BLOCK 2
THEORETICAL APPROACHES TO COUNSELLING

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UNIT 4 PSYCHODYNAMIC APPROACH*

Structure

4.1 LEARNING OBJECTIVES

After studying this Unit, you would be able to:

- *Explain psychoanalytical approach to counselling/therapy;*
- *Describe the goals and techniques of psychoanalysis;*
- *Understand the role of counselor/therapist in psychoanalytically oriented psychotherapy;*
- *Explain insight therapy and its' goals; and*
- *Describe the evaluation of insight therapies including psychoanalytical approaches.*

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4.2 INTRODUCTION

Psychodynamic approach to counselling has its roots in the classical psychoanalysis of Sigmund Freud. In fact counselling as a discipline owes a lot to the ideas and techniques of Freud. In this unit we shall discuss those counselling theories that have retained some of the defining features of the psychoanalytic tradition. Hence they all are grouped under the umbrella term *Psychodynamic approach.* These theories share the following psychoanalytical thinking:

- Belief in unconscious and psychic determinism (thoughts, feelings and behavior of the individual is determined by unconscious motivation or childhood events).
- Behaviour is the result of the interplay of internal drives.
- Role of childhood experiences, especially the first five years, in determining one's personality and present life issues.
- Client's insight during therapy as the key internal mechanism for change to occur.
- Use of defense mechanisms by the ego to avoid feeling anxiety

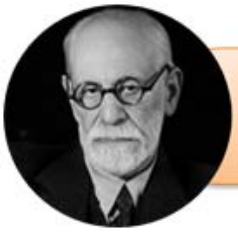
All these will be elaborated in the next section.

PSYCHODYNAMIC = PSYCHE + DYNAMIC

The term psychodynamic is a combination of *psyche* (soul translated as mind, spirit, or self) and dynamic (referring to the idea of forces, often moving in different and opposing directions)

Thus the psychodynamic approach is based on the concept of conflicting forces - inner drives, wishes, memories, and ideas – which interact within the psyche and are largely unconscious. The various theories that come under the approach differ in terms of the emphasis they lay on Freud's original ideas and techniques. However, in therapeutic practice they are quite similar. In this unit we shall study psychoanalysis proper or classical psychoanalysis, psychoanalytically oriented psychotherapy and insight therapy.

The psychodynamic therapies can be conceptually seen as existing along a continuum, with the most insight-oriented, exploratory and expressive on one end and the most supportive type at the other end of the continuum. At the expressive end of the continuum, lies psychoanalysis, with its focus on concealed meanings, past experiences and the relationship between the therapist and client, followed by analytically oriented psychotherapy. At the supportive end of the continuum, aimed at treating severe problems, the therapist provides more support and focuses on healthy adjustment and coping mechanisms.



Sigmund Freud was a student of neurology and spent 6 years dissecting brains of frogs to study them before he became the father of psychoanalysis

"The interpretation of dreams is the royal road to a knowledge of the unconscious activities of the mind".

4.3 PSYCHOANALYSIS

Psychoanalysis broadly refers to three things: a) a model of human and personality development, b) a theory of personality and human nature and c) a form of psychotherapy. In the present unit we shall be using it in the third sense. Developed in the 1890s by Austrian neurologist Sigmund Freud, psychoanalysis can be seen as a set of therapeutic techniques that help an individual release pent-up emotions or repressed thoughts, feelings and memories. Freud's theory was based on his observations and careful study of his own patients (cases). His interest in the role of the unconscious in influencing human behaviour was a result of the intriguing case of 'Anna O', who experienced physical symptoms like visual disturbances, speech problems, and partial paralysis without any apparent physical cause. It was only when she was able to recall memories of traumatic experiences in childhood that she had repressed (blocked), that her symptoms subsided. Her case was published in a book 'Studies in Hysteria' (1895) by Sigmund Freud and Josef Breuer. Breuer was Freud's colleague who was actually treating Anna O. It was Breuer who relayed the case to Freud. On the basis of this case Freud hypothesised that childhood sexual abuse or repressed sexuality was the basis of hysteria (later on called as psychosomatic disorder).

4.3.1 Psychoanalytic Theoretical Principles

In order to understand psychoanalysis as a method of therapy, one needs to understand certain concepts.

Role of Unconscious and Psychic determinism:

According to Freud, individuals are unaware of a big portion of their psyche - which he called the *unconscious.* As can be seen from the diagram (Fig. 4.1) below, all three elements of a person's personality - Id, ego and superego - are at least partially submerged in the unconscious. Freud hypothesised that the *unconscious* was composed of all the emotions and desires that would *threaten* the wellbeing of an individual if they were to

become conscious, e.g., past trauma and aggressive desires. It also contains the *most basic impulses* that are not expressed in society as directly anymore, for example, the desire to defend one's territory and kill others in doing so, which was necessary for our evolution but is no longer needed or desirable; and the desire to procreate, which in modern society has become a source of shame and guilt (particularly for some communities more than others). Finally, the unconscious also includes thoughts of self-harm and self-destruction.

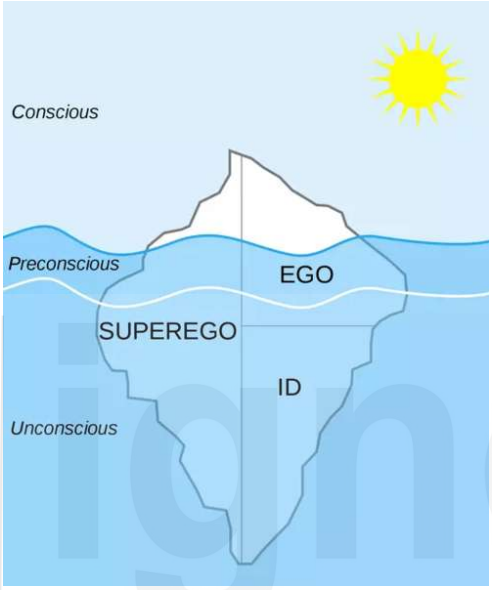


Figure 4.1: The Three Levels of Psyche given by Sigmund Freud

Source:
https://commons.wikimedia.org/wiki/File:Diagram_of_Freud%27s_Psychoanalytic_Theory_of_Personality_.webp

Freud believed that the conscious mind put all these emotions, beliefs and tendencies out of the awareness to protect an individual. These thoughts were deemed unreasonable or unacceptable. And in order to protect oneself from these dangerous thoughts, Freud suggested that individuals used *defense mechanisms* which allowed these things to be stored in the unconscious without any conscious processing.

In this way, Freud suggested that human actions were a result of unconscious desires. This meant all the actions that we described as *"accidental"* were a result of unconscious desires and even actions we described as *"intentional"* actions towards our career goals, or helping our friends, were actually rooted in unconscious desires. This tendency to view behaviour as a result of something predetermined and not free choice is known as *determinism.* When it is believed that the unconscious determines one's behaviour, it becomes a subcategory of determinism known as *psychic determinism.*It proposes that there is an underlying psychological explanation for every emotion, thought, impulse, and behaviour (Sommers-Flanagan & Sommers-Flanagan, 2015, p.45), for instance, if you get angry

at your colleague at workplace for no reason, may be he reminds you of your earlier boss who was very demanding and wanted perfection.

The Structure of Personality

Freud gave a tripartite theory of personality, that is, an individual's personality comprised of three distinct parts such as the Id, Ego and Superego.

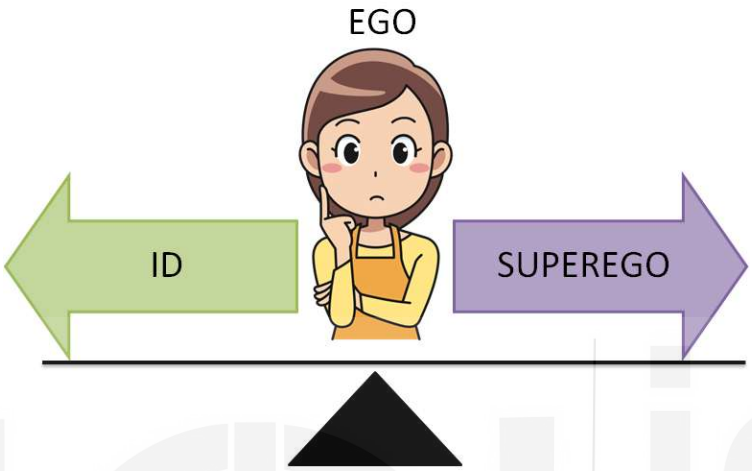


Figure 4.2: Freud's Tripartite Personality Theory

1) The Id

What it is: The id is the only component of personality, according to Freud, that is completely unconscious (as can be seen in the iceberg diagram above). It includes biological desires and contains two of the most basic urges of human beings: *aggression and sex*. Going back to our evolution, it becomes obvious why these two would be the most basic impulses. Aggression was labelled the death impulse *(Thanatos)* and sex was labelled the life impulse *(Eros)*. As the human being only needed to think of surviving and procreating during that time, we have all inherited these traits from our predecessors. However, in today's world, these impulses have either no or much less of a role. We hardly have to fight fellow human beings to survive anymore and procreation is something that has been shifted to the back burner and things like career, education and other activities have taken the front seat. While during the early days of our species, anyone who attained puberty would have to fight and procreate, now a child that age is considered a young student, who hasn't even graduated from class 12th.

What it wants: The id wants to fulfil all its desires and act on all the basic instincts. It wants the individual to act impulsively and take whatever she desires, without caring of anything or anybody else. The id does not care for the complicated cognitive processes that humans have developed since: like self-regulation, empathy and feelings of community. Whenever we fail to let the id express itself, we experience longing and intrusive thoughts (thoughts which occur when

we are at work or immersed in something else and disrupt our attention).

What principle does it function on: The id functions on the *Pleasure Principle:* i.e., it would want to do anything that provides a person with momentary pleasure.

2) The Superego

What it is: This is the part of the personality that contains all our "shoulds". It contains our ideal self (what we *should* be and do) and our conscience (largely derived from what the society thinks we *should* be and do).

Going back to the iceberg diagram (Fig.4.1), you would see that the superego takes up the most space and is equally in the conscious and the unconscious areas of our psyche. This shows how expectations we have from ourselves and expectations that others have from us are *deep-seated* and therefore, when we act against these expectations, for example even when we oppose our parents over something that is valid and important, we are punished by the superego in the form of feeling guilt and shame.

Unlike the id which is passed down to us from our forefathers and is present in us even as babies, the superego is acquired through our experiences. Children develop the superego by the ages of 3-5 years. As this superego is not a need, but an internal representation of external values, interaction with other humans and society becomes important to develop it.

What it wants: It wants individuals to be good boys or good girls in the eyes of society, follow the moral values. Whatever image that we create of the perfect version of ourselves also comes into play here. When the superego does not get its way, we experience emotions of shame and guilt (as discussed above) but also feelings of being dirty, less-than, etc., all of which make us want to behave in accordance with the wishes of the superego.

What principle does it function on: The superego functions on the principle of *Morality.*

3) The Ego

What it is: The ego is that part of the personality that is situated mostly in the conscious and preconscious area of the iceberg. It is the part of our personality that is visible to other people. It operates in the real world, within an objective reality. Its function is to sustain a person on the basis of this reality (as opposed to surviving on impulses or ideals).

The ego serves as a middle man between the id's desires and super ego's demands to channel a personality that balances the extremes and tries to achieve pleasure and resist pain. This makes the ego the

decision making component of the personality. The strength of a person's ego determines their mental health. Since ego is the part of the personality that tames the id and avoids pain while keeping social demands in mind, if the ego becomes weak, the personality can become extremely impulsive or extremely fearful of society. In this way, a healthy ego is a marker of good mental health.

What it wants: The ego aims to provide a compromise between the other two extremes of the personality. Sometimes the metaphor of the horse and horse rider is given to understand the relationship between id and ego. The id is an untamed horse and the ego is the horse rider who tames it. In this metaphor two things can be noted about Freud's concept of ego, one, both the id and ego seek pleasure, though in separate ways; and second, the horse (id) is stronger in might as compared to the rider (ego). Freud believed that the ego seeks pleasure and avoids pain. As opposed to the id which wants pleasure without regard to the society's rules, the ego tries to look for ways to obtain pleasure through socially sanctioned ways. Also unlike the id, the ego uses all higher order thinking methods to obtain its goals and calculate the best way to attain pleasure.

What principle does it function on: The ego functions on the basis of the *Reality principle*.

According to Freud, ***anxiety*** is a result of intrapsychic conflict. When the three components of personality begin fighting for domination, anxiety is born. He described three types of anxieties based on the components which is dominating the fight:

- When the superego begins dominating the ego with demands , the individual fears violating his morals and virtues. This is called *moral anxiety.*
- When the urges of the id grow so intense the the the individual begins fearing the loss of control over his/her urges, it is called *neurotic anxiety*.
- Anxiety based on real-world events where the cause can be pointed out easily (like a snake or earthquake) is known as *reality anxiety*.

Defence Mechanisms

The ego makes use of different defenses to protect itself from being overwhelmed due to these different anxieties. They are called defence mechanisms or ego defenses. They are strategies that are unconsciously used to ward off anxiety arising from unacceptable thoughts or feelings.

Some of the ego defense mechanisms are presented below.

1) **Repression:** This is the principal defense mechanism where the ego *unconsciously* pushes the painful, troubling or threatening thoughts,

experiences, events into the unconscious. A lot of survivors of childhood abuse tend to forget the details of the abuse. This has not happened because they *wanted* to forget, but because the psyche couldn't go on functioning with the memories of trauma continuing to remain in conscious memory.

2) **Regression:** During stressful times we go back to behaving in ways as we did as a child, e.g., reverting to thumb sucking when in a stressful situation.

3) **Suppression:** When the ego *consciously* tries to push experiences into the unconscious, it is known as suppression. An example of this would be trying to forget being scolded in a class.

4) **Displacement:** When the impulse is satisfied by substituting the object. For example, a woman who is upset with her mother-in-law might show her anger on her child.

5) **Denial:** Overwhelming situations are blocked by the ego from awareness. For example, believing that COVID-19 is a hoax or showing unwillingness to take vaccination for it.

6) **Intellectualization:** This defense mechanism uses intellectual components to distance painful emotions related to an event. Its aim is to relieve anxiety that is attached to a particular event. An example of this would be telling oneself that a loved one who has passed away has gone to a better place, and is no longer sick and in pain. In this way, sense can be made of a loved one's death, without it causing a psychological breakdown.

7) **Rationalization:** When an individual uses logic to explain his or her mistakes away, it is called rationalization. It absolves an individual of accountability, e.g., saying "he was the one who hit me first" as a way to justify physical violence.

8) **Reaction formation:** When the ego cannot accept the unconscious desires and beliefs, it transforms the individual to act in a way which is completely opposite of those very thoughts and beliefs.

9) **Sublimation:** Freud believed this was a defence mechanism which was not only accepted, but celebrated by society. Sublimation is when an individual can express one's basal needs (sex and aggression) in another form. He believed all forms of arts and sports were sublimation.

10) **Projection:** This defence mechanism was an addition made by Freud's daughter, Anna Freud. She believed that individuals tend to attribute their own unacceptable motives, emotions and feelings onto others. For instance, if an individual feels attracted to his cousin, the superego would forbid such an attraction and this individual would settle it by believing that actually it's the cousin who's attracted to him.

4.3.2 Goal of Psychoanalysis

The overarching goal of psychoanalysis is to make the unconscious conscious. Thus resolution of problems lies in the understanding and resolution of unconscious conflicts, strengthening of the ego, reducing the intensity of instinctual strivings as well as superego's demands and facilitating insight into one's unconscious. This results in enhancement of client's coping and adjustment to life.

The mechanism through which these goals are attained is called *insight.* Insight has been defined as the self-realization or self-knowledge that occurs when the client gets in touch with their unconscious mind and is able to connect past experiences and conflicts with the present problems and behaviour.

The insight into the unconscious dynamics leads to the reorganization of personality. This self-understanding is brought about through the analysis of childhood experiences, significant past relationships, and interpretation of the unconscious material brought forth in therapy.

In psychoanalysis, analysts are more likely to allow the full exploration of unconscious and early childhood development as compared to what psychoanalytically oriented counsellors do.

