by one creates a very relaxed state, e.g., for relaxing hands, make a fist , create the tension , feel it, and the gradually relax them by releasing the hand. When we are in anxious state our muscle groups ate tensed. Hence we need to know how to release that tension and make it relaxed.

Step 3: Presenting anxiety provoking items during relaxation state

The last step is presenting the hierarchy of anxiety provoking items one by one when the client is in a relaxed state. It starts from the lowest anxiety producing stimulus to the highest anxiety producing stimulus. The client relaxes and then presented with the first item in the list, and the the client relaxes again. Then the client is presented the next item in the list. The client visualizes each stimulus/situation for at leas 20-30 seconds. If the client experiences anxiety while visualizing any particular item, he can stop there and relax; and then visualize a new item in between, e.g., in the above instance, if Rahul experiences anxiety at the item – six days before the conference; then a new item can be introduced there – seven days before the conference.

This pairing of anxiety provoking situation with relaxation helps one to be able to face the situation and gradually gain confidence in approaching the real life situation later.

ii) **Aversive Conditioning**

Aversion helps break bad habits through associating aversive stimuli to the undesirable habit. Eventually, the undesirable habit becomes associated with the negative consequence and the behaviour is reduced.. This technique employs the principles of classical conditioning to lessen the appeal of a behaviour that is difficult to change because it is either very habitual or temporarily rewarding. The client is exposed to an unpleasant stimulus while engaged in or thinking about the behaviour in question. Eventually the behaviour itself becomes associated with unpleasant rather than pleasant feelings. One treatment method used with alcoholics is the administration of a nausea-inducing drug together with an alcoholic beverage to produce an aversion to the taste and smell of alcohol by having it become associated with nausea.

iii) **Token Economy**

Human behaviour is routinely motivated and rewarded by positive reinforcement. Token economy is based on systematic positive reinforcement where rules are established that specify particular behaviours that are to be reinforced, and a reward system is set up. A token economy is a highly effective behaviour modification technique, especially with children. In this technique, desired behaviours result in the reward of a token—such as a poker chip or a sticker—and undesirable behaviours result in the removal of a token. When children obtain a certain number of tokens, the children get a meaningful object or privilege in exchange for the tokens. Eventually, the rewarding of tokens decreases and desirable behaviours display independently.

iv) **Extinction**

Eradicating undesirable behaviour by deliberately withholding reinforcement is another popular treatment method called extinction. For example, a child who habitually shouts to attract attention may be ignored unless he or she speaks in a conversational tone. This is based on the principle that if the behaviour is not rewarded or encouraged, it will become extinct.

v) **Biofeedback**

Behaviour modification principles also can be used to treat emotional problems that are triggered by a physical symptom. Biofeedback is a method that provides immediate feedback on a person's physiological state, be it heart rate, breathing rate or blood pressure. Feedback is provided by a mechanical device that lets the person know when a particular symptom is present. By controlling the symptom, the resulting emotional response can be prevented. An example of this would be someone who has problems controlling anger. The increases in breathing rate and heart rate can be monitored and controlled with practice. Once controlled, a person is better able to control an angry outburst.

1.2.6 Potentials and Limitations of Behaviour Modification

The whole point of behaviour modification techniques is to change undesirable or harmful behaviours and replace them with healthier, more desirable ones. There are many advantages of the behavioural approach to counseling.

When applied properly, the technique can be effective in working with children, adults and animals also. In fact it can be used for changing the behaviour of any living beings. Animal trainers frequently turn to behaviour modification techniques to help pet owners turn bad habits into good habits. They also make use of behaviour techniques to train animals the different types of new behaviour as we see in animal and birds shows.

Behavioural modification aims at enabling the clients to take charge of their behaviour. Substance abuse counselors, for example, often encourage clients to take ownership of their behaviours and change them using behaviour modification techniques. The subject/client in the behavioural intervention takes an active role and ownership of the change process.

The basic concepts and methods of behaviour modification are pretty easy to understand and implement.

Behavioural approach focusses on the current behavioural problems in the context of the individual's current environment/situation. It does not analyse the past events/ happenings/situation.

Behavioural intervention spells out achievable behavioural goals in terms that enable you to measure your success. The intervention techniques follow a systemaic step by step procedure. A series of steps are delineated that to bring about change and lead to the desired behaviour.

There are a variety of therapeutic techniques and procedures associated with behaviour modification, so the technique is best used by specially trained, skilled practitioners.

Self Assessment Questions

1) Describe the process of functional analysis of behaviour with example.

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2) Seema has extreme fear for examination. Construct an anxiety hierarchy for her.

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3) Explain the meaning of token economy.

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4) List out the advantages of behavioural approach in counseling.

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5) Fill in the blanks from the following choices:

(Consequence, frequency, present, antecedent)

a) _____ refers to the number of times a behaviour occurs.

b) _____ describes the things that occur before the occurrence of the problem behaviour.

c) In the ABC model of behaviour analysis, C refers to _____.

d) Behavioural approach in counseling focuses on the _____ events.

1.3 INTRODUCTION TO COGNITIVE APPROACH

Cognitive approach in counseling emphasises the role of cognition or thought in influencing our behaviour. As opposed to behavioural changes based on reward or punishment system, the cognitive approach focuses on the role that thinking plays in how do we feel and behave. Transformation of how one thinks becomes critical in producing behavioural changes. Cognitive approach in counseling points out the dynamics of the human being in terms of his thoughts, attitudes, beliefs and values. Hence it is not simply a stimulus – response mechanism; the organism in between plays a vital role with all his thoughts and attitude in bringing about behavioural changes.

The fundamental principle here is that thoughts (cognitions) cause our feelings and behaviours. Thus cognitive therapy is based on the idea that our *thoughts* cause our feelings and behaviours, not external things, like people, situations, and events. Hence we can change the way we think to feel / act better even if the situation does not change. Thus, in cognitive therapies the counselors focus on teaching the clients how to think differently. Therefore, the goal of therapy is to help clients *unlearn* their unwanted reactions and to learn a new way of reacting. Therapists in the cognitive field work with clients to solve present day problems by helping them to identify distorted thinking that causes emotional discomfort. There's little emphasis on the historical root of a problem. Rather, the focus is on what's wrong with my present thinking that is causing me distress.

Aaron Beck developed cognitive therapy in the 1960s. The treatment is based on the principle that maladaptive behaviour (ineffective, self-defeating behaviour) is triggered by inappropriate or irrational thinking patterns, called automatic thoughts. Instead of reacting to the reality of a situation, an individual automatically reacts to his or her own distorted view of the situation. Cognitive therapy strives to change these thought patterns (also known as cognitive distortions), by examining the rationality and validity of the assumptions behind them. This process is termed cognitive restructuring.

Cognitive therapy is different from behaviour therapy in that it focuses mostly on the thoughts and emotions that lead to certain behaviours.

In other words, behaviour therapy is more action-based and cognitive therapy is the mental or emotional beginnings that drive us to perform those actions. Usually in practice both cognitive and behavioural principles are combined to deal with the problems. Hence it is called cognitive behavioural approach which counselors more frequently use in counseling. Most therapists seem to feel that the best form of psychotherapy is a combination of these two principles. This is what's known as *cognitive behaviour modification*, or cognitive-behavioural therapy,

Cognitive behavioural therapy is based on the idea that our feelings are governed by our thoughts about situations, people, and events in our lives and not those things themselves. Rather than focusing on changing the external forces we see as causing the problems, cognitive behavioural therapy focuses on changing the way we think to help us feel better. By learning to think differently, a person can develop rational self-counseling skills that can be used to deal with life. Thus cognitive behaviour therapy is defined as therapy that is based on the belief that our thoughts are directly connected to how we feel. Cognitive-behavioural therapy attempts to change clients' unhealthy behaviour through cognitive restructuring (examining assumptions behind the thought patterns) and through the use of behaviour therapy techniques. For

instance, in the treatment of eating disorders, therapists can help clients to change attitudes and thoughts about ideal body shape and weight; but also at the same time should focus on changing the client's behaviour of eating unhealthy diet and replace it with normalised eating patterns. Thus both cognitive as well as behaviour therapy are involved.