Role of a classical psychoanalyst is that of an expert, detached and distanced. Neutrality and abstinence are the two central stances adopted by a classical analyst. Neutrality fosters a "blank-screen" approach with little self-disclosure and affective expression. This is regarded as essential to promote projections of clients on to the therapist (a process termed transference, which we will study under the section on techniques). Analyst's subjective experiences and reactions to the client are considered to contaminate the therapeutic process. Therefore the analyst is expected to adhere to the rule of abstinence - that is avoiding expression of affection, advice or displaying too much of their own issues.

This in no way implies that the analyst is aloof or non-caring. Rather, the analyst is deeply involved in understanding the client's inner world and listens attentively to all that the client is saying or not saying.

The therapist's main task is that of interpretation – interpretation of the unconscious material shared by the client during therapy.

It is important to note that such an objective neutral stance of a therapist characterized classical psychoanalysis. Contemporary variations have moved toward a more active stance, where the analyst doesn't ignore his/her subjective experiences and reactions. They rely on their feelings to understand and empathize with the feelings of the client, a process that is called counter-transference.

A primary ***requirement for a client seeking psychoanalysis*** is the readiness to commit to an exhaustive long term therapy (2-4 times per week for 3-6 years). Another requirement from the client is adherence to the fundamental rule, i.e., speaking freely whatever comes to their mind without any kind of censorship. Usually, the analysis is conducted with the client lying on a couch and the analyst sitting in a chair behind him/her. This enables the client to deeply reflect and speak without much interference. This is necessary since all that the client shares becomes the material for interpretation.

The therapy eventually is able to answer some of the client's why questions, as the client gains insight into the workings of the unconscious (Why a particular symptom occurs? Why does the client feel a certain way? What patterns are repeating in the client's life?)

4.3.3 Techniques in Psychoanalysis

Psychoanalysis is a technique driven approach to therapy unlike other approaches such as the person centred approach. These techniques are used by the psychoanalyst in the safe environment of a clinic or an office. Clients are asked to lie down on a comfortable couch and to face away from the therapist so as to reduce any inhibition or intrusion by the presence of the therapist.

Interpretation:

Interpretation is the key technique in psychoanalysis, as it is a part of all the techniques that we shall discuss below. It comprises the explanations provided by the analyst to the client with respect to his/her behavior, based on the theory of psychoanalysis. The analyst helps the client understand the meaning of past and present behaviours, their symptoms, conflicts, emotions and other experiences in the light of repressed id's irrational impulses, defense mechanisms and resistances of the ego, the punitives of the super ego, role of parents and caregivers, emotional challenges while growing up, underlying motives etc.

It is the means by which the material that is repressed in the unconscious is brought forth into the client's consciousness. Dreams, free association, resistances, therapeutic relationship (transference) serve as the sources of material for interpretation.

Interpretation serves an important function, i.e., it allows the ego to integrate new understanding and insights (into awareness) and expedites the uncovering of the unconscious mind. Thus the life energy that was used up in repression and other defenses becomes free for healthy use.

Interpretations need to be timed appropriately as per the readiness of the client. If the client is not in a position to listen to, tolerate, incorporate or work with the interpretations, change is not likely. The analyst should also

base the interpretation on sufficient material shared by the client, and avoid premature conclusions. Offering partial interpretations over a number of sessions throwing light on the unconscious working of the client's mind can also be done.

Free Association:

In free association clients are encouraged to be relaxed and speak whatever comes to mind, without applying any kind of reasoning. At times they are also asked to recall childhood memories or difficult emotional experiences. The key is to suspend all kinds of rational judgment, self-criticism and censorship. The therapist provides reassurance that everything the client is speaking is relevant.

The assumption is that when free association flows spontaneously, the repressed material buried in the unconscious gets released. In the typical psychoanalytical parlance, it is the id that speaks, and the ego is silent, thus the repressions are lifted to some extent. It often results in catharsis (release of intense emotions). Free association also forms the basis of dream interpretation.

The analyst listens carefully to unravel the hidden meaning, with the assumption that everything the client speaks is relevant and reveals the unconscious. Special attention is given to any kind of resistance that client shows during free association like blocking thoughts, silence etc. and is interpreted. Resistance is the reaction by the ego to any anxiety arousing repressed material (thoughts, conflicts, wishes, memories) that might come up in free association. The task of the analyst is to identify the repressed material and see connections between events.

Resistance:

Any change process is met with inhibitory forces. So is therapeutic change, which is often met by resistance on part of the client. It is anything that works against the progress of therapy and stops the client from generating previously unconscious material. It is a kind of reluctance to reveal, that gets manifested in diverse behaviors. Side-tracking the discussion, refusing to recall dreams or childhood memories, changing the subject of discussion, irrelevant small talk, missing appointments with a therapist, coming late for therapy or postponing sessions, not paying fees, forgetting to do what was agreed upon in therapy are all interpreted as resistance.

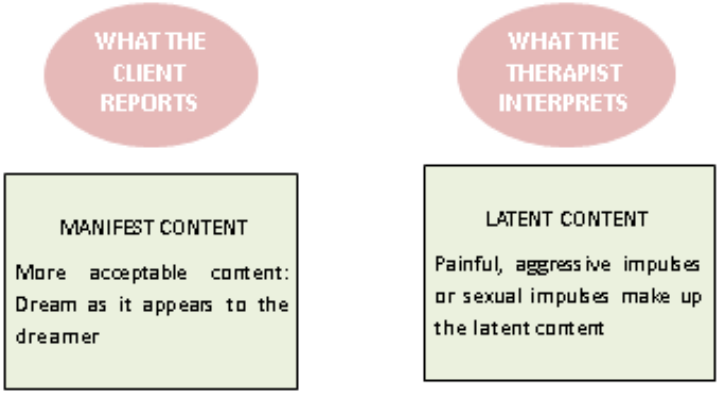
The analyst deals with resistance immediately. Client might or might not be aware of the resistance in him/her. However, the reasons for resistance are largely unconscious. They are basically defenses against the unbearable anxiety or pain that would result when the client becomes aware of the unpleasant repressed thoughts, feelings, impulses, memories etc during the course of therapy. This is repression resistance. Resentment could also set in when the analyst does not cater to the client's unreasonable and

unrealistic expectations, resulting in what is called transference resistance. Some resistance stems from the unwillingness to forego the secondary gains (like getting attention, avoiding responsibilities) from illness. Resistance comes from the id too, as the therapy puts a stop to the need gratification that was happening through symptoms or changes the direction/object of need satisfaction. When a sense of guilt for getting better or a sense of deserving punishment in the form of illness arises in the client, it is resistance of the super-ego.

Dream Interpretation:

In psychoanalysis, dreams are considered as the "royal road to the unconscious". It is because dreams are regarded as disguised forms of unconscious material. All the traumatic, unacceptable, painful experiences, conflicts, motivations and emotions are buried deep within the unconscious. Dreams are symbolic expressions of these. They are a compromise formation (the process by which ideas, memories or wishes that are repressed become safe for expression). The expression is not direct but disguised, as direct expression would be too painful for the ego. Thus dreams could fulfill desires, wishes, fears or needs which were too threatening for the individual to fulfill directly in reality. For example, sexual desires in childhood are often repressed. The ego defenses are weakened during sleep and hence repression is lifted, and the unconscious materials take the form of dreams. Dreams have both conscious as well as unconscious elements. The conscious elements results in those aspects of dream which relates to our real life and appears familiar. While the unconscious element looks unfamiliar and often bizarre.

Content of dreams has been divided into two: latent content and manifest content. *Latent content* consists of all the hidden aspects of the unconscious finding expression in symbolic language, the true meaning of which has to be interpreted. *Manifest content* consists of all the observable, conscious aspects of dreams that the dreamer sees with apparent meaning.



In interpreting dreams, the client is encouraged to free-associate to the various aspects of the dream and to recall feelings associated with parts of

the dream. The client free associates with the manifest content, while the analyst derives the underlying hidden meaning (latent content). While the client is engaged in exploration of the dream through free association, the therapist/analyst looks through their associations to look for links and patterns. The interpretation offered by the therapist helps clients become aware of the repressed aspects of their life, thus getting new insights into their problems.

Transference and interpretation of transference

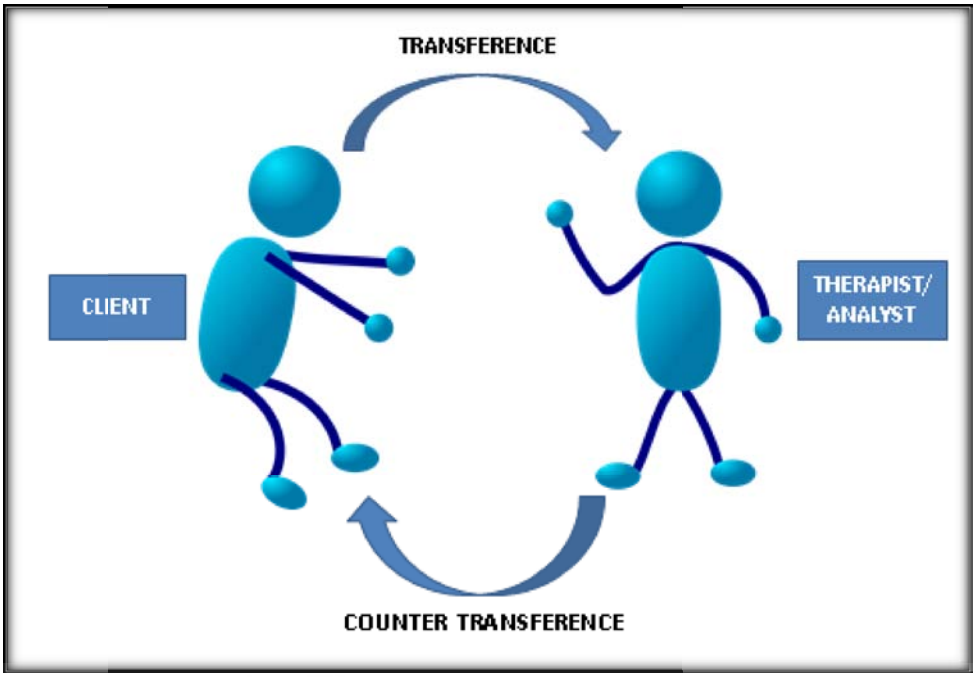
This technique deals with the relationship between the client and the therapist/analyst. Transference occurs when clients redirect onto the counsellor their emotional response to a past significant relationship, often unconsciously. In the context of therapy, it is the client's emotional response to the counselor as he/she did to some significant other in childhood like father, mother or sibling. *Transference* feelings are not based on real relations between client and the therapist; it operates on an unconscious level. It is the reproduction of past relational patterns in the present context with the therapist. Transference is cathartic, as it gives the client an opportunity to re-experience inaccessible feelings and emotions that were repressed in the past.

Transference could be positive or negative. When the client projects positive emotions like love and respect, onto the therapist, it is positive transference. When the client projects negative emotions like anger and frustration, it is negative transference.

Transference is an extremely valuable aspect of psychoanalytic treatment. It gives deep insights into how the past relationships of the client are influencing their present functioning. Depending on the kind of past relationship that is being replayed with the therapist, transference could be paternal, maternal etc.

- Paternal transference occurs when the client looks to the therapist as father or idealized father figure who is supposed to be wise, authoritative, controlling or powerful.
- Maternal transference occurs when the therapist is perceived as a mother or an idealized mother figure who is expected to be comforting, loving, nurturing.

Therapists/analysts are trained to look through the transference reaction and not react to them. If the therapist does not understand the reasons for the feelings that the client has towards them, and starts reacting to them, therapy could be hindered, e.g., if the analyst gets flattered on receiving love or admiration from the client and starts responding to the client based on the same. Supervision of counsellors is must in this regard.



This brings us to another technique, not so much used by classical psychoanalysts, but by other modern psychodynamic therapists. It is called *counter transference.* It is the therapist's emotional response to the client. It can also be seen as therapist's transfer of feelings from the past into the present relation with the client.

Countertransference reactions induced in the therapist can also be utilized to understand the clients' issues better, thereby helping the client achieve deeper understanding of his problems.

In this context, objectivity on the part of the therapist in responding to the client is required, so that therapists personal issues do not influence their reactions to clients. For example, a therapist might see the client as a helpless victim because of his/her need to control and end up overprotecting the client. Overprotecting the client could hamper clients' autonomy in therapy. Hence the therapist can take supervision to examine counter-transference. Objective counter transferenceis used to understand the feelings that the client is unconsciously communicating.

4.3.4 Evaluation of Psychoanalysis as Therapy

The fact that psychoanalysis is still practiced today after over a century of being first advocated proves its merit. The theory has been developed, updated and has inspired many other forms of therapy. Concepts like transference, defense mechanisms, resistance, dreams are utilised in other therapeutic approaches as well. The approach provides support for a number of diagnostic instruments like Thematic Apperception Test, Rorschach Inkblot tests and other projective tests and techniques. It was the first theory that affirmed childhood sexuality and inspired a lot of research.

However, psychoanalysis continues to be one of the most controversial approaches to psychotherapy. Some significant criticisms of psychoanalysis are listed below.

- It is an intensive form of therapy that is expensive and long. Hence, it is not preferred by individuals preferring a brief, problem-focused or economical approach to therapy.
- In traditional psychoanalysis, the anonymous and detached stance of the therapist creates a sense of aloofness and distance which can be difficult for some people to accept
- The therapeutic approach is available mostly in urban areas, limited to educated, middle to upper-class clients and also clients who have enough ego strength to engage in self exploration or work through conflicts. Thus it is not suitable for psychotic or disoriented clients.
- It is not useful for older clients or people who have memory lapses.
- It is not very effective for clients in crisis or bereavement.
- Thorough rigorous training required for the counselor, which is costly, time consuming and requires emotional commitment of the practitioners (mandatory personal therapy of considerable duration).
- The approach is highly deterministic in nature and ignores the impact of cultural and social factors.
- Many of the hypotheses or assumptions of psychoanalytic theory cannot be tested by empirical means, or the concepts are difficult to define. This makes empirical research difficult.

Despite these criticisms, research has found credibility in Freud's therapy. Fisher and Greenberg (1977) did a synthesis of 2000 individual studies on psychoanalysis and found support for its efficacy.

To make it more responsive to the needs of managed care and brief therapies, shorter versions of psychodynamic therapy are being developed. Psychoanalytic oriented psychotherapy is one such version. It focuses on specific problem areas, the treatment is more individually designed and the therapist plays a more active role in interpreting.

Self Assessment Questions 1

Choose the correct answers for the following questions.

1) The primary aim of analysis of transference is:

   A) increase client's insight into themselves

   B) increase client's insight into how they relate to others

   C) Increase client's insight into their dreams

   D) Reduce the intrapsychic conflict of the client

The defense mechanism that pushes our unwanted thoughts and feelings into the unconscious and out of our awareness is called

A) Regression

B) Rationalization

C) Repression

D) Projection

2) Lata is an adult *client with depression and suicidal ideation. During one session, Lata began to speak in a little girl's voice and style. What defense mechanism is she engaging in?*

A) Regression

B) Reaction formation

C) Projection

D) Repression

3) According to Freud what are the two major components of dream?

A) manifest content, presenting content

B) latent content, dynamic content

C) latent content, presenting content

D) latent content, manifest content

4) Which part of personality functions as the conscience?

A) Ego

B) Id

C) Preconscious

D) Superego

Psychoanalytical school of thought underwent many changes. While most changes were a collective work of multiple psychologists across the globe and across generations, here a few important contributors relevant to the discipline of counselling and psychotherapy

Carl G. Jung (pronounced "Yoong") added the concept of a ***collective unconscious*** to the field of psychoanalysis , believing that our unconscious is not just made of our personal thoughts but of all the unconscious thoughts of our predecessors. He also explored religious and spiritual nature behind human behaviour. His niche of psychoanalysis is known as analytical psychology

Erik H. Erikson added social dimensions to psychoanalysis and gave a psycho-social theory of development. He expanded psychological growth to cover the entire life span and famously coined the term ***"identity crisis"***

Anna Freud, daughter of Sigmund Freud, added to the field the importance of a healthy ego. Anna focussed on the development of both, a healthy and a pathological ego and her contributions are called ***"ego psychology"***. She also pioneered an approach to child psychoanalysis

Karen Horney (pronounced "Horn-eye") was a voice of ***feminism*** in the field of psychoanalysis, and she questioned many of Freud's theoretical suppositions built on a bedrock of patriarchy. Her contribution to the field was ***the theory of neurosis***, which examined the role that parental indifference played in the disorder

Otto Kernberg, developed ***transference focussed psychotherapy***, specifically for the treatment of borderline personality disorder. He is an influential contemporary figure in this field. Listen to his lecture on psychoanalysis provided in the "web resources" section of this chapter.