1.3.1 Steps/Procedure of Cognitive Therapy

The focus in cognitive behaviour intervention is the thinking pattern. Hence the first important step is to identify the faulty/irrational thought patterns. Using the Socratic method is one way to do this. By questioning our thoughts about a situation that creates anxiety and stress in us, we can pinpoint the irrational assumptions through which we view situations. If a person is upset because a friend isn't returning a phone call, he may assume that the friend is angry with him; whereas it may be that his friend might have been busy in some important work. Similarly, when the officer calls his junior repeatedly and the latter does not pick up the phone, the officer thinks that the junior knowingly avoids to do work. However, it may be that the junior could not answer the call because of some problem in the phone. Once a person understands their irrational thought patterns, they can use this information to modify their behaviour as they deal with the situations and events of their life that might be causing them problems

In many instances we jump to immediate conclusion and our behaviour becomes governed by this. However, this may lead to problem behaviour. Immediate emotional reactions to situations are created in an area of the brain known as the limbic system. This area of the brain moves fast and reacts to situations based on instantly made impressions. This is helpful when a speeding car is coming at us and we need to freak out and run, but more complex situations need a reaction based more on knowledge, facts, and experience. In these situations speed is not a virtue. The part of the brain used to process these facts is the prefrontal cortex. Unfortunately, this area of the brain takes longer to react, giving people the opportunity to act impulsively in situations using irrational assumptions. If a person can learn to modify the impulsive behaviour and wait for the prefrontal cortex to kick in (in other words, think things through), they can modify the effect the situation has on their emotional state and, sometimes, the situation itself in a more positive manner. Thus irrational ideas/thoughts need to be identified and questioned in order for the positive change in behaviour to occur.

Corey (2009) proposes the following three stages in cognitive behaviour therapy.

Phase 1: Self-Observation

This phase involves listening closely to your internal dialogue or self-talk and observing your own behaviours. You want to be especially aware of any negative self-statements that are actually contributing to your anxiety and panic symptoms.

Phase 2: Begin New Self-Talk

Once you recognise your negative self-talk, you can begin to change it. As you "catch" yourself in familiar negative thought patterns, you recreate a new and positive internal dialogue. "I can't" becomes "It may be difficult, but I can." These new self-statements now guide new behaviours. Rather than using avoidant behaviours to cope with panic and anxiety, you become willing to experience the anxiety-provoking situations. This leads to better coping skills, and as your small successes build upon one another, you make great gains in your recovery.

Phase 3: Learning New Skills

Each time you are able to identify and restructure your negative thoughts and change your response to panic and anxiety, you are learning new skills. Because you are now acutely aware of your thoughts, you are better able to gauge your anxiety and react in a more useful manner.

When your negative thoughts control you, it becomes difficult to control your behavioural responses to unpleasant situations. But, CBM can give you back some lost control. As your thoughts change from negative to positive, you start to behave differently in many situations. And, you will likely find that others react differently to the new "positive" you as well.

Self Assessment Questions

1) Discuss the meaning of cognitive therapy.

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2) Describe the stages in cognitive therapy.

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3) Fill in the blanks from the following alternatives.

(Restructuring, thoughts, distortions)

a) Cognitive therapy places emphasis on _____.

b) Cognitive therapy achieves its aim through cognitive _____.

c) The irrational thought patterns are also called cognitive _____.

1.3.2 Techniques of Cognitive Therapy

The prominent cognitive therapies are Cognitive Behaviour Therapy by Aaron Beck (1976) and Rational Emotive Behaviour Therapy by Albert Ellis (1960). Eric Berne's (1964) Transactional Analysis is also another cognitive intervention used by the therapists.

1.3.3 Cognitive Behaviour Therapy

The therapy assumes that an individual's emotions and behaviour are the outcome of the way in which he thinks about the world. According to Beck, people experience emotional problems when they engage excessively in fallacious or dysfunctional thinking. These are irrational or faulty thought patterns. Here are the ten most common irrational thought patterns or cognitive distortions (Beck, 1976; Burns, 1992).

All or none thinking

This is thinking in terms of either good or bad, e.g., your friend always needs to be good to you.

This type of distortion is the culprit when people think in extremes, with no gray areas or middle ground. All-or-none thinkers often use words like "always" and "never" when describing things. "I always get stuck in traffic!" "My bosses never listen to me!" This type of thinking can magnify the stressors in your life, making them seem like bigger problems than they may, in reality, be.

Overgeneralisation

It refers to our drawing a conclusion based only on a single incident, e.g., when you asked for some help to your neighbour and did not get it, you conclude that your neighbour is not good. Those prone to overgeneralisation tend to take isolated events and assume that all future events will be the same. For example, an overgeneraliser who faces a rude sales clerk may start believing that all sales clerks are rude and that shopping will always be a stressful experience.

Mental Filter

Those who use mental filtering as their distortion of choice tend to gloss over positive events and hold a magnifying glass to the negative. Ten things can go right, but a person operating under the influence of a mental filter may only notice the one thing that goes wrong. (Add a little overgeneralisation and all-or-nothing thinking to the equation, and you have a recipe for stress.)

Disqualifying the Positive

Similar to mental filtering, those who disqualify the positive tend to treat positive events like flukes, thereby clinging to a more negative world view and set of low expectations for the future. Have you ever tried to help a friend solve a problem, only to have every solution you pose shot down with a "Yeah but..." response? You've witnessed this cognitive distortion firsthand.

Jumping to Conclusions

People do this one all the time. Rather than letting the evidence bring them to a logical conclusion, they set their sights on a conclusion (often negative), and then look for evidence to back it up, ignoring evidence to the contrary. The kid who decides that everyone in his new class will hate him, and 'knows' that they're only acting nice to him in order to avoid punishment, is jumping to conclusions. Conclusion-jumpers can often fall prey to mind reading (where they believe that they know the true intentions of others without talking to them) and fortune telling (predicting how things will turn out in the future and believing these predictions to be true).

Magnification and Minimization

Similar to mental filtering and disqualifying the positive, this cognitive distortion involves placing a stronger emphasis on negative events and downplaying the positive ones. The customer service representative who only notices the complaints of customers and fails to notice positive interactions is a victim of magnification and minimization. Another form of this distortion is known as 'catastrophizing', where one imagines and then expects the worst possible scenario. It can lead to a lot of stress.

Emotional Reasoning

This one is a close relative of jumping to conclusions in that it involves ignoring certain facts when drawing conclusions. Emotional reasoners will consider their emotions about a situation as evidence rather than objectively looking at the facts. "I'm feeling completely overwhelmed, therefore my problems must be completely beyond my ability to solve them," or, "I'm angry with you; therefore, you must be in the wrong here," are both examples of faulty emotional reasoning. Acting on these beliefs as fact can, understandably, contribute to even more problems to solve.

'Should', 'must' statements

I must get Grade A, I should obey my parents all the time, I must have this top brand toy set, I should be loved by all – these are the statements which are irrational and illogical and lead to problems. Those who rely on 'should statements' tend to have rigid rules, set by themselves or others, that always need to be followed — at least in their minds. They don't see flexibility in different circumstances, and they put themselves under considerable stress trying to live up to these self-imposed expectations. If your internal dialogue involves a large number of 'shoulds,' you may be under the influence of this cognitive distortion.

Labeling and Mislabeling

Those who label or mislabel will habitually place labels that are often inaccurate or negative on themselves and others. "He's a whiner." "She's lazy." "I'm just a useless worrier." These labels tend to define people and contribute to a one-dimensional view of them, paving the way for overgeneralisations to move in. Labeling cages people into roles that don't always apply and prevents us from seeing people (ourselves included) as we really are.

Personalisation

When you attribute everything to your self – that you are the cause of it – it causes anxiety and distress. Those who personalise their stressors tend to blame themselves or others for things over which they have no control, creating stress where it need not be. Those prone to personalisation tend to blame themselves for the actions of others, or blame others for their own feelings.

Cognitive behaviour therapy aims at identifying our faulty/irrational thought patterns and making them conscious. The patient is then able to recognise when he is about to perform an undesirable behaviour, such as compulsive hand-washing, or when he is engaging in negative thoughts that are not supported by logic or reality. The process then calls for the patient to halt the behaviour or thought, then consciously replace it with a desired thought or behaviour.

1.3.4 Techniques Used by CBT Specialists

Therapists use several different techniques in the course of cognitive-behavioural therapy to help patients examine the dysfunctional thoughts and change to rational thoughts and behaviours. These include:

i) **Reality testing:** The client is asked to put his thought to test in the real situation. Thus the client tests it experimentally.

ii) **Validity testing:** The therapist asks the patient to defend his or her thoughts and beliefs. If the patient cannot produce objective evidence supporting his or her assumptions, the invalidity, or faulty nature, is exposed.

iii) **Guided discovery:** The therapist asks the patient a series of questions designed to guide the patient towards the discovery of his or her cognitive distortions.

iv) **Writing in a journal:** Patients keep a detailed written diary of situations that arise in everyday life, the thoughts and emotions surrounding them, and the behaviours that accompany them. The therapist and patient then review the journal together to discover maladaptive thought patterns and how these thoughts impact behaviour.

v) **Homework:** In order to encourage self-discovery and reinforce insights made in therapy, the therapist may ask the patient to do homework assignments. These may include note-taking during the session, journaling, review of an audiotape of the patient session, or reading books or articles appropriate to the therapy. They may also be more behaviourally focused, applying a newly learned strategy or coping mechanism to a situation, and then recording the results for the next therapy session.

For instance, Sheela felt bad and depressed when her friends did not take her to the market visit. Here the therapist can help Sheela identify the basic assumption she has here which is obviously an irrational thought pattern. Why should Sheela feel that she is bad if her friends did not take her? Does she have all the bad qualities? What are they? Sheela is then helped to analyse the distortions in her thinking that she is the cause, i.e., she is bad, so her friends did not take her.