4.4 PSYCHOANALYTICALLY ORIENTED PSYCHOTHERAPY

To put it simply, psychoanalytically oriented therapy can be regarded as a milder form of or low intensity psychoanalysis. The reason for the same is the flexibility in approach that a psychoanalytically oriented therapist takes, unlike a classical analyst. One of the prominent reasons for its development is practical considerations. As we have seen, psychoanalysis as a therapy is not very popular, as clients find it extremely intensive, long (lasting for several years) and expensive. Psychoanalytically oriented psychotherapy aims to widen the accessibility of the theory and practice of psychoanalysis to a greater number of people and also to a wide variety of problems.

The number of sessions usually ranges from 1 to 2 times a week in contrast to 3 to 5 times a week in psychoanalysis. Therapy could last from a few months to years. The patient usually sits up in the treatment in contrast to lying on the couch as in classical psychoanalysis.

It is the contemporary approach utilizing modified psychoanalysis. It is brief and time-limited, and therefore not as intensive as psychoanalysis proper. The therapeutic relationship is more interactive and more emphasis is placed on the ego functioning as compared to id. More focus is on current problems rather than early childhood experiences.

Psychoanalytic psychotherapy is widely practiced and is quite successful in treating a wide range of conditions like emotional problems. It is also sought by individuals who would benefit from psychoanalytic treatment but cannot make either the financial or time commitment to psychoanalysis.

Psychoanalytic psychotherapy has limited problem-focus as compared to psychoanalysis proper. It focuses on core issues of the client's life and personality. Greater emphasis is on helping the client deal with real life problems, through the exploration of the intrapsychic factors.

The **goal** of psychoanalytic psychotherapy is to help the client explore their internal life and create a capacity for self-reflexivity. Psychoanalytic psychotherapy creates in client awareness and reflection, which results in on-going symptom reduction and resilience.

The outcome is a healthy re-synthesis of the personality and a reorganization of the psychic forces (forces emanating from id, ego and super-ego). The ego is strengthened so that it can be less defensive, face external reality better and master inner tensions.

The above mentioned goals are attained through the creative process of interpretive dialogue between the therapist and the client, in which each contributes to discovering how the client thinks, feels and behaves. The

techniques used in psychoanalytic psychotherapy are the same as in psychoanalysis that we have covered earlier in detail. Interpretation is the key and there is reduced emphasis on free association. It relies strongly on transference interpretation. However, the frequency of sessions is lower as compared to classical psychoanalysis.

Strupp (1955) states that psychoanalytically oriented therapists use a variety of techniques, preferring exploration but also using passive acceptance, structuring, interpretation, and reassurance among others. They make use of suggestion, support, empathy, questions, and confrontation of resistance, as well as insight-oriented interventions in the form of clarification and interpretation (Patton & Meara, 1992).

Unlike the classical psychoanalysis in which the client lies down on the couch, in psychoanalytically oriented therapy the therapist and the client sit face to face, and interact with each other.

4.4.1 Role of the Counsellor/Therapist

Unlike classical psychoanalysis in which the therapist is expected to maintain "neutrality", in psychoanalytically oriented psychotherapy neutrality has sometimes to be suspended in order to stop severe acting out (Rössler-Schülein & Löffler-Stastka, 2013). The therapist plays a more active role in the use of techniques. He/she is involved in a give-and-take interaction with the client and guides the session more actively.

Psychotherapists who practice psychoanalytically oriented psychotherapy undergo rigorous training and supervision, often by other practicing psychoanalysts.

The therapeutic alliance and relational impact

The therapeutic alliance, as described by Bordin (1979), consists of three main components: agreement on: i) *goals* and ii) on the therapeutic *task*; and iii) the emotional *bond* between the client and the therapist. This conceptualization of the relationship between the client and the therapist not only emphasizes the classical Freud's formulation of unconscious distortions in the therapeutic relationship, but also underscores its conscious and collaborative aspects.

Psychoanalytically oriented therapies rely strongly on the therapeutic relationship. The idea is that the transaction and experience inherent in the client-therapist relationship contains curative elements. The therapeutic interaction leads to repairing skewed development of the client that have its origin in childhood experiences with family members or other important caregivers early in life. The outcome of this interaction is usually insight. It is a kind of relational learning that is called *corrective emotional experience* (Alexander & French, 1946). It lets the client re-experience the past unresolved conflict, but give a new ending to it. For instance, there

might be ruptures in the therapeutic relationship which needs to be negotiated by both the therapist and the client. This reparation of therapeutic relationship provides opportunities for corrective emotional experience, at times through the confrontation of client's defences or through the analysis of transference reactions.

It is also through *internalization* that change is facilitated(Gabbard & Westen, 2003). When the client develops some attributes or affective attitudes that originally belong to the therapist, it is called internalization. For instance the client might internalize the ability to self-soothe after repeatedly being soothed by the therapists or the ability to self-reflect after internalizing the therapist's analytic attitude.

4.4.2 Evaluation

Psychoanalytically oriented psychotherapy emerged due to the falling interest in classical psychoanalysis. Relatively smaller number of therapists practice psychoanalysis proper, as brief, time-limited versions of psychodynamic therapy are becoming more popular.

Psychoanalytic oriented therapy is more interactive, emphasises ego functions in contrast to the id, and focuses on current problems more rather than early childhood experiences. Blomberg, Lazar and Sandell (2001) provide strong support for the relevance of psychoanalysis. Psychodynamic therapy is effective in treating people suffering from depression, somatoform disorders, anxiety, relationship difficulties, self-esteem issues, sexual issues and many more.

It can be noted here that insight is at the foundation of psychodynamic therapies. Let us now look into the depths of insight therapy.

Self Assessment Questions 2

1) What led to the development of psychoanalytic oriented therapy?

   ……

   ……

   ……

2) How is psychoanalytically oriented psychotherapy different from classical psychoanalysis?

   ……

   ……

   ……

4.5 INSIGHT THERAPY

The APA dictionary of Psychology defines insight therapy as any form of psychotherapy based on the theory that a client's problems cannot be

resolved without his or her gaining self-understanding and thus becoming aware of their origins. The therapist's task is to help the client understand how their beliefs, thoughts, feelings, experiences and life events from their past impact their present issues and concerns. The past that we bury inside does have a rippling effect on our present.

There are different *types of insight therapies – psychoanalytic, psychodynamic, gestalt, existential and humanistic*. All these approaches to insight have the common emphasis on client's in depth exploration of their self-in-context, and involves interaction between the client and therapist. Depending upon the approach, the client would explore the deeper levels of their unconscious and their past or they would uncover their existential authentic self.

In this section we shall discuss insight therapy from the psychodynamic perspective.

Jopling (2001) summarizes the standard view of insight therapy as:

"(a) Insight-oriented psychotherapy is a valid method of personal discovery that allows clients to discover truths about themselves, and to acquire bona fide self-knowledge; (b) the methods of the insight-oriented psychotherapies have specific and non suggestive effects; (c) one of the primary agents of therapeutic change in the insight-oriented psychotherapies is the therapist's use of interpretations; and (d) the client's acquisition of truth-tracking insight is a necessary condition for therapeutic improvement." (p. 22).

4.5.1 Goals of Insight Therapy

As the name suggests, the goal of insight therapy is facilitating insight in the client. The idea that increasing the client's insight into his or her own unconscious psychological processes leads to change may be regarded as the core of the psychoanalytic tradition. It must be noted that insight cannot be given or planted by the counselor, rather through interaction with the counselor and self explorations the client arrives at insight.

The goal of this therapy is to make the clients' unconscious fears, unconscious desires and unconscious motivations conscious. This would give the client the required freedom to overcome hurdles, symptoms or behaviors that are currently impacting clients' functioning. Insight therapy aims at helping the clients resolve conflicts and issues related to the following:

a) Childhood: Going back to the client's childhood is central in psychoanalytic insight therapy. A person's childhood can have a significant impact on their adult life. What we go through as a child shapes future experiences in life, shapes our personality, thoughts and beliefs. For instance, a child who lacks a warm and close relationship

with their parents might grow up to be a very withdrawn person who dislikes connecting with others.

b) Abuse: Experiencing some kind of physical or sexual abuse in the past might also come up during insight therapy.

c) Struggles with interpersonal relationship/ Troubled relationship in the past: An individual's struggle with different relationships, e.g., with colleagues or friends or others in general might be indicative of an unhealthy relationship with a significant other in the past. This could also have roots in difficulties with parents or caregivers while growing up.

Studies have shown that as the client gains insights into their problems, which is basically understanding the unconscious causes of the problems, their symptoms get reduced.

From the psychodynamic perspective, insight can be defined as getting in touch with the unconscious and bringing the unconscious into the conscious. It is realizing the connections between past experiences, feelings, motivations and conflicts which have been repressed, with present behaviour, problems and perceptions. Insight can be a sudden flash of realization or a gradual self understanding.

Insight is both cognitive and emotional. Merely intellectual insight does not lead to behaviour change. For insight to be effective it needs to be accompanied by intense emotional experience. Thus insight is accompanied by catharsis - expression of pent up and repressed emotions. Freud regarded emotional insight as the most potent form of insight.

Insight can be the revelations of the maladaptive defenses being used to ward off anxieties or conflicted emotional states, recognition of unmet needs and motivations underlying behavior or relationship patterns, understanding symptoms or overt behaviour as a form of disguised inner conflicts, linking transference reactions and past relationships etc. In particular, increased understanding of recurrent patterns of maladaptive relating to self and others is often emphasised.

Jopling (2001) provides the following criteria for evaluating if insights are true (a) if they match with the facts of the client's psychology and life processes, (b) if they are followed by overt changes in the client's behaviour, (c) if the changes are internal, (d) the process of exploration moves forward, (e) they are analogous to and consistent with insights in other case histories, and (f) they make previously unintelligible experiences intelligible.

4.5.2 Techniques in Insight Therapy

Insight therapy relies on the same techniques that classical psychoanalysts use. These include free association, dream interpretation, resistance and

transference. As we have seen earlier, interpretation forms the backbone of insight therapy too.

Interpretation

Therapist's skillful use of interpretations help the client reach insight. The therapist links clients' past and present experiences in the here and now and helps the client develop a new explanation for their symptoms. This makes the symptoms appear more manageable to the client. The clients look at their symptoms with an increased understanding and evaluate their usefulness. The accompanying emotional catharsis frees the client to act in new, more constructive ways.

Insight is empowering for a client as it brings greater clarity in life and self understanding. They are empowered to make changes since they better comprehend how their past experiences are harming their present. It gives internal freedom to the individual.

For example, with a client experiencing low self esteem, the therapist might analyse the client's childhood years to find non-supportive parenting and bullying in school, which evoked negative emotions about self that were repressed.

Transference interpretation

Isight in the psychoanalytic sense often involves understanding of recurrent, maladaptive relationship patterns. Therefore use of transference interpretations becomes a key technique.

Exploration of affect

Emotional insight requires exploration of affect and emotional processing of memories and other psychological material brought forth in therapy. These experiences or memories can be from the client's childhood or previous adult years.

4.5.3 Evaluation of Insight Therapy

Like other psychodynamic therapies, effectiveness of insight therapy also depends upon the client-therapist relationship. Building rapport, trust and openness is essential for the client to open up about difficult issues. The therapist plays an important role in this. They identify behavioral patterns from the client's past that could be affecting their behavior and relationships at the present time.

Insight therapy has found some empirical support, indicating a positive link between increased insight during treatment and outcome. Few studies also suggest that increase in self-understanding precedes symptom change and regard insight as a curative factor in therapy. It is effective for anxiety, depression, eating disorders, relational, family or academic problems.

However, there is a need for more precise measurements as well as more research to specify the conditions in which insight facilitates change.

Some of the criticism is also based on the fact that the insights generated might be placebo insight and that the pressure in the therapeutic encounter may cause clients to experience "insights" such as illusions or deception, or adaptive self-misunderstandings which do not possess any explanatory power (Jopling, 2001). Al-shawi (2006) also questions insight oriented therapies by asserting that such therapies *absorb* the client into the therapist's framework due to increased suggestibility, power and even deceptive control in the therapeutic settings.

Self Assessment Questions 3

State True or False for the following statements:

1) Cognitive insight is better than emotional insight.
2) Insight therapy is only psychodynamic in nature.
3) Insight is accompanied by catharsis.
4) Getting in touch with one's conscious and brining the conscious into unconscious is insight.
5) Transference interpretation is one of the major techniques of insight therapy.

4.6 LET US SUM UP

In this unit we studied psychodynamic approach to counselling, which is basically an umbrella term that incorporates several other theories and therapies that have their roots in Freudian psychoanalysis. Psychoanalysis theory and therapy have been described in greater details as they form the backbone of other therapies discussed. Techniques like interpretation, transference, dream analysis and resistance are common to all the therapies discussed. Psychoanalysis also relies on free association. It should be noted that insight is also the defining feature of all psychodynamic therapies. However, insight therapy has specifically been developed from the perspective of psychoanalysis with its focus on exploration of the client's past and identification of causes or origins for presenting problems. Contributions and criticisms of each of the therapeutic modalities discussed have also been presented.

4.7 KEY WORDS

Insight refers to gaining self-understanding and thus becoming aware of the origins of problems in oneself.

Transference is the client's emotional response to the counselor as he/she did to some significant other in childhood like father, mother or sibling.

Counter-transference involves therapist's transfer of feelings from the past into the present relation with the client.

Psychic determinism viewsthat there is an underlying psychological explanation for every emotion, thought, impulse, and behaviour.

Defense mechanismsprotet the individual from unreasonable or unacceptable desires and impulses by putting these in the unconscious without any conscious processing.

Thanatos is the death impulse which indicates the basic urge of agression as given by Freud's psychoanalysis theory.

4.8 ANSWERS TO SELF-ASSESSMENT QUESTIONS

Answers to Self Assessment Questions 1

1) B (increase client's insight into how they relate to others)
2) C (Repression)
3) A (Regression)
4) D (latent content, manifest content)
5) D (Superego)

Answers to Self Assessment Questions 2

1) In order to cater to the needs of managed care and brief therapies, shorter versions of psychodynamic therapy like psychoanalytic oriented therapy emerged. These were also shorter and economical.
2) Psychoanalytically oriented psychotherapy is brief and time-limited, and therefore not as intensive as psychoanalysis proper. The therapeutic relationship is more interactive and more emphasis is placed on the ego functioning as compared to id. More focus is on current problems rather than early childhood experiences.

Answers to Self Assessment Questions 3

1) False (emotions need to accompany intellectual insight for change to take place)
2) False (insight therapy is of different kinds like gestalt, existential etc.)
3) True
4) False (getting in touch with one's unconscious and bringing the unconscious into the conscious is insight.
5) True

4.9 UNIT END QUESTIONS

1) Explain the theoretical principles of Freud's theory of psychoanalysis.
2) Analyze the inter-relationship between the id, ego and superego.
3) Evaluate the importance of insight therapies.
4) Describe the role of counselor/therapist in psychoanalytically oriented therapy.
5) Explain defense mechanisms with examples.

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Web Resources:

1) https://courses.lumenlearning.com/hvcc-abnormalpsychology/chapter/psychoanalysis-and-psychodynamic-therapy/
2) https://www.simplypsychology.org/psychoanalysis.html

Videos:

3) https://www.youtube.com/watch?v=UOkG8J9OxKs (Lecture of psychoanalyst Otto Kernberg)
4) https://www.youtube.com/watch?v=7emS3ye3cVU (Yale university lecture on Freud's Psychoanalysis)

UNIT 5 EXISTENTIAL-HUMANISTIC APPROACH*

Structure

5.1 LEARNING OBJECTIVES

After studying this Unit, you would be able to:

- *Explain the basic view of human nature from the perspective of existential and humanistic theories;*
- *Describe the basic process of counseling and strategies/techniques used by existential and person-centered psychotherapist; and*
- *Understand the contributions and limitations of these approaches.*

5.2 INTRODUCTION

Counseling has been influenced by multiplicity of perspectives. Human potentials and problems can be considered from diverse pathways – psychodynamic, cognitive, behavioral, affective, interpersonal, existential and humanistic approach. In the previous unit you learned about

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psychodynamic approach to counseling and therapy. In this unit, we would study one of the strongest pillars of counseling psychology, the third force in Psychology – the existential-humanistic approach. In the next unit, you will learn about cognitive-behavioral approach to counseling. These three approaches make up the backbone of counseling and therapy.