1.4 RATIONAL EMOTIVE BEHAVIOUR THERAPY

Albert Ellis is the founder of the Rational Emotive Behavioural Therapy. He talks about the irrational beliefs which are responsible for our behavioural and emotional problems/disturbances.

According to Ellis (1962), the eleven common irrational beliefs are:

- It is essential to be loved and approved by every significant person in one's life.
- To be worthwhile, a person must be competent, adequate and achieving in everything attempted.
- Some people are wicked, bad, and villainous and should be blamed or punished.
- It is terrible and disastrous whenever events do not occur as one hopes.
- Unhappiness is the result of outside events and a person has no control over such despair.
- Something potentially dangerous or harmful should be a cause of great concern and should always be kept in mind.
- Running away from difficulties or responsibilities is easier than facing them.
- A person must depend on others and must have someone stronger on whom to rely.
- The past determines one's present behaviour and thus it cannot be changed.
- A person should get upset over the problems and difficulties of others.
- There is always a right answer to every problem, and a failure to find this answer is a disaster.

These beliefs are called irrational because these are rigid, not based on the fact. The REBT help the clients to identify the irrational beliefs and think more rationally. This is done by the ABCD model proposed by Ellis where

A	*refers to activating events i.e., events/situations causing the distorted thinking*
B	*refers to beliefs, the evaluative beliefs – rational or irrational – which we have about the activating event*
C	*refers to the consequences – the emotional, behavioural and cognitive consequences of the beliefs*
D	*refers to disputing the beliefs on which our irrational thoughts are based*

1.4.1 The Sequence in the REBT Model

First, the activating events are identified, then the consequences of this event are identified. Events lead to consequences. However, events as such do not lead to consequences. The consequences or our responses are based on our belief system about the events/situations. When these beliefs are irrational, it results in problems; hence, we need to dispute these. Let us see one example. One evening, Hari was not doing his study and was watching TV; his mother scolded him saying he always sees TV and does not do his studies properly. Hari felt very sad for his mother's scolding. Here the activating event (A) is mother's scolding; consequence (C) is Hari's sadness; this sadness resulted because of Hari's belief (B) system – that my mother always scolds me or nobody loves me - ; this irrational belief then needs to be disputed (D). Disputation is the most important step in the REBT therapy.

Cognitive behavioural approach is widely used for dealing with a range of disorders. Obsessive compulsive disorders, phobias, panic disorder and post-traumatic stress disorder are all conditions that are effectively treated by cognitive behaviour modification. Cognitive-behavioural therapy attempts to change clients' unhealthy behaviour through cognitive restructuring (examining assumptions behind the thought patterns) and through the use of behaviour therapy techniques. Cognitive-behavioural therapy is a treatment option for a number of mental disorders, including depression, dissociative identity disorder, eating disorders, generalised anxiety disorder, hypochondriasis, insomnia and obsessive-compulsive disorder.

1.4.2 Potentials and Limitations of Cognitive Behavioural Approach

Cognitive behavioural approach aims at correcting problematic underlying assumptions, thus leading to long-term results. Thus the cause of the problem is corrected.

The structured nature of therapy sessions ensures bringing about fruitful result/outcome. It very much reduces the possibility that sessions will become "chat sessions" in which not much is accomplished therapeutically.

The course of treatment is shorter than that of conventional talk therapy. This makes the cognitive behaviour modification as a less expensive means of obtaining mental health treatment.

The self-help element of cognitive behaviour therapy enables the clients to on their own to maintain their own treatment even after formal therapy has ended.

Cognitive behaviour modification can be performed individually or in group therapy sessions.

These therapies are best known for treating mild depression, anxiety, and anger problems.

Cognitive-behavioural therapy may not be appropriate for all patients. Patients with significant cognitive impairments (patients with traumatic brain injury or organic brain disease, for example) and individuals who are not willing to take an active role in the treatment process are not usually good candidates. It may not be appropriate for small children also who will not have the language capability to think through their assumptions and thought patterns.

Self Assessment Questions

1) Elucidate with example the various types of cognitive distortions given by Beck.

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2) What do you mean by irrational beliefs? Write down three irrational beliefs with example.

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3) What is the ABCD sequence in Rational Emotive behaviour therapy?

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4) What do you mean by home-work assignment in cognitive behaviour therapy?

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1.5 LET US SUM UP

This unit gives some insight into the behavioural and cognitive approach to counseling. The behavioural approach is based on the two learning theories of classical conditioning by Pavlov and operant conditioning by Skinner. The principles and procedure of behavioural approach are described in detail. We also learned about the different behavioural techniques. One of the important techniques under behavioural counseling is systematic desensitization which aims at shaping the behaviour of the person in a systematic manner. We also came to know about the cognitive behavioural techniques such as cognitive behaviour therapy and rational emotive behaviour therapy which are widely used for dealing with various problem behaviours. The combination of cognitive therapies with behaviour modification has been found to be more effective than either of these approaches alone. They have

been found to be successful in managing many maladaptive behaviours such as phobia, depression, anxiety etc. Finally the merits and limitations of the behavioural and cognitive approach to counseling were also discussed.

1.6 UNIT END QUESTIONS

1) Explain and contrast the behaviour modification and cognitive therapy in counseling.
2) As part of behavioural assessment, what are the different aspects of behaviour that we need to study? Describe with the help of an example.
3) Take a case example. Describe the procedure of systematic desensitization.
4) Give three examples of children's behaviour in classroom learning situations where token economy can be used.
5) Briefly explain Beck's cognitive behaviour therapy,
6) Describe the ABCD model of Rational Emotive Behaviour therapy with an example.
7) List out five problems found among school children and describe the behaviour and cognitive techniques you will use for any three of them.

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UNIT 2 APPLICATION OF COGNITIVE THERAPIES IN COUNSELING

Structure

2.0 INTRODUCTION

Unit 1 has already described the meaning and procedure of behavioural and cognitive approaches to counseling. In this unit we will be discussing the uses and applications of these approaches in different types of counseling situations. These two are important approaches to counseling which find wide applications in a variety of settings because of its ease of use and effectiveness. Counsellors employ the different techniques under these approaches in contexts ranging from educational to as diverse as military and sports counseling. Cognitive therapy focuses on the relationship among cognition, emotion and behaviour in human functioning. The cognitive approach is based on the observation that automatic thoughts that are exaggerated, distorted, mistaken or unrealistic play a major role in psychopathology. These automatic thoughts are shaped by an individual's beliefs, assumptions and schemas. Our perception and interpretation of events greatly depends on these. Irrational thoughts and assumptions shape one's response to experiences and situations, e.g., a child's irrational assumption that "I am no good" will make him shy away from his classmates and in the process he will not be able to make friends. This in turn will reinforce his assumption "I am no good". Hence cognitive therapies focus on changing the irrational assumptions and belief systems of the clients.

In this unit, the cognitive approach which aims to understand why the client is appraising events in particular ways and why he feels the way that he does, etc. will be discussed. For instance, negative thoughts and feelings about one's situation and circumstance lead to depressive feelings, inaction and lack of interest in anything. These depressive feelings and mood in turn give rise to negative thoughts in the individual. Thus it is a vicious cycle of thoughts influencing our feelings and emotions, and again emotions affecting our thought patterns. Sanders & Wills (2005) point out that an external event will have a very different impact on different people because each individual has, first, a different personal domain on which the event impinges. Second, each person has an idiosyncratic way of appraising events because cognitions, perceptions, beliefs and schemas will have been shaped by the individual's unique personal experiences and life history. The aim of cognitive therapy is to understand both the person's personal domain and their idiosyncratic way of appraising events.

2.1 OBJECTIVES

After going through this unit, you will be able to:

- Develop an understanding of the application of cognitive behavioural therapies.
- Appreciate the use of cognitive behaviour therapies in a variety of settings.

2.2 APPLICATION IN DIFFERENT SETTINGS

Cognitive behavioural is a major approach in counseling. The basic premise underlying this approach is the idea that automatic thoughts shape both individual's emotions and their actions in response to events. For example, when the teacher tells the student "meet me after the class", the student starts thinking," Oh, I am gone now, I must have done something serious and something bad will come to me now." Given the presence of this thought in the student's mind, his emotions and behaviour will be shaped accordingly. Cognitive therapy tries to bring client's focus on these irrational thoughts and beliefs, and modify them. In fact, most of us have illogical or irrational thoughts, but when we can not let go of them and they start affecting our actions and behaviours, then it is a problem situation. For example, the thoughts that are problematic for clients who suffer with obsessive compulsive disorders(OCD) are shared by 90 percent of the population (Salkovskis et.al.1995). OCD sufferers however, pay attention to these thoughts in a different way. Non-sufferers can let these thoughts go whereas OCD sufferers cannot. Similarly, those of us who are constant worriers focus more on the worries and cannot let them go. In contrast many of us who are also faced with the same worries do not let these worries control or overpower us. Cognitive therapy aims at making the clients aware about these dysfunctional thoughts and changing them to appropriate rational thoughts.

2.2.1 Educational Setting

Students' behaviour presents a lot of challenge to the present day teacher. In addition to the academic pressure/activities, teachers need to deal with such behaviours of students such as student misconduct, aggression, disobedience or disrespect for authority, hyperactivity, inattention, lack of self-control, teasing, bullying etc. Behavioural excesses and deficits affect negatively the academic performance of the students and hamper positive peer relationships as well as healthy relationship with the teachers.

Application of cognitive behaviour modification in the classroom and school context mainly addresses two aspects, viz., (i) instructional interactions between teachers and learners; and (ii) behavioural interaction between teachers and their learners. Thus it is made use of in a variety of situations such as the following

- increasing academic grades by adopting effective study habits
- increasing one's self confidence to speak in front of a group
- increasing social skills to interact with people in the social gathering
- following a healthy exercise programme
- reducing unhealthy pattern of eating
- decreasing use of abusive language, e.g., using swearing words
- reducing test anxiety

Different strategies are used such as self management, applied behaviour analysis, positive behavioural support, behaviour modification and therapy.

Cognitive Behavioural Interventions (CBI) can be a viable approach for teachers to remediate behavioural deficits and excesses by providing students with the tools necessary to control their own behaviour. CBIs involve teaching the use of inner speech ("self-talk") to modify underlying cognitions that affect overt behaviour (Mahoney, 1974; Meichenbaum, 1977).

Since theorists consider the internalisation of self statements fundamental to developing self control, deficient or maladaptive self statements are viewed as contributing to negative beliefs about oneself, which can contribute significantly to childhood behaviour problems, including aggression. Kendall (1993) noted that cognitive-behavioural techniques for the remediation of social deficits can incorporate cognitive, behavioural, emotive, and developmental strategies, using rewards, modeling, role-plays, and self-evaluation.

CBI incorporates behaviour therapy (e.g., modeling, feedback, reinforcement) and cognitive mediation (e.g., think-aloud) to help clients deal with a variety of problems and situations. For example, not hitting or pushing a peer when teased can be mediated by inner speech such as "That makes me mad, but first I need to calm down and think about this." The fundamental assumption of CBI is that overt behaviour (e.g., hitting or pushing a peer when teased) is mediated by cognitive events (e.g., "I'm going to let him have it") and that individuals can influence cognitive events to change behaviour. Cognitive strategies incorporate a "how-to-think" framework for students to use when modifying behaviour rather than any explicit "what-to-think" instruction from a teacher. Thus, verbal self-regulation, i.e., using self-talk to guide one's behaviour to deal with a problem situation can be effectively used. This is especially relevant to marital problems and family disturbances. Many a times problems arise because the parent reacts impulsively to the child's misbehaviour – 'how can he do like this; how can he not listen to me?'; or the couple gets angry and says harsh words to each other immediately in the event of some misunderstanding – 'he always forgets when he has promised for an evening out; I only end up tidying the house after a party'. In contrast, self talk can be used to deal with such situations in a positive manner, e.g., "Ok, this makes me angry, but first let me think about it." This makes the individual aware of the immediate thought which comes to his mind and gives him time to think about the situation in a clear manner.

Hughes & Hall (1989) points out that cognitive- behavioural approach can be used to help solve a variety of children's learning and adjustment problems, e.g., impulsivity, depression, anxiety, interpersonal problem solving, effects of mild handicaps, problems with arithmetic and reading. For instance, in case of a student exhibiting inattentive, impulsive behaviour – the cognitive behavioural therapy may involve a contingence contract which specifies certain contingencies in response to a targeted behaviour; and also a component o self talk which aims at inhibiting the impulsive behaviour.

Etscheidt (1991) studied the effectiveness of cognitive behaviour therapy in decreasing the aggressive behaviours of students with Emotional and Behaviour Disorder (EBD) as compared to students who did not receive the instruction. Etscheidt's program components were adapted from the Lochman, Nelson, and Sims (1981) Anger Coping Program, which provides students with a way to change aggressive responses into appropriate alternatives by modifying their thinking processes regarding the circumstances surrounding certain situations. The instruction also assists students in

developing, evaluating, and selecting appropriate alternative responses. Etscheidt's goals included increasing self-awareness; identifying a student's reaction to peer influences; providing avenues to identify problem situations; and using problem-solving techniques to identify, evaluate, and select alternative solutions for a specific social situation.

In Etscheidt's program, students used the following sequential strategy when approaching a problem situation:

1) Stop and think before acting. Students are taught to restrain aggressive responses through the use of covert speech.
2) Identify the problem. The students are required to distinguish the specific aspects of a problematic situation that may elicit an aggressive response.
3) Develop alternative solutions. Students generate at least two alternative solutions to a problematic situation, either thinking about something else until able to relax and/or moving to another location in the room to avoid further provocation.
4) Evaluate the consequences of possible solutions. Students assessed the benefits of each possible solution.
5) Select and implement a solution. The students carried out the selected alternative.

Findings showed that the students in the control group exhibited significantly more aggressive behaviours than those who received the training.

Behaviour management will always be a significant part of the teacher's role and responsibility. Hence, cognitive-behavioural interventions comes handy to the teachers to help provide students with methods to successfully control their own behaviour. CBI may offer a viable method for assisting students to manage their thoughts and behaviours, thus creating better learning environments and experiences for them.

Self Assessment Questions

1) How will you use 'self – talk' to overcome problem of shyness in a classroom situation?

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2) Give examples of two problem behaviour in children where cognitive behaviour therapy can be used.

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2.2.2 Clinical Setting

Cognitive therapy has been found to be useful in a variety of clinical disorders such as anxiety, depression, substance abuse, personality disorders, antisocial personality disorder, obsessive-compulsive disorder etc.

Freeman et. al. (2004) has described the application of cognitive behavioural therapies in a wide range of disorders which are described as follows. In treating

schizophrenia and other psychiatric disorders, cognitive therapy is used in combination with pharmacotherapy, not as an alternative to medication.

Cognitive therapy can be used to improve client's compliance with a medication regimen, to help them recognise their symptoms and cope more effectively with them, to improve social problem solving and stress management and to treat comorbid problems such as anxiety and depression. Cognitive behavioural interventions are of great significance because of their potential to reduce the costs associated with in-patient treatment and to improve the client's quality of life.

Further, cognitive therapy when used in combination with medication, emphasises early identification of hypomania and depressive episodes; strategies for dealing with these episodes; regulation of the client's sleeping, eating, and activity levels, reduction of the client's vulnerability and exposure to triggering situations, and enhancement of medication compliance.

Cognitive therapy is also used in case of eating disorders. It focuses on the restructuring of dysfunctional beliefs about food, weight, and one's self (particularly in regard to body image and self worth). Dietary education and monitoring of food intake are emphasised. For instance, in case of the anorexics cognitive behaviour therapy have found much usefulness. The behaviour of the anorexic may be characterised by a pattern of social withdrawal, rigorous exercise, and ritualistic eating habits. The weight loss is very drastic. The emotional profile of the anorexic is marked by a pattern of depression, fear of obesity, and loss of self-confidence. Body-size misperception is a significant feature of the anorexic disorder.

Cognitive Therapy with the anorexic involves challenging the faulty thinking and beliefs of the patient. For example, if the patient expresses apprehension around the issue of losing competence if she gains weight, the therapist can help her develop a working definition of competency that will establish a concept of whether or not it is influenced by weight changes.

She can be asked such questions as, "your friend who is a good singer, weighs more than you; so would you appreciate her less because she is fat?" This type of questions will gradually make her start thinking about her beliefs and assumptions. Questioning the anorexic about what would happen if their worst expectations came to happen may minimize the imagined effects of the event.

The person who wants to be "thin" is obviously anxious when she considers herself "fat." The counselor may inquire, "What's the most horrible thing that could happen if you were to gain weight?"

Cognitive distortions are numerous in the anorexic and must be gently challenged. Distortions such as dichotomous thinking, ("If I gain weight, I'll be considered obese."), overgeneralisations, ("I will never get any better and my eating will never improve."), magnification, ("Gaining any weight will be more than I can take!") must be directly, but gently confronted in counseling.

The individual may be asked to reinterpret what she sees. The anorexic is encouraged to design experiments to test the validity of specific irrational thoughts. For example, the anorexic individual may be encouraged to interview her friends for preferences in physical appearance, checking out how often people select a friend based exclusively on the merit of weight.

Cognitive behaviour intervention also finds application in somatoform disorders. This involves changing beliefs about the nature and consequences of the somatic concerns (Salkovskis, 1989). In addition, coping strategies used for stress management and anxiety reduction are also used.