Many ideas in counseling and psychotherapy have originated in philosophies. The existential-humanistic approach to counseling is an amalgamation of existential and humanistic schools of thought. The basic difference in this approach and others is the relative importance it gives to client's subjective experiences and their personhood, rather than symptoms; and the focus on growth of clients rather than pathology. All problems are seen as originating from diminished ability of the client to make authentic, meaningful, and self-directed choices in life. Hence, the overall goal of therapy is to increase the individual's self-awareness, thereby empowering him/her to make healthy and appropriate choices. The major themes inherent in this approach is that of responsibility and freedom to make choices, owning the choices made and self-acceptance and a constant movement towards self-actualization and growth.

The existential-humanistic theories are also called as 'humanistic theories' whose main focus is on the individual as responsible for their own growth and development. This requires an increased awareness and understanding of oneself. Humanistic theories can include existential, person-centred and gestalt theories.

5.3 EXISTENTIAL THERAPY

Existential therapy owes its genesis to the European philosophers Martin Heidegger (1889–1976), Soren Kierkegaard (1813–55) and Jean-Paul Sartre (1905–80). Have you ever experienced any dreadful situation in which you feel that it's the end of your world? In this journey called life, one is sometimes thrown into such circumstances. Many people have gone through crisis, pain and suffering – experiences quite unique to themselves. The challenges faced, if taken positively, provide a myriad of opportunities and can turn the tide in favor of the one who is struggling. All the three pioneers in existential therapy - Victor Frankl (1905-1997), Rollo May (1909-1994) and Irvin Yalom (1931-) - had an extreme situation in their life which rendered them opportunity to test some perpetual questions that pervades human lives – questions pertaining to meaning in life, existence of God, death, self, etc. All of them in common were interested in issues of freedom, meaning of life, anxiety, search for values, responsibility, isolation and death.

Existential therapy is not a very well-defined or structured approach to therapy. It is often not considered as a separate school as it doesn't offer any concrete model of therapy. It is considered more of a philosophical approach towards therapy, asking deeper existential questions on human suffering,

meaninglessness and other themes mentioned above. The approach is often considered to just "assist client" in finding meanings through reflection and by recognizing various alternatives and by making them decide on their own.

In fact existential therapists like van Deurzen do not even consider the client as being sick rather as someone who is "*sick of life or clumsy at living*" (van Deurzen, 2002). This points to the very basic premise of existential therapy – human beings are free and can change by taking responsibility and making choices in their lives.

Such freedom is implied when Mahatma Gandhi said "You can chain me, you can torture me, you can even destroy this body, but you will never imprison my mind" in his fight against British Rule in India. Similar is the view expressed by Victor Frankl, believed to be one of the founding members of existential theory and therapy,who said that "everything can be taken from humans - except one thing, that is the freedom of mind or the attitude one can have in any given situation". So the choice is always with the individual.

Viktor Frankl, Austrian Neurologist (1905-1997)

Source: Wikimedia Commons

"Everything can be taken from a man but one thing: the last of the human freedoms – to choose one's attitude in any given circumstances, to choose one's own way."

View of Human Nature

With the motivation to help people suffering from existential crises like meaninglessness and alienation, the existential tradition seeks to strike a balance between recognizing the limits of human existence at one end of the spectrum to the limitless possibilities and potentials of human life on the other. It also juxtaposes the brighter side of life (courage, hope, meaning) with the darker side (anxiety, dread, death).

The approach recognizes the inquisitive human nature that constantly questions about self and the world. It assumes that humans are motivated to make sense of their existence; and existential therapy facilitates this meaning making process. It also recognises the unfolding nature of self processes and

looks at individuals as a set of possibilities that manifests as per the choices they make.

Some basic dimensions of human nature according to the existential approach are:

- Self awareness: Humans have the distinct capacity for becoming self aware. Awareness leads to freedom, freedom implies choice and choice comes with responsibility. Acknowledging the freedom to be as well as recognizing the contextual and social constraints and negotiating the two constitutes life. Choosing to expand one's awareness implies growth.
- Choice and responsibility: Humans have the responsibility of shaping their own destiny. They are the masters of their own selves and have the necessary freedom to choose among different life paths and take action. The ones who exercise their choice and take responsibility are authentic.
- Humans have the basic need to maintain their uniqueness and individuality as well as are motivated by relational and social needs. The paradox of creating one's distinct identity, of having the courage to be our true self and of establishing meaningful relationships with others describes life.
- There is an ongoing search for meaning, purpose, values and goals in our lives. When we experience meaninglessness or emptiness in our lives, we are motivated to create a new life with purpose.
- Humans experience anxiety in their efforts to become their authentic self. This anxiety, called existential anxiety, is inevitable. It results when we come face to face with death or loss, pain and suffering, meaninglessness and existential vacuum, isolation and uncertainty in life.
- Death is inevitable and rather than avoiding it, awareness of its inevitability makes life significant and helps us appreciate the present. Acknowledging the impermanence of life can serve as a motivation, or act as a wake-up call to enjoy the beauty of the present moment.

Soren Kierkegaard was a notorious scholar of his times. He challenged the prevailing Christian beliefs in society and argued that religion required one to doubt. He also liked to challenge his own ideas by publishing contradictions of his work under different names.

One of Martin Heidegger's most influential writings, *"Being and Time" (1927)* is actually an unfinished work. It influenced future existential thinkers like Sartre, who read this work when he was held as a prisoner of war during World War II.

Jean-Paul Sartre was awarded the Nobel Prize in literature in the year 1964 and he turned it down. Sartre also turned down many other honours in his lifetime, never wanting to affiliate his work to any particular institution, nation or individual.

The main therapeutic ***goal of existential therapy*** is to help the client become self aware and embrace their authentic self. This includes inviting clients to come to terms with their problems, supporting them to come up with the alternatives to reclaim and re-own their lives with authenticity. The specific goals include helping clients be fully present to themselves and in relationships, motivating them to take charge of their lives with responsibility, and to broaden their perspectives of looking at themselves and the world. The task is to assist clients in exploring their lives further, by learning lessons from the past and creating something valuable in the present.

So, the goals of existential therapy are varied, with the crux being helping the client move towards greater acceptance of self and situation, becoming more aware, exercising choice and creating their own destiny. All this eventually helps in making life more meaningful. These goals make it quite evident that existential therapy is primarily an exploratory approach, where there is exploration of experiences pertaining to choice, identity, love, death and freedom.

5.3.1 Role of the Counselor

Understanding the subjective world of the client is the primary role of an existential counselor. They do not adopt an objective, detached stance, rather focus on creating caring and intimate relationships with clients. The counselor ensures that the client realizes the importance of personal responsibility and accepts responsibility for their life and their choices. Blaming the other or the situation is not an option. Even when the client does blame others for their life conditions, the counselor motivates them to look into their contribution to the problem situation. The counselor invites clients to become self-aware, for only when a person is self-aware can s/he accept and live life responsibly. It's like the therapist holding up a mirror for the client to reflect and confront themselves. This helps them realize how they are living an inauthentic life and restricting their existence and makes them ready to change for their future.

This therapeutic journey is considered to be a unique and creative process for each client. The counselor in their own authentic way of relating to the client creates space for exploration and experimentation, and encourages them to do the same in real life situations too, outside of therapy.

Client's experience in therapy

The clientin existential therapy plays an active role. In the process of reflection and exploration of self in the world, clients experience diverse shades of emotions from fear to anger, joy, sadness to excitement. They become increasingly aware of how they are shackling themselves and hence might also taste some bits of existential freedom. Agency and responsibility is emphasised. Translating their realizations into action is a mark of effective therapy. Taking small steps towards a more fulfilling, happy and meaningful life with courage and hope, recognizing the freedom that they have (no matter however small) and extending the freedom through these small steps is emphasised by existential thinker Rollo May.

5.3.2 Techniques/ Strategies

Viktor Frankl, a leading existentialist, have come up with 'logotherapy' which emphasizes on finding meaning in life. "He who has a why to live can bear with almost any how" (Frankl, 1963, p.121). Thus meaning making is important which acts as a motivational force for human to live. It highlights the client's experiences and subjective world to find out meaning inone's existence here in this world.

Existential therapy is not a technique driven approach. It focuses on understanding the subjective experiences, the unique life world of each client. The focus is not on diagnosis or planning interventions, rather on describing, understanding and exploring the client's subjective reality like a "fellow traveller" or "philosophical companion". Every therapeutic interaction is unique based on how creatively the therapist carves out a session, depending upon client's problems and concerns, and therapist's own personality and style. Being responsive to client's needs is the key. Like other humanistic-existential approaches, the relationship between the client and the counselor is central to the change process.

Client-counselor relationship

Existential therapists give central prominence to their relationship with the client. It is an authentic relationship, something that is referred to as an encounter between "I and thou" (Buber, 1970). In such relations there is true dialogue, with the interaction being direct and mutual between two individuals. It is a mutual journey of self discovery for both the counselor and client. Therapy is viewed as the context during which the relational and existential problems of the client come to surface. Thus the focus is on the 'here and now' interaction between client and counselor.

Rather than specific techniques, it is the attitude of the therapist that counts. Therapist's honesty, integrity, courage and authentic ways of being influences the client also to be progressively authentic. If the therapist is non-genuine and non-transparent, the client too would remain guarded and defensive.

The therapeutic relationship is marked by respect and faith in clients' potential to change towards an authentic existence, genuine concern and empathy for client's inner experiences, and presence of the therapist. Presence implies attunement of the therapist to the client's subjectivity, a sense of connection and companionship, and not just a focus on the content of the client's sharing.

5.3.3 Evaluation

Existential therapy can be easily integrated into most therapeutic traditions as an overarching framework. Creative integration of cognitive behavioral techniques with themes from existential approaches has already been done. It is argued that the emerging trend towards positive psychology is in line with that of the existential approach's affinity towards authenticity, subjective experiences, personal growth, agency, responsibility and meaning in life. Existential practice has been applied in a variety of settings and with a diverse population of clients, including those with substance abuse issues, ethnic and racial minorities, gay and lesbian clients, and psychiatric inpatients. It is effective for clients coping with developmental crises, experiencing grief, confronting death, or facing a turning point in life.

However, existential approach to therapy has also often been criticized as it lacks systematic principles and techniques of psychotherapy. It remains one of the most widely influential, yet least officially embraced approaches. This could be due to the increasing preference for manualized and structured therapy or evidence-based practice. Concepts such as "authenticity" or "being-in-the-world" are difficult to define and hence difficult to research. Another major drawback is the amount of maturity, experience and training required from the practitioners. The existential therapist needs to be wise, and must be capable of profound human understanding of life and its nature. Yet the most important aspect of existential therapy is its stance on placing a value on the darker side of human experience and to be able to explore, experience and make meaning out of it.

Some also regard existential therapy as too individual centric and as discounting social factors in shaping human concerns. The therapy would also be limited in the face of clients believing very strongly in the absence or lack of choice due to environmental or situational constraints. The pressures we face due to family or community (e.g., the influence of khap panchayat, complex social institutions in the north India regions related to various decisions in people's lives) cannot be negated.

Self Assessment Questions 1

Fill in the blanks.

1) _____, _____ & _____ are the pioneers in existential therapy.

2) Goal of existential therapy is to help the client become more _____.

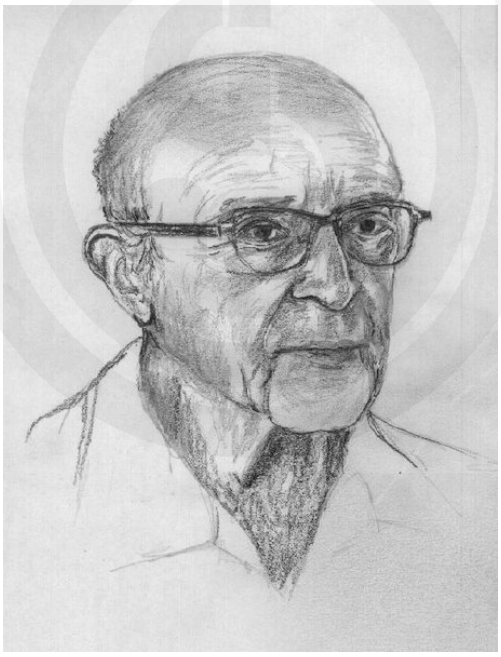
3) According to Buber, authentic relationship between two individuals is _____ encounter.

4) _____ is central to change in existential therapy.

5) Freedom comes with _____.

5.4 PERSON-CENTERED THERAPY

Developed by Carl Rogers in the 40s, Person-Centred Therapy (PCT) was an extension of his thoughts on human beings, their potential and the best way to facilitate their growth. Today, this therapy is categorized as an affective approach, a group of approaches which have a subjective view of human nature and rely on the human ability of self-awareness as fuel to personal growth. Person-centred therapy uses a phenomenological approach, that is, focusing on the experiences of the person, how does the person experience herself and the world around.This direct personal experience or organismic experiences related to one's self are crucial for one's learning, enhancement and self-growth.



Carl Rogers, American Psychologist (1902-1987)

Source: Wikimedia Commons

"When I accept myself just as I am, then only I can change".

View of Human Nature

PCT has its roots in the fundamental belief that each human being is rational and worthy. They also know inherently what is best for them. Furthermore,

he believed that most people were inherently good, positive, constructive, forward moving, and trustworthy (Rogers, 1957). PCT also believes that people try to work towards becoming the *best version of themselves* (i.e. towards optimal functioning) as opposed to working towards *reducing their in-built flaws* (like defenses and cognitive distortions). The need for individuals to *actualise*is considered the fundamental human drive. Rogers believed that each individual not only had the potential to actualise, but also had an inner voice that guided them towards what was right or best for them, what he called an individual's *organismic valuing process*.

Self-actualization is the key driving force of one's existence and influences the actions and behavior of human beings. The main focus is on the 'self' and finding a meaning and purpose in life. Rogers' theory is also called self theory. How an individual perceives his/her self, their experiences, and their interpretation of reality are important. If there is incongruence between the perceived reality and actual reality, it may result in maladjustment in the individual.

Cause of psychological distress

According to PCT, the cause of distress in individuals is the separation between their real experiences (what they can actually do, how they actually feel) and their self concept(what they think they can do and strive to become). The self-concept is influenced by society and its expectations from individuals. Thus there is a gap between the real self and the ideal self.

Imagine you have joined paragliding training, but are not able to learn as quickly as others in your class. In one of the sessions, you heard your trainer say to other students, "Oh no, this student just isn't getting it! By this time in my training, I was able to stay in the air for at least 60 seconds!". You would begin doubting yourself. Maybe you would make a personal goal for yourself and say, "I will try to stay in the air for 10seconds at least, before I hit the ground". If you are unable to do so, you would feel bad about yourself. What has happened here is that society has put conditions on you "By this time I could stay in the air for 60 seconds". This forces you to put conditions on yourself, "if this happens, only then I'll consider myself worthy". Instead of accepting yourself for where you were in your journey, you forced yourself to accomplish a goal based on social expectations. The more this gap between reality and expectations increases, the more are the chances of a person experiencing a complete psychological breakdown.