2.2.3 Personal-Social Situation

Cognitive behavioural therapies have also been found to be beneficial in dealing with personal social related issues. Many a times we are bogged down by our lack of motivation and have doubts with regard to our self efficacy. "I know I'll make a mess of it, It always happens that way only" – such type of thought affects our behaviour accordingly. Cognitive behavioural therapy can prove helpful to the individuals in such type of situations.

Anger has come to be recognised as a significant social problem. In the last two decades, cognitive behavioural therapy has emerged as the most common approach to anger management (Beck & Fernandez, 1998). Beck et. al (1998) have done a meta-analysis of the various researches conducted during the twenty long years and reported the efficacy of cognitive behavioural therapy for anger management.

Cognitive therapy addresses the issue of social anxiety also. Social anxiety is characterised by the following :

a) misperception of themselves in terms of appearance, ability, and self-worth,

b) feelings of guilt, anger and embarrassment arising from past social situations,

c) think that they have to behave perfectly in social situations, and

d) procrastination habits that exist because of social anxiety worries and doubts

The systemaic desensitisation can be used to deal with issues related to social anxiety. The "systematic" part of systematic desensitisation is highly important. In behavioural therapy for social anxiety, the progress must be *systematic, step-by-step, hierarchical, and repetitious*. If it moves too fast, or if it is too much, this therapy will not be helpful. It is very important that any process of desensitisation be gradual and systematic. Self-assertion strategies are taught to the persons with social anxiety. They are also made to realise through the therapy the need to be more realistic and not to expect perfectionism on their part in social situations.

Cognitive behaviour therapy also addresses issues related to how to increase one's self esteem and confidence, how to deal with relationship matters, marital issues, overcoming fears and phobias, and all types of mental disturbances.

Cognitive behavioural therapy has been found to be effective in dealing with stress of our day - to - day living. Cognitive therapy for stress rests on the premise that it's not simply the events in our lives that cause us stress, it's the way we think about them. For example, two people may be caught in traffic. While one person could view this situation as an opportunity to listen to music and get relaxed, another person may focus on the wasted time or the feeling of being trapped, and become distressed.

When something does not turn up the way we had expected, we become upset which affects our other things also. We had planned to go for a concert in the evening, but could not reach home in time because of some overwork at the office. This creates stress in us. There are hundreds of examples of how our thoughts and our negative self talk color our experiences and can lead to a triggered stress response or a calm demeanor. Granath et.al. (2006) in their study on stress management

programme reported both cognitive behaviour therapy and yoga as promising stress management techniques.

Cognitive behaviour therapy suggests that cognitions can influence behaviour and that there is a reciprocal relationship between cognition, behaviour and the environment. The personal-social problems faced by the individuals have often all these dimensions related to the person's behaviour, cognition and the environmental situation. Hence cognitive behavioural therapy attempts to find out these relationships, makes the individual aware about it, and the irrational assumptions or dysfunctional thought patterns underlying it; thereby facilitating the individuals to deal with their problems.

Self Assessment Questions

1) What are the important characteristic features of Cognitive Behaviour Therapy?

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2) Describe the clinical applications of cognitive behavioural therapy.

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3) Explain the use of cognitive behavioural therapy in case of a child with low self confidence.

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4) How do you treat an anorexic with cognitive behaviour therapy?

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2.3 LET US SUM UP

This unit has focused on the application of cognitive behaviour therapy in a wide range of situations. Cognitive therapy is a model of psychological therapy that proposes how we feel, how we think and how we behave are all inter-related, and changes to thoughts and behaviour will influence feelings. It makes use of strategies which try to modify the thinking processes of the client in a systematic way so that it results in a positive change in the client's symptoms/problems.

The cognitive part of the therapy refers to thinking or learning and is the part of therapy that can be "taught" to the person. The person then needs to take what has been taught, practice it at home, and through means of repetition, get that new "learning" down into the brain over and over again so that is becomes automatic or habitual. This is essentially the same process as school or college learning. You are taught some new information or skills, and then you learn them. When you learn them well enough (through repetition), this affects your memory processes (and physiologically your brain's neural pathways) and allows you to begin thinking, acting, and feeling differently. This takes persistence, practice, and patience, but when a person sticks with this therapy, and does not give up, noticeable progress begins to occur.

Cognitive therapy or cognitive behavioural therapy uses a variety of cognitive and behavioural techniques such as CBT, REBT, behaviour therapy, self management, modeling. In this unit, the application of cognitive behavioural therapies to various situations covering educational, clinical and personal-social is described. Cognitive behavioural therapy addresses the thoughts, behaviour and feelings of the individual/ client. In addition to this focus on the individual's behaviour, cognition and feelings, attention should also be paid to the situation, context and the environment variables. Thus an ecological perspective in cognitive behavioural therapy will be more beneficial and effective.

2.4 UNIT END QUESTIONS

1) List out the different problems and issues related to the teaching-learning in the classroom. In this context, discuss the use of cognitive behavioural therapy.
2) Describe the application of cognitive behavioural therapy with regard to various personal social issues/problems.
3) Cognitive behaviour therapy is the most widely used approach in counseling. Justify.

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UNIT 3 COGNITIVE BEHAVIOUR MODIFICATION

Structure

3.0 INTRODUCTION

Cognitive behaviour modification is a most commonly used intervention in counseling. It focuses on identifying dysfunctional self-talk in order to change unwanted behaviours. In other words, behaviours are viewed as outcomes of our own self-verbalisations. Hence by changing our self talk we can change our behaviour.

Cognitive behaviour modification (CBM) was developed by merging behaviour therapy with cognitive therapy. It is an intervention that combines cognitive and behavioural learning principles to shape and encourage desired behaviours. Although behaviour therapy and cognitive therapy are drawn from different theories, each shares an emphasis on alleviation of symptoms and a focus on the present in developing a course of treatment. In cognitive behaviour modification, the client is trained to recognise destructive or harmful thought patterns or behaviours, then replace them with helpful or constructive thoughts and behaviours.

To be more specific, cognitive behaviour modification refers to theoretical and applied orientations that share three underlying assumptions: (a) an individual's behaviour is mediated by cognitive events; (b) a change in mediating events results in a change in behaviour; and (c) an individual is an active participant in his learning. In short, the cognitive behavioural approach assumes that individuals have both the capacity and preference for monitoring and managing their own behaviour (Heflin & Simpson, 1998). In this unit the different techniques of cognitive behaviour modification will be described.

3.1 OBJECTIVES

After going through this unit, you will be able to:

- Define cognitive behaviour modification
- Describe the meaning of different techniques of behaviour modification
- Explain the different techniques of cognitive behaviour modification
- Analyse the application of behaviour modification techniques in counseling situations

3.2 TECHNIQUES OF COGNITIVE BEHAVIOUR MODIFICATION

In the earlier unit (unit1) cognitive behaviour modification has been described in detail. Here we will focus on the four techniques used by counselors under cognitive behaviour intervention. These are techniques of Stress Inoculation, Self-Instructional, Self-Management and Problem Solving.

3.2.1 Self Instructional Technique

Self instructional training was developed by Donald Meichenbaum (1977) as part of cognitive behaviour therapy. We usually engage in self talk and the nature of our self talk affects our behaviour. Faulty and irrational verbalisations result in anxiety and other emotional and behavioural problems. Hence, in self instructional training the clients are taught to keep track of self statements that are destructive or negative, and are then given training to substitute them with more adaptive ones through homework assignments and practice. Thus healthy self talk replaces the negative self talk or internal statements. Identifying and modifying the negative/destructive/ unhealthy internal statements to positive statements reduces the stress and anxiety.

First, the client is made aware of the negative self talks going on within him. Then, the client is helped to understand/realise how his negative verbalisations lead to the anxiety or fear or other emotions and behaviour of him. Next the client identifies the positive self talk he needs to do in place of the negative ones. He is then given training to make the positive self talk a part of him through practice.

The self instructional training can be used successfully to deal with anxiety, fear, addiction, compulsive behaviours, unhealthy eating habits etc. For example, the child who is obese has unhealthy eating habits. He eats junk food and goes on eating very frequently. He is not able to stop eating and gobbles up more than he should be eating. Self instructional training can help him control his eating habits. The child needs first to identify the kind of internal verbalisations that goes on while succumbing to the temptation of eating. Then he has to practice positive self talk which will be his instruction to the self whenever he engages in unhealthy eating habit.

3.2.2 Stress Inoculation Technique (SIT)

Stress Inoculation Training given by Meichenbaum (1985) is a complete cognitive behavioural intervention package that makes use of cognitive restructuring, self instruction, self-monitoring, problem solving, relaxation training etc.

Stress Inoculation training prepares the individual in advance to handle stressful events successfully. The use of the term "inoculation" is based on the idea that as vaccination inoculates people against diseases; similarly stress inoculation training helps inoculate the person against the stressors in life. In SIT, patients are educated about stressful situations and the general nature of stress, the negative outcomes they may be vulnerable to experiencing when confronted with stress, and steps they can take to avoid those negative outcomes.

Thus stress inoculation is designed to bolster individual's preparedness and develop a sense of mastery. The treatment goals of SIT are to bolster the clients' coping repertoire (intra- and interpersonal skills), as well as their confidence in being able to apply their coping skills in a flexible fashion that meets their appraised demands of the stressful situations.

In SIT, the clients become more aware of what things are reminders (also referred to as "cues") for fear and anxiety. They learn how to detect and identify cues as soon as they appear so that they can put the newly learned coping skills into immediate action. In doing so, the patient can tackle the anxiety and stress early on before it gets out of control.

SIT consists of three interlocking and overlapping phases:

Phase 1 Conceptual educational phase

In the initial conceptualisation phase, the client is educated about the nature of stressors and how certain ways of thinking leads to stress and mental disturbances. They are helped to differentiate between aspects of their stressors and their stress-induced reactions that are changeable and aspects that cannot change, so that coping efforts can be adjusted accordingly. Acceptance-based coping is appropriate for aspects of situations that cannot be altered, while more active interventions are appropriate for more changeable stressors.

Phase 2 Skills acquisition and skills consolidation phase

In the next phase of skill acquisition the client is given training on a variety of skills such as emotional self-regulation, relaxation, problem solving, cognitive appraisal, cognitive restructuring, communication and socialisation skills. However, the particular choice of skills taught should be on the basis of the client's unique needs, strengths and vulnerabilities. The skills are then rehearsed so that they become easy to act out.

Phase 3 Application and follow-through phase

In this last phase of application, the client applies the skills learnt in the real life situation. The client is also provided opportunities to practice coping skills in simulated situations using the methods of visualisation, modeling and role playing. After counseling is over, follow up session is organised to find out the effectiveness of the training the client received.

Stress inoculation training aims at building psychological immunities in the individual to deal with stress. It has been helpful in reducing interpersonal and general anxiety. For example, these techniques may be used when a person has an upcoming job interview, speech, or test. Stress inoculation has also been used to treat phobias, fear of heights, and chronic anger problems. It is used as both a treatment as well as a preventive measure. Stress inoculation training is not merely a collection of different coping techniques. It is more than that; it is highly client- sensitive, and involves collaborative mechanism keeping in mind the client's goals and future plans. All these contribute to the comprehensive and robustness of stress inoculation therapy.

Self Assessment Questions

1) Self instructional training involves replacement of negative self talk by healthy self talk. Elaborate with example.

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2) Explain the meaning of "cues" in Stress Inoculation Training.

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3) What do you mean by 'inoculation' in stress inoculation training?

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3.2.3 Self Management Technique

Self management strategies make use of cognitive and behavioural skills by the individuals to maintain self-motivation and achieve personal goals. Most people who decide to use self-control or self management strategies are dissatisfied with a certain aspect of their lives. For example, they may feel they smoke too much, exercise too little, or have difficulty controlling anger. Thus, the goal of self-management strategies is to reduce behavioural deficiencies or behavioural excesses.

Behavioural deficiencies occur when an individual does not engage in a positive, desirable behaviour frequently enough. For example, a student who rarely studies may not graduate. Behavioural excesses occur when an individual engages in negative, undesirable behaviour too often. This results in a negative future consequence. For example, a person who smokes may develop lung cancer. The client is taught to identify, monitor, and bring changes in his behaviour deficit or behavioural excess so that it leads to desired behavioural changes.

There are a variety of self management strategies that make use of stimulus control, reinforcers and punishers to modify the undesirable behaviour. In fact these strategies can be grouped under three broad categories such as (i) Environmental strategies (ii) Behavioural strategies (iii) Cognitive strategies

i) **Environmental Strategies:** Environmental strategies involve changing times, places, or situations where one experiences problematic behaviour. Examples include:

- changing the group of people with whom one socialises
- avoiding situations or settings where an undesirable behaviour is more likely to occur
- changing the time of day for participating in a desirable behaviour to a time when one will be more productive or successful

ii) **Behavioural Strategies:** Behavioural strategies involve changing the antecedents or consequences of a behaviour. Examples include:

- increasing social support by asking others to work towards the same or a similar goal
- placing visual cues or reminders about one's goal in one's daily environment

- developing reinforcers (rewards) for engaging in desirable behaviours or punishers for engaging in undesirable behaviours
- eliminating naturally occurring reinforcers for undesirable behaviour
- engaging in alternative, positive behaviours when one is inclined to engage in an undesirable behaviour
- creating ways to make a desirable behaviour more enjoyable or convenient
- scheduling a specific time to engage in a desirable behaviour
- writing a behavioural contract to hold oneself accountable for carrying out the self-control program

iii) **Cognitive Strategies:** Cognitive strategies involve changing one's thoughts or beliefs about a particular behaviour. Examples include:

- using self-instructions to cue oneself about what to do and how to do it
- using self-praise to commend oneself for engaging in a desirable behaviour
- thinking about the benefits of reaching one's goal
- imagining oneself successfully achieving a goal or using imagery to distract oneself from engaging in an undesirable behaviour
- substituting positive self-statements for unproductive, negative self-statements

Thus self management techniques use self observation, self instruction, self praise, self reward and self punishment to bring about desirable changes in their behaviour.

Self-management strategies are useful for a wide range of concerns, including medical (such as diabetes, chronic pain, asthma, arthritis, incontinence, or obesity), addictions (such as drug and alcohol abuse, smoking, gambling, or eating disorders), occupational (such as study habits, organisational skills, or job productivity), and psychological (such as stress, anxiety, depression, excessive anger, hyperactivity, or shyness). However, if symptoms are severe, self-management strategies should be used in conjunction with other therapies.

3.2.4 Problem Solving Technique

In life we are faced with so many problems related to our school, college, home, work and varied life situations. We need to solve them effectively in order to lead an efficient life. Problem solving comes handy here as a tool, a skill and a process. As a tool it helps you solve a problem or achieve a goal. As a process it involves a number of steps and as a skill, it can be used throughout life to deal with various problems and situations.

Problem-solving has two distinct phases: (i) a problem definition phase and (ii) a problem solution phase.

i) **Problem definition phase:** When defining a problem:

- Be specific
- Be brief
- Express your feelings about the problem
- When solving problems:
- Brainstorm solutions
- Evaluate their costs and benefits

- Decide on the best solution
- Be willing to compromise

ii) **Problem solution phase:** Thus problem solving involves a number of steps such as,

Problem definition – It involves stating the problem in clear terms. What actually is causing the problem? It helps to think in terms of what actually I want. How is the present situation affecting me? How do I want it to change? All these help in specifying the problem.

Problem analysis – After defining the problem, it needs to be analysed or thought of from different angles/perspectives. This enables in further clarification of the problem.

Goal setting – It involves establishing goals what you want to achieve. Based on your analysis of the problem, what is it that you want to change or achieve?

Generation of alternatives – Next step is to generate as many alternatives as possible to achieve the goal. Don't bother about whether they are realistic or will be effective or not? The requirement task is to list down all the possible solutions.

Decision making – This step refers to analysing the solutions/alternatives and deciding on a particular solution. Each alternative is examined, pros and cons are listed out and decision is taken.

Implementation and verification – The last step involves implementing the solution you have chosen and evaluating its effectiveness. It is verified whether the strategies/ techniques adopted led to the solution of the problem.

Problem solving is a cyclical process. If the solution is not found to be effective, again the process starts; and the problem is defined and analysed again, and goals set and solutions found. The client plays an active role in the problem solving process.

Self Assessment Questions

1) Describe the different strategies of self management.

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2) What are the different steps involved in problem solving?

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3) Differentiate the problem definition and problem solution phase.

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3.3 LET US SUM UP

Cognitive behaviour modification is a combination of *behaviour therapy* and *cognitive therapy.* In this intervention technique, you can track from the beginning how your thoughts affect your feelings and then, in turn, your behaviours. If you realise that the originating thought about a situation is irrational, you can realise that the resulting feeling and action are also irrational, and then you can modify your thought. In this unit you learned four techniques of cognitive behaviour modification such as Self Instructional, Stress Inoculation Training, Self Management and Problem Solving. The meaning and procedure for each technique are described. Further, the uses of these techniques are also mentioned. Cognitive behaviour modification (CBM) is at the root of treatment for anorexia nervosa, and other eating disorders. It is also commonly used in the treatment of various anxiety disorders. Since many eating disorder patients experience co-occurring disorders such as anxiety and depression, it makes cognitive behaviour therapy an even more powerful treatment option.

3.4 UNIT END QUESTIONS

1) List out the different situations/problems in the school context in which self instructional training can be used.
2) Explain the different stages of stress inoculation training.
3) 'Stress Inoculation Training helps build up psychological immunities'. Discuss.
4) How will you use self management technique for a child with aggressive behaviour?
5) Evolve a self management strategy to help a child overcome excessive television viewing.
6) Elucidate the problem solving strategy by taking a case example.

3.5 SUGGESTED READINGS

Gladding, S.T. (1996). *Counseling: A Comprehensive Profession* (3rd ed.). New Jersey: Prentice-Hall Inc.