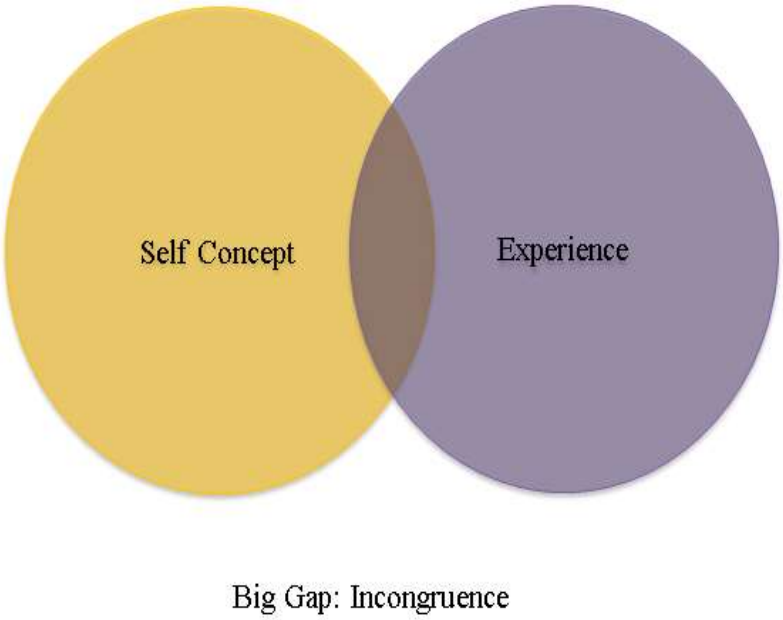


Figure 5.1: State of Incongruence

Incongruence is a state when there is less overlap between real experiences (what they actually do and experience) and their self concept (what they think they can do or feel). When an individual is in a society, she is fed notions of what she should be and how she should act and she develops a *Conscious Learned Self*, a notion of herself that she created based on social expectations. When such a person tries to succeed, she does that based on the same social expectations ("My father said I would be a doctor when I grow up, so my self concept says that I love biology, and now I will give the medical entrance and succeed). This person is now trying to achieve a goal of personal and professional growth, but it isn't her own goal, it is a goal that society forced upon her. This is called *society based actualization.* What would happen if this person fails to clear the medical entrance? As society has created *conditions of worth* (you will be valued only if you fulfill certain criteria), this makes an individual start treating her own self in this manner - by setting conditions of self-worth and showing only conditional positive self regard. When there is a big difference between one's experiences and one's self concept, the person is said to experience *incongruence.* When a person who is experiencing incongruence is put in a *threatening situation* (where the gap between the real experience and self concept is very evident), the person will experience anxiety, and become defensive. If these defenses are unable to subdue the anxiety, the incongruence will continue to increase, eventually leading to a psychological breakdown.

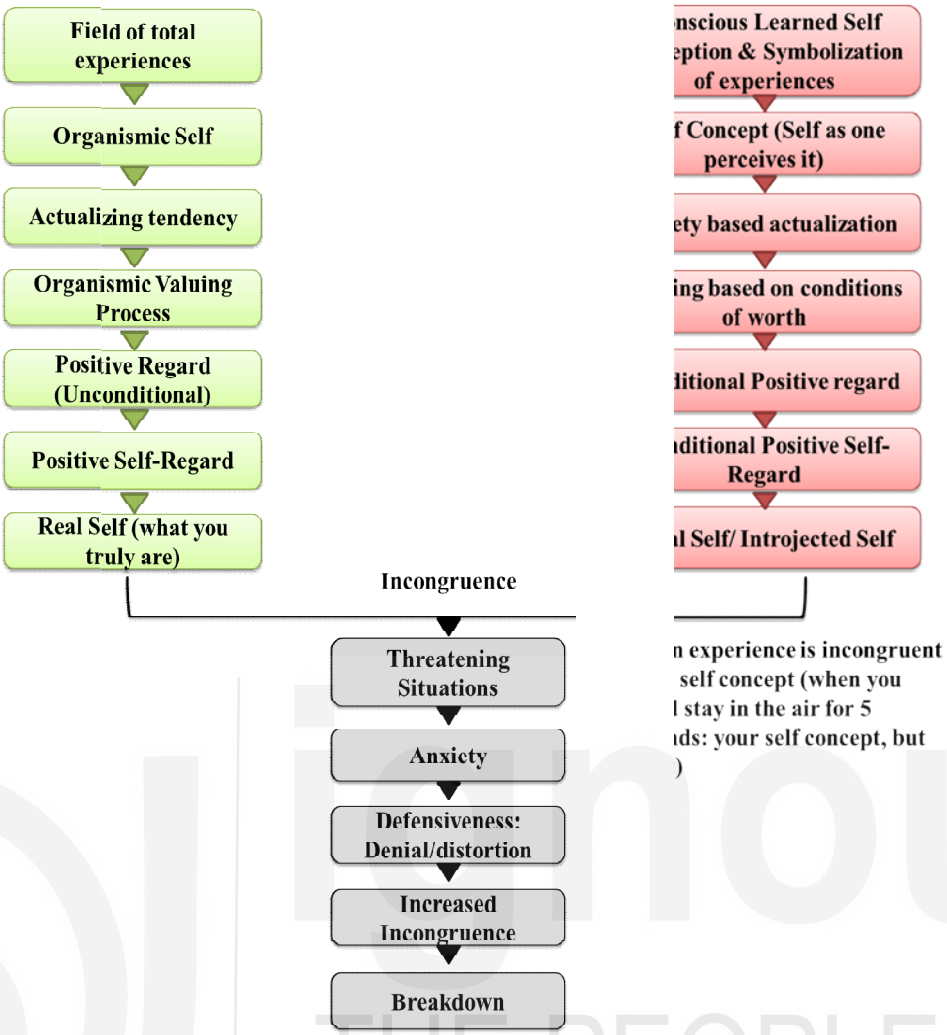


Figure 5.2 : Schematic flowchart of person centered conception of problem

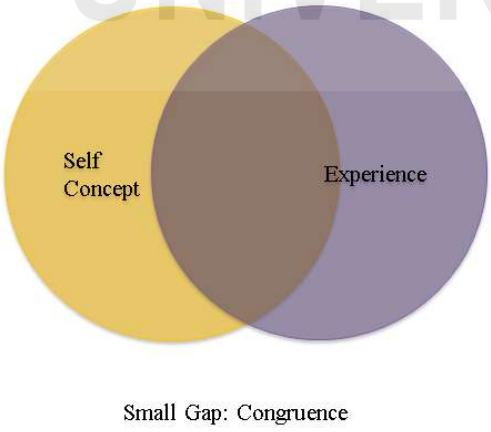


Figure 5.3: State of Congruence

That being said, one must have a motivation to do better and be a better version of themselves. This means there will always be some gap between one's real and ideal self. A lesser gap with more realistic expectations does not cause a psychological breakdown, but becomes a source of growth and actualization.

The main aim or **goal of person-centred therapy/counseling**, also called client-centred therapy/counseling, as the name indicates, focuses on the development and actualization of the person. Following can be described as the various goals of person-centred therapy.

- *Increase a person's openness to experience:* PCT encourages clients to explore all aspects of their being. The therapeutic goal is to provide the client with a space where she can explore all different areas of her attitudes, beliefs and emotions. It therefore helps the client understand herselfbetter.
- *Decreasing the level of incongruence:* The first goal of PCT is to decrease the level of incongruence. Clients seek therapy in distress. The first step to help the client move forward is to lessen this distress. Helping the clients to reflect upon the gap between their real and ideal selves and acknowledge that they are currently giving their own selves conditioned positive self-regard helps foster a journey that seeks to decrease this gap.
- *Getting in touch with one's organismic valuing process (OVP):* Rogers described the OVP as a person's innate tendency to know what is best for them, and knowing what to change in order to have a more fulfilling life. Furthermore, he believed that once one can get in touch with this innate feeling, they will constantly have an internal voice that motivates them to move towards a more fulfilling life. Helping clients attain this awareness is another goal of PCT.
- *Striving for actualization:* PCT places focus on the growth and development of an individual. As opposed to psychodynamic and cognitive-behavioural approaches, PCT and other Humanistic approaches don't see removal of disorder as the goal of therapy. Instead, these approaches consider self-actualization the goal of therapy. Self-actualization is when a person completely realizes her potential and develops to the full of her abilities. This is a stage where an individual functions to the best of her capabilities. The goal of PCT is to help the client start working towards this end, to actively seek not just a distress-free state, but a full-capacity state.
- *Developing as a fully functioning person:* Finally PCT aims to help clients reach a phase where they have congruence, high organismic value, are aiming for actualization, and through all this are capable of experiencing completeness and joy.

5.4.1 Role of the Counselor

In PCT the role of a counsellor is to be *without a role.* This is one reason why PCT is also known as *non-directive counselling*. The counsellor's function in therapy is not one that can be learned or imitated, but one that has to be experienced: a role of empathetic listener who has faith in the client's own

ability to lead her life. It is the beliefs and attitudes that the counsellor has that shape his role as a therapist, and not a set of learned techniques. Yes, clients sometimes seek guidance, but a PCT counsellor is neither an expert in the client's life nor a teacher (like in CBT). The counsellor's role therefore is not like a mother birdwho pushes a baby bird off a cliff to help it fly, but that of a steady nest, where the bird can continue to nurture itself before it flies away. When to make the flight, how to make the flight - the counsellor puts these decisions to the client.

As the therapist's attitude holds primacy, we must explore the kind of attitude that is suitable for PCT. The counsellor shows care, respect, acceptance and understanding towards the client, while being genuine or authentic. She aims to facilitate and not direct a client. PCT is also open to a client's explorations. The client can shift the focus on therapy from the "primary concern" to other areas which have been denied in the past. The counsellor must provide such an avenue whereby the client can feel free to explore any facet of her life.

For a PCT therapist, the client's understanding of what is going on holds most importance. Even if the counsellor uses psychological tests along the course of therapy, the "final scores" don't hold the importance, but what the client understands from the test and its results does. In this way, the expert in the therapy is the client: by saying this, PCT does not mean that the client is an expert in counselling or human psychology, but instead that the *client is an expert in her own life.*

Client's experience in therapy

In PCT, the client's experience and the counsellor's attitudes determine the degree of therapeutic change and success of therapy.

When the therapist provides a suitable environment, it is hoped that the client would feel safe and respected and begin the process of *self-exploration*. The clients would begin looking at all aspects of their life and the full range of their experiences. As time progresses and the relationship between the counsellor and client strengthens, the client experiences increasing '*freedom'* to expand the areas of exploration.

This increase in a degree of engagement is also seen in the volume and quality of *self-disclosure.* Clients begin sharing emotions and thoughts that were not a part of their ideal self (like guilt, shame, jealousy), and had been ignored by the clients' conscious awareness because of being *"inappropriate"*. Clients now come to accept and appreciate themselves in the course of therapy. The goal of therapy is to help clients reach a point where they can deal with conflicts, to come to grips with problems, and "overbalance the regressive and self destructive forces" (Rogers, 1951)

5.4.2 Techniques/ Strategies

As the outcomes of PCT rely *solely upon the counsellor-client relationship*, Rogers gave six conditions which had to be met in order for a therapeutic intervention to work. He called these six the *necessary* and *sufficient* conditions for the success of therapy, i.e. not only did he say that these six were important to fulfill for therapy to be successful, but also that even if only these six conditions were met, no matter everything else, they are sufficient to bring about successful therapeutic change. Of these six, three are requirements from the therapist side:

1) **Therapist's Congruence or Genuineness:** This condition requires the therapist to be honest and genuine with the client. This means that the counsellor must be her real self during a session. The counsellor's genuineness or *authenticity* helps her share her personal experiences, respond to the client with her real thoughts on the matter and not put on a facade. This is a condition that PCT therapists must strive towards. It must also be noted that therapists are also on their journey towards actualisation and reducing the incongruence between their own real and ideal selves, so the aim to be as genuine as possible (not to be perfect) and constantly aim to be more genuine with the client.
2) **Unconditional Positive Regard:** As mentioned in the paragliding example above, attaching conditions of worth harms a person. In this light, a PCT therapist provides the client with unconditional positive regard. The therapist accepts the clients and their experiences as they are. This does not mean that the therapist approves everything that the client does, nonetheless, the counsellor accepts that this is how it is in this present moment. As a PCT counsellor believes that each human being is capable of goodness, even if the counsellor doesn't condone the client's present behaviour, she would still consider the client as a whole, a valuable being.
3) **Empathic understanding:** The last condition for a counsellor to fulfill is to provide the client with empathic understanding. This is experiencing the client's feelings as if they were your own, but without losing the "as if" quality. A PCT counsellor must strive to see a client's feelings from the client's perspective (as if those feelings were the counsellor's own) but not get carried away with those feelings.

The other three conditions pertain to the client and counsellor-client relationship.

1) **Client incongruence:** The client's incongruence (difference between real and ideal self) is what motivates a client to go on a journey of self exploration.
2) **Client-counsellor relationship:** The client and the counsellor are in a *psychological contract:* an agreement that the client will be devoted to

growth, while the counsellor will offer unconditional acceptance to facilitate the client's journey. Within this relationship the client feels safe and motivated to get better.

3) **Client's perception:** The client should be able to perceive the counsellor's unconditional regard and empathy.

Apart from these conditions, PCT does not rely on concrete techniques. However, Moon (2007) delineated some salient features of the way Rogers' responded to some of his clients (observed from video and audio recordings of their sessions). Some pertinent points are shared below:

1) *Non-expert language:* It was seen that even if the client asked Rogers for suggestions or advice, Rogers refused to take the position of the expert and responded in a manner that was humble and conveyed to the clients that they were the experts of their lives.

2) *Meta-statements:* This was Rogers way of introducing and making the client aware of his genuine thoughts in the moment, but also making the client aware that he was being genuine and sharing his real response. For example, instead of saying, "that sounds so disturbing", he would say, "I *guess what I want to say is that* this all sounds so disturbing". It should be noted that in both the statements, he was being genuine. However, in the latter statement he was able to convey to the client that he is being honest and true to his heart in front of the client.

3) *Affiliative Negative Assessments:* It was seen that Rogers responded to client's negative statements using negative empathic responses. What is a negative empathic response? Let's suppose a client says the following: "I just can't keep living with this guilt, yet I can't get rid of this feeling! It seems impossible!". Responding to such a statement by saying, "It sure is a tough task" would be a negative empathic response. Here, the counsellor has said something "negative" if it is seen without context, but because the client was also framing sentences in a negative way, his (counsellor's) empathic response would also mirror it.

4) *Invitations for Repair:* Rogers also directly asked clients if his understanding of their statements, perceptions and inner world was accurate.

5.4.3 Evaluation

Person centered therapy shifted the scope and culture of therapy drastically. As an approach, it empowered the clients as experts of their own life, demystified therapeutic techniques by moving away from technical jargons, and it was the first therapy that provided transparent records of completed cases. This helped draw many allied disciplines into the fold of psychotherapy, as professional counselling spread across schools, organisations and their management and parents.

PCT is well suited for early phases of intervention (mild and moderate mental health problems). It can be employed in the group and individual settings, and across disorders (anxiety disorders, alcoholism, psychosomatic problems, interpersonal difficulties, depression, cancer, personality disorders, etc.)

PCT has made major contributions to the field of psychotherapy. It re-conceptualised the client as an active part of the change making process. It also popularized the use of the word "client" (someone who needs assistance) as opposed to the previously used word "patient" (someone who is sick). It took into account clients' inner experiences and their interpretation of them. It also focuses on long-term counsellor training (one that evolves values, beliefs and attitudes) as opposed to a short-term technique-centred training. It is a flexible approach which takes clients' affective states into account and because of client-centeredness, it can be adapted to various cultures.

The therapy also has certain limitations. The focus on therapist's being as opposed to fixed techniques leaves room for therapist's shortcomings becoming a major hurdle to therapy. This is because the entire efficacy of the therapy depends upon the therapists' unlearnable, inherent traits, and if those are absent, the therapy won't be effective. Furthermore, since this approach is non-directive, a lot of the onus of change lies with the client. If the client is shy or non-verbal, PCT would not be effective. PCT would work best with insightful and hardworking clients. PCT also discounts past experiences as significant influences in the person's present. While over emphasizing on past experiences is too deterministic, completely discounting them is counter productive too. Lastly, the six conditions given by Rogers have been critiqued for being neither necessary nor sufficient (Kirschenbaum, 2007).

Self Assessment Questions 2

1) What are the three necessary qualities of a person-centered counselor?

   ……

   ……

   ……

2) Name the two defenses that Rogers discusses in his theory.

   ……

   ……

   ……

3) Why is PCT a non-directive approach?

   ……

   ……

   ……

5.5 LET US SUM UP

In this unit we studied the existential and humanistic approach to counseling. These are experiential and affective in nature. Clients' subjective experiences, their emotions, and relationships are emphasised during therapy. The client-counselor relationship is also central in these approaches. However, with respect to specific techniques and intervention methods, existential and person centered approaches are primarily dependent on therapist's attitude and the relational space carved. Views of human nature, goals of counseling/therapy, role of counselor or therapist and the client-counselor relationshipin both existential and humanistic approach are described.