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UNIT 4 SOLUTION FOCUSED COUNSELING AND INTEGRATIVE COUNSELING

Structure

4.0 INTRODUCTION

Solution Focused counseling is is a brief therapy which focuses on solution finding rather than looking at the history of the problem etc. It is based on solution focused brief therapy model. Solution focused therapy focuses on people's strength, competence, and possibilities instead of their deficits, weaknesses and limitations (O'Hanlon & Weiner Davis 1989). As such, it represents a dramatic shift in focus from previous approaches that seek to identify and explain problems and their origins. Solution focused therapy is a form of brief therapy. The number of sessions varies, but is usually under ten sessions with an average of four or five. Sometimes just one session is adequate.

Most counseling approaches focus on problems, thus implying that something is wrong with the client. This emphasis on deficits usually leads to an extensive and time consuming exploration of problems, etiology, histories and causes. In contrast, the solution focused counseling takes a positive approach of the client and puts emphasis on the generation of solutions based on the strengths and assets of the client.

In this unit we will discuss the solution focused approach in counseling and describe the solution focused brief therapy. Further we will also discuss about the integrative approach to counseling which emphasises on the integration of different approaches to address the common goal of the client's benefit and betterment.

4.1 OBJECTIVES

After going through this unit, you will be able to:

- Define solution focused counseling;
- Explain the assumptions of solution focused therapy;
- Describe how to carry out the solution focused brief therapy;
- Analyse the pros and cons of solution focused therapy; and
- Explain the concept of integrative counseling.

4.2 MEANING OF SOLUTION FOCUSED COUNSELING

Solution focused counseling focuses on what clients want to achieve through therapy rather than on the problem(s) that made them to seek help. The approach does not focus on the past, but instead, focuses on the present and future. The major emphasis is on the solutions rather than the problem. Brief solution-focused counseling is grounded in four decades of psychotherapy outcome research on the essential ingredients of therapeutic change (Hubble, Duncan, & Miller, 1999). Based on multiple analyses of research in counseling and psychotherapy, Lambert and colleagues (Asay & Lambert, 1999; Lambert & Ogles, 2004) concluded that effective outcomes result primarily from the operation of four "common factors" of change. Common factors are the essential ingredients of change that operate across different clients, problems, settings, and theoretical models. These elements are also referred to as "nonspecific factors" because they operate across all theoretical approaches and are not specific to any one particular model. Successful therapeutic outcomes appear to result primarily from the operation of four interrelated factors. These factors, and their percentage of contribution to successful outcomes, are as follows:

Client factors (accounting for 40% of change): Everything that the client brings to counseling—strengths, interests, perceptions, values, social supports, resilience, and other resources

Relationship factors (accounting for 30% of change): The client's experience of respect, collaboration, acceptance, and validation from the counselor

Hope factors (accounting for 15% of change): The client's positive expectancy and anticipation of change

Model/technique factors (accounting for 15% of change): The counselor's theoretical model and intervention techniques

Thus it can be seen that clients have a major contribution toward the success of counseling. Solution focused counseling believes in the strength of the clients and believes that clients have the capacity to find solutions.

The solution focused brief counseling (SFBC) was developed by Steve deShazer (1985). He discovered that by focusing on solutions rather than problems, clients were getting better faster than with traditional counseling modalities. Thus there is a shift of focus in the SFBC from the traditional problems focus to a solution focus, where exploring the problem was minimized. SFBC outlines an active role of the client, attributing the success of the therapy mostly to the client's efforts.

Implicit in the model is the belief that clients are not always overcome by problems, e.g., depressed clients are not always depressed, there are times when they are not depressed. Thus clients can always identify times and situations when the problem was not there. By rediscovering these resources/ instances, clients are encouraged to analyse them and repeat those successes. Thus SBFC approach emphasises problem solving and client-produced solutions. It does not go for in depth exploration and the causes and origins of the problem; thereby reducing the time required for counseling; hence it is called 'brief'. Moreover, when the focus is on solutions, actions become of primary importance and insight is deemphasised.

4.2.1 Key Assumptions of Solution-Focused Counseling

Murphy (2008) delineated the following assumptions of solution focused counseling:

1) *If it works, do more of it. If it doesn't work, do something different.*

This assumption captures the pragmatic nature of solution-focused counseling. It involves identifying what works and doing more of it; encouraging the clients to build on their strength, success and other resources. If it doesn't work, then try something else. The value of any technique rests on its practical usefulness in promoting change and moving clients closer to their goals.

2) *Every client is unique, resourceful, and capable of changing.*

Adopting a position of curiosity enables us to approach every client from a fresh perspective that honors his or her unique circumstances, goals, and resources. It encourages the clients to recognise and apply their unique strengths and resources toward meaningful goals. Viewing clients as capable and resourceful does not deny the seriousness or pain of a problem. It does, however, create solution opportunities that might otherwise be overlooked.

3) *Cooperative relationships enhance solutions.*

The quality of the client-practitioner alliance is the best predictor of outcomes in counseling (Wampold, 2001). Effective counseling relationships are built on mutual respect and common goals. This includes our accommodation of clients' goals, resources, and feedback, and their trust in our commitment and ability to help them reach their goals.

4) *Client feedback improves outcomes.*

In addition to creating cooperative and accountable relationships, obtaining formal feedback from clients on outcome and alliance has been shown to double the effectiveness of counseling (Lambert et al., 2003).

5) *No problem is constant.*

Regardless of how constant a problem seems, there are always fluctuations in its rate and intensity. Solution-focused counselors seek out these fluctuations or "exceptions" to the problem by directly asking for them (e.g., "Tell me about a recent time when the problem did not occur, or wasn't as bad as usual"), exploring the conditions under which they occur (e.g., "What was different about that time than usual?"), and encouraging students and others to do more of whatever they have done to bring them about (e.g., "What will it take to make that happen more often?"). In addition to providing clues to solutions, discussing exceptions may increase people's hope in the possibility of solutions and in their ability to bring them about.

6) *Big problems do not always require big solutions.*

Solution-focused counseling is based on the practical notion that one small change in any part of the problem system can ripple into larger and more significant changes.

O'Hanlon & Weiner Davis (1989) have provided the following assumptions which act as the foundation of solution-focused therapy:

People 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.

Self Assessment Questions

1) What do you mean by solution focused counseling?

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2) Solution focused counseling puts emphasis on the present and future. Elaborate.

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3) Discuss the importance of bringing about small changes in one's behaviour in the context of solution focused brief therapy.

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4.3 PROCEDURE OF SOLUTION FOCUSED BRIEF THERAPY

Solution focused work can be seen as a way of working that focuses exclusively or predominantly on two things.

a) Supporting people to explore their preferred futures.

b) Exploring when, where, with whom and how pieces of that preferred future are already happening.

Thus solution focused therapy starts with the client envisioning a preferred future, i.e., what does he want, how does he want his future to be. The therapist/counselor uses respectful curiosity to enable the client to envision their preferred future. With the help of the therapist the client starts his journey of achieving his desired goals.

By helping people identify the things that they wish to have changed in their life and also to attend to those things that are currently happening that they wish to continue to have happen, SFBT therapists help their clients to construct a concrete vision of a *preferred future* for themselves. The SFBT therapist then helps the client to identify times in their current life that are closer to this future, and examines what is different on these occasions.

By bringing these small successes to their awareness, and helping them to repeat these successful things they do when the problem is not there or less severe, the therapists helps the client move towards the preferred future they have identified. To support this, questions are asked about the client's story, strengths and resources, and about exceptions to the problem.

4.3.1 The Miracle Question

This is a method of questioning that a coach, therapist, or counselor uses to aid the client to envision how the future will be different when the problem is no longer present. Also, this may help to establish goals.

A traditional version of the miracle question would go like this:

"Suppose our meeting is over, you go home, do whatever you planned to do for the rest of the day. And then, some time in the evening, you get tired and go to sleep. And in the middle of the night, when you are fast asleep, a miracle happens and all the problems that brought you here today are solved just like that. But since the miracle happened overnight nobody is telling you that the miracle happened. When you wake up the next morning, how are you going to start discovering that the miracle happened? ... What else are you going to notice? What else?"

In another instance/situation, the counselor may ask,

"If you woke up tomorrow, and a miracle happened so that you no longer easily lost your temper, what would you see differently?" What would the first signs be that the miracle occurred?"

The client (a child) may respond by saying,

"I would not get upset when somebody calls me names."

The counselor wants the client to develop positive goals, or what they will do, rather than what they will not do -to better ensure success. So, the counselor may ask the client, "What will you be doing instead when someone calls you names?"

Thus the counselor enables the client to identify the resources through the use of solution talk, that is focus is on what is right and working for the client rather than what is wrong and problematic. Thus solution talk is practised rather than problem talk.

4.3.2 Exception Seeking

In this, the clients are encouraged to seek out instances of exception when the problem was not present, for instance ; when, where and how these instances occur, are considered and then solutions are developed based on these.