5.6 KEY WORDS

Unconditional positive regard means that the therapist accepts the clients and their experiences as they are; however, this does not mean that the therapist approves everything that the client does, nonetheless, the counsellor accepts that this is how it is in this present moment.

Conditions of worth refers to the assumption that we will be valued only if we fulfill certain criteria.

Existential therapy aims at helping the client become self aware and embrace their authentic self, and thus focuses on issues of freedom, meaning in life, responsibility, anxiety, and search for values in one's life.

Logotherapy is given by Viktor Frankl whichemphasizes on finding meaning in life.

Organismic valuing processrefers tothe capacity of the individual where their inner voice guides them towards what is right or best for them.

Incongruence is a state when there is less overlap (i.e., big gap) between real experiences (what they actually do and experience) and their self concept (what they think they can do or feel).

Conscious Learned Self refers to a notion of oneself that one creates based on social expectations.

Empathic understanding refers to experiencing the client's feelings by the therapist as if they are one's own, but without losing the "as if" quality.

5.7 ANSWERS TO SELF ASSESSMENT QUESTIONS

Answers to Self Assessment Questions 1

1) Victor Frankl, Rollo May and Irwin Yalom

2) authentic and self aware
3) I-Thou
4) Therapeutic relationship/ Client-counselor relationship
5) responsibility

Answers to Self Assessment Questions 2

1) The three necessary qualities of a person-centered counselor are genuineness or congruence, empathy or understanding the clients' inner frame of reference and offering a non judgemental space or unconditional positive regard.
2) The two defenses discussed by Rogers that the individual uses to defend himself/herself in a threatening situation are denial (the reality doesn't exist at all) and distortion (the reality is altered to suit one self).
3) PCT is a non directive approach since the counsleor doesn't direct the course of therapy. The client is regarded as an expert of their lives and hence give direction to therapy. The counselor only facilitates the process.

5.8 UNIT END QUESTIONS

1) How has Rogers conceptualized psychological problems? Why is conditional positive regard unhealthy?
2) What are the defining themes of an existential therapy?
3) Evaluate existential therapy in terms of client-counselor relationship.
4) Explain the six conditions described by Rogers for the effectiveness of therapeutic intervention in person-centred therapy.
5) Critically evaluate existential approach to therapy.

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Web resources

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- https://www.ccpeweb.ca/en/services/psychotherapy/humanistic-existential-approach/
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1414693/
- https://www.britannica.com/science/humanistic-psychology

Video

- https://www.youtube.com/watch?v=NFT89grAUOI (Video counseling session of Carl Rogers, Fritz Perls with Client Gloria)

UNIT 6 COGNITIVE AND BEHAVIOURAL APPROACH*

Structure

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6.1 LEARNING OBJECTIVES

After studying this Unit, you would be able to:

- *Develop an understanding of cognitive and behavioural approaches to counseling and therapy;*
- *Explain behavior therapy, cognitive therapy and rational emotive behavior therapy in terms of their assumptions, theoretical frameworks, client-counselor relationship and techniques; and*
- *Analyze the therapies in terms of their applications, advantages and limitations.*

6.2 INTRODUCTION

The field of therapy was largely dominated by the school of psychoanalysis (discussed in unit 4 earlier) in the early 1900s. The second half of the 20th century however, brought about a change in this. In the 1950s a new school of thought arose and this would gain momentum in the next 20 years or so to not only rival the popularity of psychoanalysis, but also be the preferred choice among the two alternatives.

The many behaviour and cognitive approaches that developed during this time differed from psychoanalysis in two key ways:

- They emphasized on *client action* as opposed to client passively waiting for insight
- They believed the *locus of trouble to lie in the present*, as opposed to the past and childhood

In this Unit you will learn about behaviour therapy, behaviour modification, cognitive behaviour therapy, and rational emotive behaviour therapy in terms of their assumptions, theoretical frameworks used, techniques, major applications and limitations.

6.3 BEHAVIOUR THERAPY

6.3.1 Emergence

Behaviourism advanced when J.B. Watson (1913) stated that only observable behaviours can be the empirical roots that will sustain the field of Psychology in the future. The 1950s and 1960s saw psychologists across the globe simultaneously beginning to develop therapeutic approaches that relied on theories of learning. These approaches emerged in the United States, South Africa and Great Britain. They focussed on changing the behaviour of individuals experiencing psychological distress to help them cope better. Phobias, bed-wetting and tension-related disorders were being tackled using insights from Pavlov's classical conditioning. In Africa, Wolpe and Lazarus

(1966) were developing the technique of systematic desensitization around the same time while the theoretical frameworks for operant conditioning were being laid down by Thorndike (1905) and Skinner (1938). Using learning as a basis for therapy soon gained momentum. Bandura's social learning theory (1962, 1977) provided this movement a much needed caveat, i.e. empirically proving the sociological variables that impact learning.

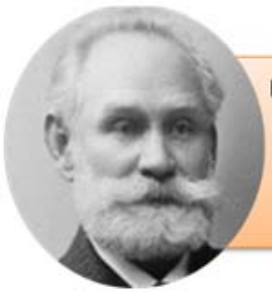
Behavioural repertoire: The sum total of voluntary and involuntary overt behaviours

Learning: A relatively permanent, observable change in behaviour that results from experience and practice

Shaping: Modelling behaviour through demonstration and prompting

6.3.2 Assumptions of Behaviour Therapy

1) Behaviour is a result of the *external environment, internal cognitions and other mental processes* such as attitudes and beliefs.
2) Using *learning theories are a valid method* to bring about significant and lasting psychological change.
3) The *client plays an active role* in decreasing her/his psychological distress by learning new ways of coping and self-management.
4) Effectiveness of therapy is *measurable using empirical methods* i.e. impact of therapy on the client can be measured using standardised psychological tools.
5) Success of therapy is marked by *translation of therapeutic goals to real life situations*, not just reproducing them during sessions or having knowledge and insight regarding them.
6) The therapeutic goals can only be reached if the client has *self-efficacy,* i.e., has faith that change is possible, and that she is capable of bringing about that change.
7) Psychological ailments are not disorders, but *"problems in living"* (Fall, Holden & Marquis, 2017).
8) Therapeutic interventions and *techniques aren't universal and must be tailored* to the needs of each client and their presenting problems.



Ivan Pavlov had a large kennel full of a wide variety of animals. After his initial career wherein he studied short term illnesses and his animals usually died, he devoted his career to studying animals' physiology for a long term. This required him to maintain a large number of healthy animals all at once – hence his kennel

6.3.3 Theoretical Frameworks

The field of behaviourism has moved from its initial conceptualization of a human being as a "tabula rasa" to viewing humans as 'beings' who actively engage with their external environment through an internal world comprising attitudes, beliefs and values. We will be discussing all the main theoretical frameworks in the following section.

Classical Conditioning

Developed by Ivan Pavlov in the 1890s, Classical conditioning pairs a natural stimulus (for instance, a rattlesnake, which naturally elicits fear) with a neutral stimulus (for instance hearing a rattling noise), to get a desired response i.e. *fear*. Eventually this would lead the neutral stimulus to produce the same response as the stimulus i.e. even hearing the rattling noise would elicit fear.

Skinner was extremely investigative as a child. He built telegraph machine that ran from his home to his best friend's home. The two of them even built a machine to separate ripe berries from unripe berries.

Operant Conditioning

This is the model of learning that focuses on rewarding individuals for displaying desirable behaviours and penalising them for displaying undesirable ones. Here learning is achieved through reinforcements and punishments. Reinforcements work to increase desirable behaviour and punishments work to decrease undesirable behaviours.

Table 6.1: Positive and Negative Reinforcements and Punishments

	Positive (means adding)	**Negative** (means removing)
Reinforcement (to increase the behaviour)	Adding some pleasurable things to reward the individual (example: giving chocolate to a child for scoring 90% in a test)	Removing something displeasing to reward the individual (example: reduce bad body odour after showering; thus it reinforces taking shower that removesthe negative stimulus of bad smell)
Punishment (to decrease the behaviour)	Adding something displeasing (example: giving child a time-out for throwing a tantrum)	Removing something pleasing (example:not allowing the child to play video games for throwing a tantrum)

As opposed to the prevailing notions at the time, Albert Bandura (1977) highlighted the importance of personal variables and observation in learning. While he agreed that classical and operant conditioning were important modes of learning, he laid emphasis on cognitive mediational processes i.e. the role of thoughts, attitudes and values in learning. He also brought to light the learning that occurs in humans just by virtue of being present in a certain environment, through process like imitation and modelling and termed it *observational learning*. These changes shifted the prevailing paradigm which viewed children as being acted upon by their environment to their being a reciprocal interaction between the environment and individual.

Cognition:The mental processes involved in gaining information, comprehending it and storing it.

Cognitive mediational processes: Values, beliefs and attitudes of each individual towards the stimuli. For instance, if the stimulus of a chocolate covered in a green wrapper is used and the child has had a mint chocolate covered in a green wrapper before and disliked it, the child would not salivate at seeing the chocolate or display behaviours showing a desire for the chocolate.

Bandura entered the field Psychology accidentally. He was a student with no classes in the morning. He joined the a psychology course just because he was free

6.3.4 Role of Client and Counselor/Therapist

Role of therapist in therapy

The therapist's role is that of a teacher and model during therapy. His job entails information collection, designing an intervention and continually subjecting the outcomes of therapy to empirical validation. The process of information collection would require the therapist to ask for presenting problems, clarify them, synthesize an outcome behaviour with the client which would subdue presenting problems, and create a therapy that would lead to that outcome behaviour. The therapist is also responsible for maintaining conditions favourable for behaviour change during the course of the therapy and model ideal behaviour for the client.

Role of client in therapy

The client is an aware participant in the therapeutic process. She aids the therapist in deciding what the outcome behaviour should be and participates in therapeutic work through engagement, cooperation and self-monitoring. These behaviours on the client's behalf are essential for therapeutic work to be successful. The client plays the role of an alert student during the therapy and experiments with a variety of behavioural responses. This eventually allows the client to increase her behavioural repertoire.

Relationship between client and counsellor

While behaviourists understand the appeal for warmth and empathy in a therapy, they do not consider these attributes sufficient for change. Lazarus (1989) considers a client's respect towards the therapist as an essential component of the therapeutic relationship as it allows the client to trust the professional and engage in self-disclosure, both of which are invaluable for therapy to translate into long lasting behavioural outcomes. Behaviourists view counsellors as problem solvers who direct the client towards displaying more adaptive behaviours.

6.3.5 Techniques

The following is a brief description of counselling techniques arising from different behavioural approaches:

1) *Relaxation training:* This method focuses on achieving mental and muscle relaxation. The clients are initially given extensive instructions and then expected to practice it on their own. Relaxation training can last anywhere between 4 to 8 hours of guided instruction (Corey, 2012), but is also being administered in an "abbreviated format" now (McNeil and Lawrence, 2002). Clients are taught the technique and expected to practice it as homework. They may also be required to maintain a log of their practice and experiences related to it.

2) *Role play:* After agreeing upon a behaviour which would be helpful, client and counsellor engage in role play. For example, Kuhu has social anxiety and finds it hard to communicate with strangers in public situation. The counsellor in this case would assume the role of a stranger (boy or girl) and Kuhu (the client) will try to exhibit the *desirable* behaviour. She will go and say "hello" to the stranger and start interaction with her. Role play allows the client to expose herself to the stress-inducing situation in the safe environment of therapy. It also allows her to correct responses she doesn't like, and adapt to the varying styles of conversations that the counsellor chooses. The counsellor can be very kind, or rude or anxious like Kuhu herself!

3) *Graded task assignment:* This is a technique which is used in tandem with other behaviour therapy techniques. An example of graded task assignment during the role-play exercise above would be to first let Kuhu

engage with a mild mannered counsellor-stranger. Step 2 would be to let her engage with someone who is loud and energetic and may be more threatening to approach. Step 3 would be to let her engage with someone who is hostile. The final gradation would be to have her reproduce the results of the role play in the real world. Behaviourism also says that all behaviours can be broken into smaller mini-behaviours. The gradation technique uses this to break a complex task – i.e. talking to strangers – into smaller and increasingly complex behaviours.

4) *Activity scheduling:* This refers to the creation of a daily routine or activity list. The therapist and client together create this in order to provide structure for the client. It helps an anxious client be aware of her priority actions and also answerable to the counsellor for them. It also stops a depressed client from falling back into inactivity and slumber.

5) Pleasure rating: This technique relies on the pleasure received from positive reinforcement. The therapist asks the client to chart how much *pleasure she anticipates before* performing the desired behaviour and the *amount of pleasure she actually feels after* performing the desired behaviour. If the pleasure felt after receiving the reinforcement (for the desired behaviour) is more than anticipated, it provides a push for the client to repeat the *desired behaviour.*

6) *Systematic desensitization:* This technique requires the client and counsellor to chart the client's anxiety provoking stimuli in a hierarchy – from least threatening to most threatening. Let's say that the client is scared of rejection. The client is then exposed to the anxiety provoking stimuli in an ascending order. Once the client begins to master facing the least threatening stimuli (for example, just the thought of being rejected by a stranger), then the therapist moves on to the next level (for example, a person you wanted to befriend ignored you when you said "hi!"). This technique can be employed through imagery – wherein the client and counsellor imagine scenarios and calibrate a response for them or in vivo (real life), wherein the client is asked to perform the behaviours in the real world.

7) *Flooding:* Instead of rating the threatening stimuli in an ascending order, this technique exposes the client to the most threatening stimuli directly and fully after teaching relaxation to the client prior to it– which in the above example could be the client approaching a stranger to befriend, and then stranger not only refusing friendship, but also making fun of the client. This technique uses the theory of classical conditioning. Classical conditioning pairs natural stimulus (need for belonging) with a conditioned stimulus (mockery by peers) to elicit a conditioned response (feeling disheartened, alone and unloved). Flooding relies on the fact that in the absence of the conditioned response (feeling disheartened, alone and unloved), the conditioned stimulus would lose its effectiveness i.e. if we can arrange for a client to feel loved and safe in a therapeutic

environment, mocking by peers wouldn't cause debilitating anxiety after a while.

8) *Aversion therapy:* This technique is employed in order to discourage unhealthy behaviours in clients. This is particularly helpful in cases where clients have drinking, smoking and drug addictions. Here the pleasurable stimulus (alcohol) is paired with a painful stimulus (e.g., mild electric shocks). The client is asked to consume alcohol while the therapist and medical professionals administer mild electric shocks per sips. These shocks act as positive punishment (addition of something unpleasant) and decrease the problematic behaviour.

9) *Eye Movement Desensitization and Reprocessing (EMDR):* This technique has been employed vastly as a solution for trauma. The goal of this technique is to use minimum exposure to trauma and to re-write one's memories to be more adaptive and helpful narratives, instead of anxiety provoking ones. Let's take the case of Riya, a girl who was physically abused by her father as a child and had to be hospitalised as a result more than once. In this case, the therapist recognised through intensive interviews and history taking that Riya's memories cause her to think "I deserved to be hit. I was a bad daughter", which then leads to anxiety attacks. EMDR would require Riya to perform three tasks almost at the same time: 1) recall the memory 2) verbalise what she thinks when she recalls the memory and 3) constantly look at the therapist's index finger which rhythmically moves back and forth at a quick pace. This third task makes sure that though a traumatic memory is being recalled and disturbing cognitions are arising from them, the client is actively engaged in another task physically – looking at the therapist's moving finger. The technique's aim is to rephrase these cognitions into more adaptive statements like, "I was as good as I could be", "I am safe now and there is no need to worry".

6.3.6 Evaluation

Contributions

- **Applications:** Behaviour therapy techniques can be used as interventions for anxiety and phobias (flooding, systematic desensitization, etc.), depression (activity logs, relaxation training, etc.) and even trauma (EMDR).
- **Critical evaluation of both therapy and client:** Neither what the therapist offers nor what the clients think are *"unconditionally accepted"*. The therapist continually evaluates his interventions empirically and also challenges the client's assertions of limitations or *"problems in living"*
- **Ethical benefits of a positivistic inclination:** A behaviour therapist has clear-cut boundaries. They delve in a client's life only to the extent to

impact behaviour – thereby don't have to face many grey areas ethically. Ethicality of the therapeutic relationship therefore can be maintained much more easily.

- **Transfer of knowledge:** Large groups of people can be trained to provide behaviour therapy and as interventions can be learned by all clients, it's effectiveness increases.
- **Time and money effective:** As the therapy is time bound and short term (compared to other modes of therapy), it is monetarily and temporally convenient.
- **Global reach:** As the theoretical roots of this approach are well known, behaviour therapy is available across the globe in in varying formats.

Limitations

- **Power imbalance between the counsellor and client:** This approach views the therapist as the expert and the client as a "student" who must "learn and imbibe" from the therapist. The power dynamics in the therapeutic relationship are therefore lopsided – with the control residing with the therapist. This can result in clients feeling obligated to "go along" with whatever the therapist says, even when they are uncomfortable with it. This can also lead to high attrition rates (clients leaving therapy before completion).
- **Symptom focussed solutions:** Behaviour therapy aims to change behaviour – the symptoms of a supposedly unobservable cause – through theories of learning. The underlying causes however, are never really brought forth. So even though behaviour therapy cause the behaviour to change in specific situations, the cause continues to remain and may continue to cause problems in the future.
- **Lack of emphasis on client's emotional world:** The client's emotional world – how they feel about their problem or the therapy or the therapist – are all not only irrelevant to therapy but not even discussed during the course of therapy. The client's emotional state can be very useful for therapy and provide great insight to a therapist. Ignoring this aspect of a client completely is one big lacking of behaviour therapy.

More to Know:

Clients leaving therapy before completion is very common. In a 2008 article, Barrett et.al. discuss the many reasons why most therapies have a high rate of attrition. The age, gender, ethnicity, distance to travel in order to receive therapy, the waiting period and many more factors come together to determine why clients leave therapy before completion.

1) What do you think happens when people withdraw from therapy before completion?

2) Can you think of reasons why you or someone you know would leave therapy?
3) Should they leave therapy or should they stay?
4) How would you as a counsellor deal with a client who wants to leave?

6.4 BEHAVIOUR MODIFICATION

Using theories of learning in therapy to eliminate or reduce undesirable behaviours is called behavior modification. All the therapeutic interventions mentioned in the section above can be called behaviour modification techniques.

In 1977, an American psychotherapist, Donald Meichenbaum, developed **Cognitive Behavior Modification** (CBM). Much like the behavior modification techniques described in the previous section, this technique also aimed to *change behaviour*.

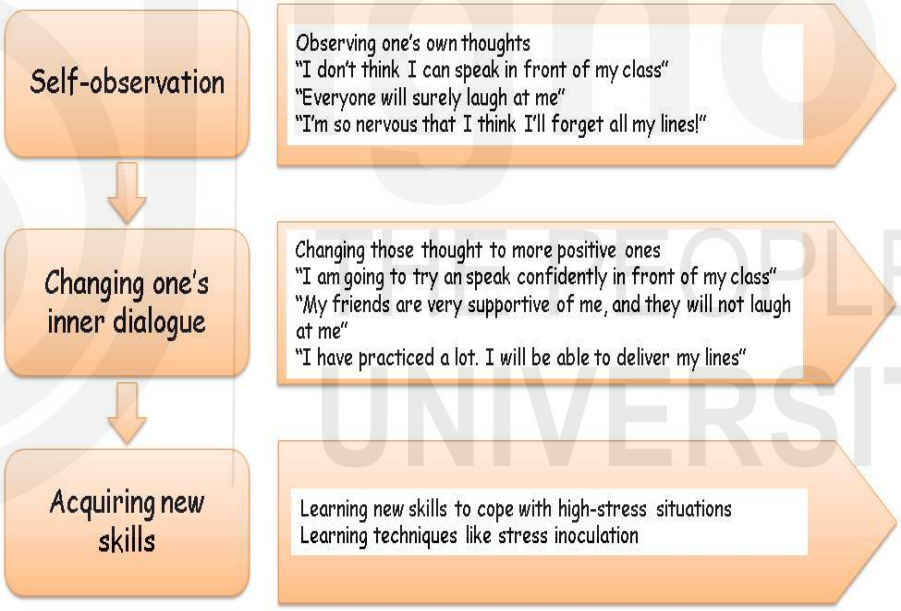


Fig. 6.1: Meichenbaum's Cognitive Behaviour Modification

Unlike the above techniques however, this one focussed on a *person's inner thoughts* as a source of unhealthy behaviour and therefore believed in changing those thoughts in order to change behaviours. Cognitive behaviour modification is a therapy that employs a teaching approach wherein the counsellor teaches the clients (or the client teaches herself) different skills. CBM works in a 3-step framework: (i) observing one's thoughts, (ii) changing thoughts which lead to maladaptive behavior and (iii) acquiring skills that help individuals to cope better. Meichenbaum focussed on helping his clients develop skills to cope with stress, and made the term *"stress inoculation"* famous. Like humans are vaccinated with weaker or dead viruses to help them develop immunity against these viruses, Meichenbaum

thought that exposing people to smaller stressors, bit-by-bit, would help them develop tolerance towards bigger stressors.

Self Assessment Questions 1

1) What is the difference between systematic desensitization and flooding?

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2) Name the major theories that provide the bases for behaviour therapy.

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3) What is behaviour modification?

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BEFORE WE GO AHEAD: Sorting Terminologies

The terms "Cognitive Behaviour Therapy (CBT)" and "Cognitive Therapy (CT)" are often confused. Are they the same? Can we use them interchangeably?

The answer is ***NO.***

Cognitive Therapy (CT) was developed by Aaron Beck and is a type of therapy. CBT on the other hand is an umbrella term used to describe the many kinds of therapies that employ behavioural and cognitive tools to help clients. CBT comprises of at least 20 different therapeutic styles, varying in their techniques but sharing some bedrock assumptions like: the relationship between therapist and client is collaborative, the basis of psychological ailments are cognitive problems, their focus on psycho-education (teaching client to cope better) as a means of changes and rely on the connection between affect, behaviour and cognitions.

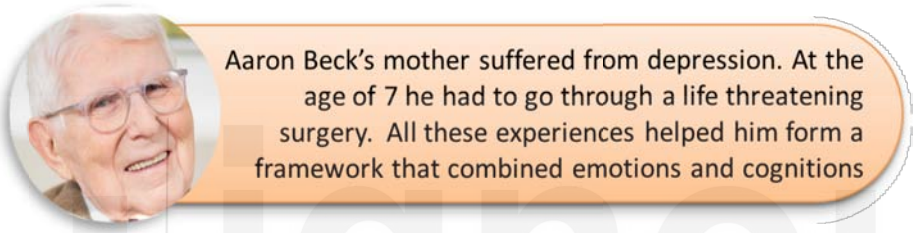
6.5 COGNITIVE THERAPY

6.5.1 Emergence

By the 1960s, behaviour therapy was slowly evolving to include methodologies that worked on the unobservable – on thoughts, emotions and the inner world. The influence of the inner workings of the mind was undeniable. This led to a surge in theoretical perspectives which aimed to

theorize the internal frameworks to study the relationship between cognition, behaviour and emotion.

Beck was on the path to empirically validate Freud's theory when he began his journey as a psychologist. Ultimately, not only he could not verify the Freudian theory, but he began seeing a pattern in his results that led him to create his own theory of psychological ailments. Beck's research repeatedly pointed towards faulty cognitions in patients with depression which eventually led him to describe a depressed client as one with ***"dysfunctional thinking"***. The empahsis here is on how do we interpret or perceive a situation that in turn affects our actions and emotions. So one needs to be aware of these negative interpretations and accordingly change their cognition to engage in alternative ways of thinking and behaving.



6.5.2 Assumptions

1) People's cognitions are made of both ***factual and inaccurate*** thoughts. Both of these kinds of thoughts can co-exist in a person. ***Psychological illnesses*** are a result of the perpetuation of ***maladaptive behaviours*** which result from these inaccurate thoughts. Thus it uses a cognitive model to explain mental health related problems.

2) Humans' minds are capable of ***conscious thinking*** (also called a secondary process), as well as ***unconscious impulses*** (primary process). Cognitive therapy (CT) aims to process all thoughts consciously. CT believes that internal communications can be and should be audited, i.e., brought into conscious focus and examined for validity.

3) The theory also relies on the notion of ***universality in cognition***. Cognition and all the structures that interact with it (emotions, behaviours, etc.) are universal and do not differ from culture to culture.

4) Like behaviourism, cognitive therapy (CT) also relies heavily on ***empirical testing***. Therapists and clients are free to examine the therapy's outcomes objectively and reject the therapeutic structure if it fails to produce results.

5) Unlike behaviourism, however, CT gives the ***client much more authority***. Client has the ultimate authority to describe what a particular cognition (e.g., "I feel stupid") means. The therapeutic framework also strongly relies on the client's motivation and efficacy for change.

6) Therapeutic goal is to change the ***core cognitive schema*** of the client which leads to ***personality change.***

6.5.3 Theoretical Framework

Beck (1976) points out three levels of cognition in the cognitive model which characterize human cognition or the way we think. These are core beliefs or schema, dysfunctional assumptions, and negative automatic thoughts.

Fig. 6.2: Three Levels of Cognition

- **Core Beliefs**

  The human mind consists of thousands of ***schemas*** or concept maps with millions of linkages that help us process information quickly. Since the schemas are mental representations of things/objects/people etc., they can be subject to inaccuracies. For something as factual as the concept of what a dog is, it is easy to correct the schema, but for something as subjective as your worth in the eyes of your parents, the task is much harder. Beck extended this understanding of (objective/factual) schemas to *subjective* thoughts i.e. attitudes, opinions and beliefs. The base schemas which individuals hold on these matters were labeled as their *core beliefs*.

  Thus schemas are deeply ingrained beliefs, our core beliefs which are not easily changeable, are rigid and influenced by early experiences.Beck describes the core beliefs in respect of the 'self' (e.g., "I am not worthy"); 'others or the world' (e.g., 'people are biased'); and 'the future' (e.g., "I will never be happy").

  This ***cognitive triad*** is reflected in the cognitive theory of depression.Beck theorised that depression is a result of three factors, each of which cause and sustain the other two. According to him depression is triggered when a client has (i) a negative view of herself, (ii) tends to interpret most events in her life negatively or through a pessimistic lens and (iii) has a bleak or dark expectation from her future.

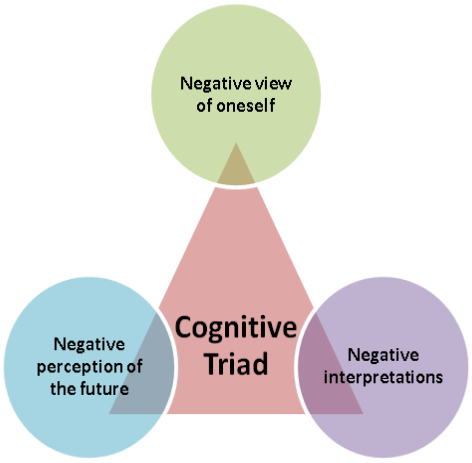


Fig. 6.3: Beck's Conceptualization of Depression: The Cognitive Triad

Furthermore, he explained that people experiencing depression choose to selectively ignore achievements and success that contradict their negative self-concept. All of this leads to the manifestation of a negativity that permeates all parts of the client's life and is labelled as depression.

- **Dysfunctional Assumptions/Beliefs**

  People make various assumptions about how to live their life. Sometimes these assumptions reflect 'conditional rules for living' which are unrealistic. These dysfunctional assumptions or beliefs are maladaptive in nature and lead to problems in interaction and functioning among people.

- **Negative Automatic Thoughts (NATs)**

  Negative automatic thoughts activated spontaneously without any conscious control. These thoughts arise in response to specific situations, for instance, in an interview situation, the person may have negative automatic thought as 'I am going to falter in the interview'.

  Beck noticed how specific ***stimuli triggered an emotional response*** in his patients and that emotional response translated into a *personalised notion* of the patient. These personalized notions which were formulated while in the middle of an emotional response had a high likelihood of being false.

Cognitive Distortions

Beck described many types of "errors in reasoning" that led clients into faulty thinking. These illogical thinking processes or cognitive distortions are unhelpful thinking habits which lead to biases in our thinking. These distortions in our thoughts happen automatically. Hence we need to be aware of them to modify them. Some of the cognitive distortions are described below:

1) *Magnification and Minimization:* The tendency to perceive situations more or less seriously than they are. For instance, failing in one subject

and labelling oneself a "failure" would be magnification; and jumping a red light, crashing into a car and calling it a "tiny mistake" would be minimization.

2) *Labelling and Mislabelling:* The tendency to describe oneself solely on the basis of one's failings. For instance, thinking "I'm a useless, washed up athlete" after losing one race on Sports Day, even though you have won medals in many other races and events.

3) *Personalization:* The tendency to hold yourself responsible for things that rationally can't be caused by you. For instance, believing that your friend's bad mood is definitely because of something you did, even though your friend has denied it and she tends to be upset sometimes because of her family.

4) *Dichotomous thinking:* Thinking in 1s and 0s – things can only be good or bad, never grey. It is also called polarization for its "all or none" approach. For instance, Anushka helped you with your practicum so she's the best! But she did not invite you to her birthday party later that month, so she's the worst and her previous help was fake!

5) *Emotional reasoning:* The tendency to believe that emotional validation is equivalent to rational validation. For instance, thinking that because *you truly feel* that this time your partner meant his apology and he won't abuse you again (even though it has been a repeated behaviour of abuse and apology for a few months now), since you *know it in your heart*, it must be right.

6) *Arbitrary Inferences:* Making judgements in the absence of any real data. For instance, believing that because you didn't take a call from a friend who is dealing with depression, she is going to hurt herself and it will be your fault.

7) *Selective Abstraction:* The tendency to pick isolated details and make inferences from them that are largely out of context. For example, at a party, Ankush's friend remarks, "God Ankush! You're a funny guy to have around! You always make me laugh!" Ankush isolates "funny guy to have around!" and starts thinking that the only reason his friends invite him to events is because he entertains them and his only value is as the joker of the group.

8) *Over generalization:* The tendency to make extreme assumptions on the basis of a single data point; for instance, believing that all teachers think of you as a naughty and disobedient student after being scolded in the class once by the Mathematics teacher.

6.5.4 Therapeutic Technique

Cognitive therapy relies on the client much more than the behaviour therapy. Client's desire to change and the therapist's knowledge about faulty cognitions provide grounds for a collaborative framework. Both collaborators

ensure that they (a)prevent the personality from devolving (b) recognize cognitive anomalies,and **(**c) combat them rationally to bring about the goal of therapy, that is, lasting and positive change in the personality.

Furthermore, it also emphasizes on the client-counsellor relationship. Beck's approach was among the first to focus on the relationship that the counsellor builds with the client. He recognised the counsellor's warmth, empathy, acceptance, rapport building skills as pivotal to the output of therapy.

The techniques used in cognitive behavioural approach can be described under ***cognitive techniques*** (focusing on changing the person's 'cognition') and ***behavioural techniques*** (focusing on changing the person's 'behaviour'). Examples of some cognitive techniques are guided discovery, keeping a positive data log (Padesky, 1994), and thought record, all of which aim at making the individual aware about her thoughts, question their beliefs, analyze evidence for their assumptions, explore alternatives, and look at instances in support of a more positive and adaptive belief/schema.Behavioural techniques include activity scheduling, graded task assignment, behavioural experiments, and relaxation exercises. The focus here is to plan out the day's schedule, engaging in deliberate behaviour and test one's assumptions and beliefs.

Socratic questioning: This is a technique as part of Guided discovery, wherein the therapist asks the client a series of *open-ended*, *thoughtful* and *pin-pointed* questions, which encourage the client to *reflect* on her problems. This requires the client and counsellor to have a well formed rapport and be intensely focussed on the client's issues.

6.5.5 Role of Client and Counselor/ Therapist

Role of the therapist in therapy: The therapist brings knowledge to the therapy - knowledge about how cognitions function, how cognitive distortions arise and how to combat them. The therapist does this by being creative and using Socratic questioning, a method the therapist has honed well. The therapist's knowledge, directive engagement, and questioning together accelerate the process of the client's discovery of her problems. The counselor/therapist's role is to provide guidance to the client and co-investigate issues that she is facing. Collaboration is a feature of cognitive therapy which plays a role while deciding which thoughts are distorted and which are not, what and how much homework would be appropriate for the client, and even while devising novel ways to combat automatic thoughts.