4.3.3 Establishing Positive Goals

In this the clients are encouraged to have positive goals (what they 'can' do) rather than negative goals (i.e., to stop doing something, e.g., fighting, disrupting, playing etc.). The counselor helps clients identify positively worded goals that reflect what they do want to happen which will be a measurable goal.

4.3.4 Resources can be Internal or External

Internal refers to the client's skills, strengths, qualities, beliefs that are useful to them and their capacities. External refers to supportive relationships such as, partners, family, friends, faith or religious groups and also support groups. This helps the client identify new ways of bringing these resources to bear upon the problem.

4.4 POTENTIALS AND LIMITATIONS OF SOLUTION FOCUSED COUNSELING

According to Iveson (2002), "Since its origins in the mid-1980s, solution-focused brief therapy has proved to be an effective intervention across the whole range of problem presentations. SFBC has wide applications, especially in the school setting. The school counselor has an enormous task of providing counseling to all the students in the school.

Given this the practicing school counselors find it difficult to find the counseling theoretical approaches which can be effectively used for the school setting. Though the counselors need to know all the theoretical approaches including psychodynamic, behavioural, transactional analysis, cognitive behavioural, Adlerian and person-centred, they face a tough task to use the counseling strategies that can actually be applied given the realities of a school setting. In this scenario, the solution focused therapy offers them a great technique which has effective application in the school setting.

SFBC gives rise to immediate observable changes in the behaviour which the clients often want. Clients, parents and teachers or other stakeholders in counseling often want immediate change and solution to the problem. Solution focused therapy helps in bringing about quick changes. This also helps motivate the client.

Some of **the merits** of solution focused counseling can be mentioned as given below:

- SFBC is more action-oriented.
- It is brief as is indicated by its name and less expensive as less number of sessions are required.

- Counselors who use this method make a conscious use of time by engaging the client quickly and keeping the client focused on goals and priorities.
- SFBC is strengths-based. It focuses on the strengths and skills and resources of the client.
- SFBC uses the positive expectations of therapists to affect client success.
- Clear goals are identified early on in the process of solution focused counseling. Because of this, both client and counselor know what success will look like and can more easily identify when therapy is no longer needed.
- SFBC may help in reducing the symptoms of stress, anxiety, and depression and interpersonal relationships may be improved.

Self Assessment Questions

1) What do you mean by the 'miracle question'?

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2) Explain the meaning of positive goals and describe its importance in solution focused counseling.

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3) Discuss the advantages of solution focused counseling.

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4.5 CONCEPT AND MEANING OF INTEGRATIVE COUNSELING

Counseling field is marked by a myriad of theories each with its own assumptions, procedure and techniques, contributing to the common goal of helping the client. Each theory has its own strengths and limitations. A practicing counselor is required to understand the basic concept of all the theoretical approaches to counseling. However, when it comes to implementation, the counselor may get bound by the applicability of a particular approach to the concerned situation/context. For instance, it will be difficult to apply psychodiagnostic counseling approach in the school context. Counselors have their own preferences for a particular counseling approach which may not always be applicable and effective to the concerned client's problem and situation.

Hence there is a need to be flexible and integrate the theories in order to develop an individualised counseling style. The concepts and techniques can be borrowed from a variety of theoretical models, integrated and applied to phases of the counseling process from initial to termination stages. Integrative counseling is the process of selecting concepts and methods from a variety of systems.

However, counselors need to have a clear in-depth understanding of various theories, then only they will be in a position to integrate. Simply put, practitioners cannot integrate what they do not know (Norcross & Newman, 1992).

Thus integrative counseling is a real challenge in the sense that the counselor needs to know the clients and his situation, culture, background thoroughly in addition to the theoretical knowledge of various approaches in order to deliver success/result. Rather than stretching the client to fit the dimensions of a single theory, practitioners are challenged to tailor their theory and practice to fit the unique needs of the client (Corey, 2009).

Since the early 1980s, psychotherapy has been characterised by a rapidly developing movement toward integration. The reason behind this movement is the growing awareness that human behaviour is so complex to be explained by a single theoretical approach or a set of techniques pertaining to a particular counseling approach. Because no one theory has a patent on the truth, and because no single set of counseling techniques is always effective in working with diverse client populations, some writers think that it is sensible to cross boundaries by developing integrative approaches as the basis for future counseling practice (Lazarus, 1996).

4.5.1 Approaches to Integrative Counseling

There are multiple pathways to achieving an integrative approach to counseling practice. Three of the most common are technical eclecticism, theoretical integration, and common factors (Arkowitz, 1997). Technical eclecticism refers to selecting suitable techniques from different theoretical approaches according to the client's needs and resources and using those to achieve the counseling goals.

Whereas theoretical integration refers to generating a new theory based on the best of different theoretical approaches. Each theory has its own strong points and merits. Theoretical integration aims at taking those best pars of each theory and formulating a new theory which will be the best. The *common factors* approach attempts to look across different theoretical systems in search of common elements.

Although there are differences among the theories, there is a recognisable core of counseling composed of nonspecific variables common to all therapies. This perspective on integration is based on the premise that these common factors are at least as important in accounting for therapeutic outcomes as the unique factors that differentiate one theory from another.

Arnold Lazarus (1997), the founder of multimodal therapy, espouses technical (or systematic) eclecticism. Multimodal therapists borrow techniques from many other therapy systems that have been demonstrated to be effective in dealing with specific problems. This approach has been widely used. However, it should not be a mere collection of different techniques from other theories, the counselor should be sound in understanding each theoretical approach and justify the selection of counseling techniques.

Thus the counselor may have preference for a particular theoretical orientation. But during the process of counseling, he may decide on a range of counseling techniques

derived from different theoretical approaches and apply these in the counseling setting. This becomes much more significant and relevant especially in the present day multicultural and multilingual context.

However, the challenge is for counselors to think and practice integratively, but critically. In order to develop integrative approach to counseling, counselors need to have in depth knowledge of all the theories, then only they will be in a position to synthesize and integrate. As already pointed out, it is not simply borrowing techniques from different theoretical approaches. Developing an integrative perspective is a lifelong endeavour that is refined with experience. It requires time, effort and experience.

4.5.2 Potentials and Limitations of Integrative Counseling

Human being is always considered along the three dimensions of thinking, feeling and behaviour. An integrative approach to counseling focuses on the thoughts, feelings and behaviour of the client. Effective counseling should address all these three aspects of behaviour to achieve desirable goals. Hence the counselor needs to make use of the cognitive, affective and behavioural counseling techniques. Such a combination is necessary to help clients *think* about their beliefs and assumptions, to experience on a *feeling* level their conflicts and struggles, and to actually translate their insights into *action* programs by behaving in new ways in day-to-day living.

Preston (1998) contends that no one theoretical model can adequately address the wide range of problems clients will present in therapy. He says it is essential for therapists to have a basic grasp of various therapeutic models and for them to have at their disposal a number of intervention strategies. For him, the pivotal assessment question is, "What does this particular person most need in order to suffer less, to heal, to grow, or to cope more effectively?" Preston recommends that a practitioner's selection of interventions should be guided by their assessment of the client.

The limitations of the integrative counseling depends on the sincerity and seriousness with which the counselor approaches this. An undisciplined way of picking techniques from different counseling approaches is a major drawback of integrative counseling which the counselor needs to guard against. Integrative counseling involves real work and thorough understanding of different approaches and careful selection of various techniques keeping in mind the client's values, resources and cultural background.

Self Assessment Questions

1) Explain technical eclecticism.

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2) Discuss the challenges to integrative counseling.

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4.6 LET US SUM UP

The present unit describes two significant approaches to counseling such as Solution focused counseling and Integrative counseling. It has explained the meaning and assumptions of both solution focused counseling and integrative counseling. Given the present day realities of fast-paced life, no one has the time for spending long sessions in counseling. Further in certain settings, for example in the school context, immediate solution is required. Solution focused brief counseling has the answer to it. It focuses on the solution and starts with the solution in mind; and then works back to find out the modalities to achieve it.

The Solution focused counseling puts a premium on the client, believing in the client's capability to identify the resources available with him, capitalise on these and find the solution with the help of the therapist. Clients are able to deal with a wide variety of concerns using SFC if they are able to set a goal for change. The method is effective for many of the concerns with which clients come to the counselor. Integrative counseling has also started gaining acceptance as it is based on flexibility and having the client's betterment as its ultimate goal. However, it requires real effort and in depth knowledge and experience to successfully practice integrative counseling.

4.7 UNIT END QUESTIONS

1) Explain the key assumptions of solution focused counseling.
2) Taking a case example, describe the procedure of solution focused counseling.
3) Discuss the merits of solution focused brief therapy in the present day school context.
4) Client plays a central role in solution focused counseling. Elaborate.
5) Discuss the meaning and approaches of integrative counseling.
6) Discuss the advantages of integrative counseling in the present day context.

4.8 SUGGESTED READINGS

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