Role of the client in therapy: A client undergoing CT is taught to recognize cognitive distortions. Her job is to (a) realise biased information processing from unbiased one, and (b) to systematically remove these distortions and biases. Over the course of therapy, the client would learn to use conscious control of her thoughts and override the automated distorting and devolving

processes. By the end of therapy, CT aims to make the clients their own therapist.

The counsellor-client relationship: The counsellor client relationship in cognitie therapy is in between of the "student-teacher" approach of a behavior-therapist and the "complete-agency-to-the-client" approach of a humanistic-therapist. The counsellor is an expert in terms of cognitive techniques, functioning of human cognition and techniques that modulate it, but the client is responsible for giving meaning to all her thoughts and contextualizing the therapist's knowledge into her own life. Both determine whether the client's cognitions are reasonable and useful for healthy functioning, thereby preventing present and future dysfunction. The therapy does follow the learning model, but sees the client as an agentic being.

6.5.6 Evaluation

Applications

- **CT's contributions to depression research**: CT largely contributed to the understanding of depression. The prevailing notion about depression labelled it as "anger directed inwards. Beck started viewing depression as a result of cognitive distortion too. To further his approach, he was able to find evidence of distortions in the dreams of his depressed clients. This helped formulate a cognitive theory of depression. Beck is also credited with designing the Beck Depression Inventory and devising and employing CT to specifically aid clients with depression.
- **Other applications:** CT is currently being used for family therapy (where individual and combined family cognitions are scrutinised), anxiety disorders, parent training, skills training and many more areas. The nature of the therapy - brief, client empowering and structured - makes it easy to transfer the basic techniques of CT across different types of settings.

Limitations

1) **Over-simplification of the inner world:** One criticism of CT is that it provides a very simplistic understanding of the inner world of humans. The theoretical assumptions assume that mental processes occur in a very linear fashion: first the individual would have a distorted thought → which will lead to psychological distress → which can be brought to the client's notice → who will remove the distortions. As we are well aware, just knowing about what is logically right doesn't change the way we think about it. This brings us to the second limitation.
2) **Role of emotions overlooked:** Much like behavior therapy, cognitive therapy overlooks the role that emotions play in aiding and prohibiting psychological distress. Though CT allows the client to discuss emotions, it ignores them when it comes to devising an intervention.

Self Assessment Questions 2

1) How do cognitive therapists explain maladaptive behaviour?

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   ……

   ……

2) What is a cognitive triad?

   ……

   ……

   ……

3) Given below are some cognitive distortions. Identify their type.

   a) I could not prepare a healthy meal today. I can never stick to a healthy lifestyle.
   b) I am a failure. I failed in my maths test.
   c) It's because of me that my brother is so rude.
   d) I am feeling anxious. Something bad is about to happen.
   e) A good player should always win.

6.6 RATIONAL EMOTIVE BEHAVIOUR THERAPY

6.6.1 Emergence

Rational Emotive Behaviour Therapy was a type of cognitive behaviour therapy pioneered by Albert Ellis. Ellis came out in strong opposition to the then dominant approach of therapy (psychoanalysis), going so far as to say that not only did the approach fail to help the client feel better, but in most instances, it made them feel worse.

Ellis realised that behavioural methods can also be applied to covert processes and internal dialogues and came up with a therapy that helped clients restructure their philosophical and behavioural styles. Combining his theoretical approach with empirical rigor, Ellis defined an educational approach to provide psychological intervention.

Albert Ellis

"people have remarkable sameness in the ways in which they disturb themselves *emotionally*. They have thousands of specific irrational ideas and philosophies which they creatively invent, dogmatically carry on, and cause great distress and misery to themselves."

6.6.2 Assumptions

1) The source of psychological problems are ***irrational thoughts***. These thoughts are generated by the clients themselves, and therefore, according to REBT, the cause of ***psychological distress are the clients themselves***.

2) Cognitions, emotions and behaviours are ***interrelated and interact*** with each other. Therefore, changes in cognition will eventually bring about behaviour change.

3) Ellis also believed that an individual's ***connectedness*** with other people in her community also determines her psychological well being(Ellis adopted this concept from the Adlerian concept of communality).

4) The process of ***therapy is an educational*** one, wherein the therapist is an expert and the client takes on the role of a student.

6.6.3 Theoretical Framework

- **The Birth of Irrational Beliefs**

  Ellis theorised that our first encounter with irrational beliefs is external. A person of importance or a "significant other" introduces these irrational to an individual during childhood. The individual then *"learns"* these beliefs. Individuals are also capable of creating these beliefs by themselves. Sustaining these beliefs is harmful to the self.Various ways in which these beliefs are sustained involve giving oneself auto-suggestions that these beliefs are beneficial; repetition, e.g., thinking "I am a failure" again and again at the slightest setback; and enacting behaviours supportive of these beliefs, e.g., not participating in competitive activities because you believe that "you're a failure".

- **The Need for Acceptance**

  One of REBT's most radical beliefs is that humans **don't** need acceptance in order to live healthily. It acknowledges that a lack of acceptance from near and dear ones can cause an individual to develop irrational, self-defeating beliefs, but it does not see receiving that acceptance as a cure.

  An REBT therapist would ask a client to face the emotions that come with lacking acceptance - face the sadness, loneliness and even anger. These emotions turn into internal dialogue which is often assigning blame - *"I should be loved by my father. If my father doesn't love me, it*

must mean I am unworthy. But even if I am unworthy, a father should love his child unconditionally".

Two things have happened in this emotion-to-thought change:

i) a blame has been assigned to self, along with the label of being "unworthy". This thought will now have a life of its own, amplifying and validating itself, causing harm to the individual.

ii) The second thing that happened in the emotion-to-thought translation was the creation of rigid and absolutist notions.

Emotions are fluid, we can feel very angry and after the heat of the moment, the anger subsides. But thoughts have a tendency to be much more rigid. Absolutist notions refer to those notions which are uncompromising and don't leave room for any flexibility.

Revisit the above statement and underline the words that show rigidity of thought.

(Answer: *"I should be loved by my father. If my father doesn't love me, it must mean I am unworthy. But even if I am unworthy, a father should love his child unconditionally"*)

Blame and rigidity of thought are what an REBT therapist aims to target and change. The acceptance of another can not be obtained by any therapist, and believing in the agency of an individual (the ability of an individual to act and bring about positive change in her own life), the REBT therapist works on the client instead.

- **The A-B-C Model**

  Imagine you are strolling through the market and you come across a 6 or 7 year old child, who is crying and asking her mother to buy a teddy bear for her. If you are asked the question "why is the child crying", what would you say?

You may say,

a) The child is crying because she wants a teddy bear and she is sad that she can't have one,

b) The child is crying she is throwing a tantrum to get the teddy, or

c) The child is crying because the mother is too strict or unresponsive.

Can you think of other children who are facing a similar situation but are not responding to it by crying? What makes one child respond one way and another respond in another?

The A-B-C model says every situation can have multiple emotional reactions to it, depending upon the way a person chooses to process it.

Fig. 6.4: The ABC Model

Whenever an incident happens **(Activating event)**, our existing thoughts and beliefs related to the event **(Beliefs)** impact the way we respond **(Consequences)** to the incident. Ellis explains that it is our **irrational beliefs** arising from how we interpret the situation/event, that leads to negative consequences. So this modelmakes it possible for applying an intervention (or therapy) to the beliefs (B), in order to bring about change in emotions and behaviours. Hence the focus here is on irrational beliefs of the individual, wheras the focus in Beck's theory is on the cognitive triad.

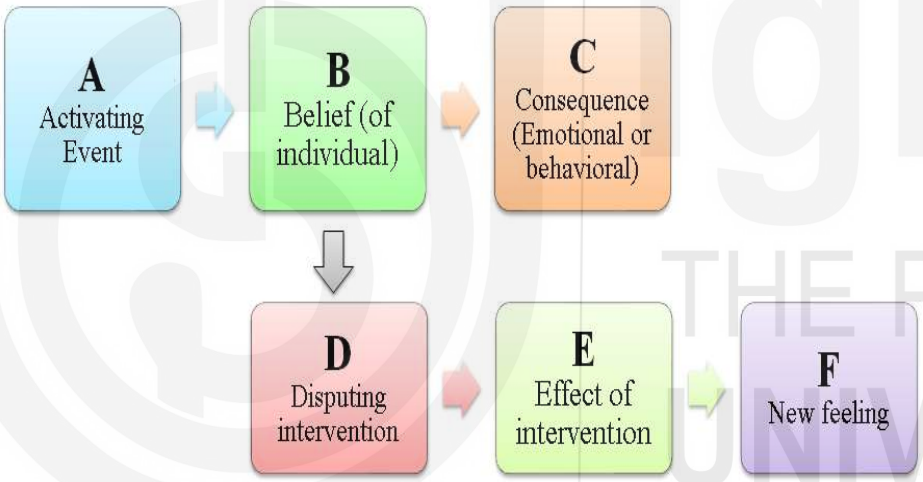

Fig. 6.5: The Mechanism of REBT

The **(D)** here represents the objective questions the clients and counsellors ask about thoughts to verify if they are true or false, **(E)** represents the effects of therapy which eventually causes a change in the way one feels **(F).** Fig. 6.4 above shows how REBT works to change beliefs and bring change in emotions and behaviours.

6.6.4 Techniques

Working on thoughts

1) *Therapist's interruption:* This is part of the process when the client shares her beliefs with the counsellor and the counsellor questions the client objectively and corrects the irrational thoughts.

2) *Self correction:* Clients are also given homework, wherein they are encouraged to identify all their rigid and absolutist thoughts (the ones with "must's" and "should's"). After identifying these thoughts, the clients are encouraged to apply the A-B-C model to change them.

3) *Becoming an REBT teacher:* It is easier to identify the irrationality of another person's beliefs objectively than to identify one's own. This is the reason why clients are encouraged to practice observing irrational beliefs in others as an exercise to become better at identifying them.

Working on behaviours

1) *Language change:* As it has been shown above, simple statements can cause one to develop long-lasting, self-defeating thoughts. Consciously changing one's language to say statements which are less rigid, less absolutist, less self blaming can have a similar long-last but self supportive impact.

Working on emotions

1) *Rational-emotive imagery:* This is an intensive technique where clients are asked to think, feel and act as they want their healed self to. They are also asked to imagine worst-case scenarios, feel however they feel, report those feelings and then try to feel less intensely and more appropriately about such scenarios. It is thought that if clients mentally practice these scenes, when they happen in reality, the clients will be able to respond to them appropriately. (Appropriately here means that even an incident evokes sadness, the client should feel sadness, but not be traumatised)

2) *Using Humour:* According to REBT, emotional disturbance can also result from an individual seeing herself too seriously and losing perspective of the vastness of events in comparison to the whole picture. This is why therapists encourage clients to use humour to tackle the strength and intensity of their thoughts. Counsellors themselves employ humor during therapy to respond to clients.

3) *Shame-attacking:* Ellis devoted much time to developing ways to rid his clients of self-destructive shame. He created exercises and encouraged his clients to stubbornly refuse to feel ashamed. Clients are given assignments where they are asked to act slightly different from social expectations, for instance wearing "loud" clothes, replying in a different waythan the usual to an elder in the family who is rude to you or returning a dish that was wrongly prepared at a restaurant. All these exercises and assignments are aimed at helping the client realise that while the emotion of shame has a role to play, excess of it can be extremely detrimental to the self-image and life of an individual.

6.6.5 Role of Client and Counselor/Therapist

Role of therapist in therapy: The role of an REBT counsellor is complicated. Ellis expected REBT to accept the client unconditionally, but also reject their irrational beliefs openly. This means that the counsellor must come to view the client as a person who makes mistakes, but nevertheless is capable of leading a healthy and successful life. Another aspect of the therapist is that unlike other counselling schools, Ellis did not believe that warmth of a counsellor played a significant role in the success of therapy. He even cited instances where warmth could be harmful. So an REBT counsellor wouldn't spend much time building a warm relationship with the client. REBT requires the counsellor to be good communicators, well-versed in techniques of REBT, competent, active and directive during therapy. They must also be able to diffuse sessions with the timely use of humour.

Role of the client in therapy: The client plays an active and diligent role in therapy. The client is supposed to work hard to continually grow throughout and even after therapy. All clients entering therapy are expected to acknowledge that a problem exists. Additionally a client entering REBT is expected to also accept that irrational beliefs are the core of the problem. Clients are expected to learn and practice REBT techniques, in order to change their beliefs and they are also expected to use these techniques outside the scope of therapy, i.e. if one is going to therapy to deal with marital conflict, the REBT therapist would expect the client to apply those techniques to change irrational beliefs in other domains as well (like problems with friends etc.).

The counsellor-client relationship: As mentioned above, the counsellor-client relationship is that of complete acceptance. Another feature of this relationship is complete honesty from the therapist and an expectation of the same from the client. The counsellor does not hold back objective truths in order to indulge a client's feelings, nor does she encourage long cathartic (when one vents all her emotions by talking) expressions of the client. Ellis saw all these behaviours as obstacles in achieving the true therapeutic goal.

6.6.6 Evaluation

Applications

1) REBT can be applied to marital, family and individual counselling. It has produced outcomes for individuals with anxiety, depression, psychotic disorders, hostility and many more.
2) REBT can also be applied in group sessions, as it employs a teaching mode and requires clients learn some basic techniques to challenge irrational beliefs.
3) REBT is best suited for mild to moderate psychological ailments that require brief intervention.

Limitations

1) *Power imbalance:* The counsellor in REBT is considered an expert. The mode of therapy is itself labelled "teaching". All of this combined gives the therapist a lot of power over the client. Not only can this be misused by the therapist, it can also be a problem if the therapist is not well trained or competent.

2) *Ignoring clients' problems:* REBT places emphasis on a primary problem that needs intervention. The related problems or what are labelled as "secondary problems" are left outside the scope of therapy. This may not be the best approach to bringing about lasting change.

3) *Confrontational style:* REBT encourages therapists to challenge clients' irrational beliefs. This confrontational style may not suit all clients. Moreover, given that this is a brief therapy format that doesn't focus on building a warm relationship, it becomes more difficult to accept a therapist's confrontations.

4) *Balancing the past and the present:* While all forms of behaviour and cognitive therapies focus on the present concerns, completely ignoring the past and early childhood hinders therapy in the long run.

Self Assessment Questions 3

1) Expand the acronym ABCDE as used in Rational Emotive Behaviour Therapy.

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   ……

2) Give one cognitive, one emotional and one behavior technique as used in REBT.

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6.7 LET US SUM UP

In this unit we studied different approaches to counseling from the behavioral and cognitive perspectives. While the behavioral approach looked at the problems of the clients only in terms of maladaptive behaviors, cognitive therapies take into consideration the maladaptive and erroneous thoughts as the basis of client's issues and problems. The unit outlines the theoretical bases of behavioral counseling and cognitive counseling as well as their techniques and therapeutic relationship.

6.8 KEY WORDS

Operant Conditioning refers to the model of learning that focuses on rewarding individuals for displaying desirable behaviours and penalising them for displaying undesirable ones.

Negative Reinforcement refers to removing something displeasing/ unpleasant to reward the individual and increase the likelihood of behaviour.

Positive Punishment refers to adding something displeasing/unpleasant to decreas or reduce the behaviour.

Cognitive Triad consists of negatve view of oneself, negative interpretations about others/the world around, and negative perception of the future.

Cognitive Distortions are illogical thinking processes orunhelpful thinking styles which lead to biases in our thinking.

Dichotomous Thinkingrefers to polarization in thinking, and follows an "all or none" approach, that is, things can only be good or bad.

The ABC Model involves an Activating event orincident; Beliefs, our existing thoughts and beliefs related to the event; and Consequences, the way we respond to the event/incident.

6.9 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) Both systematic desensitization and flooding are behavioral techniques. In systematic desensitization the client is exposed to least threatening anxiety provoking situation/stimulus and is trained to feel secure in it before moving on to more threatening stimulus.While in flooding the client is exposed to anxiety provoking threatening stimulus all at once, in a safe environment and not gradually.
2) Pavlov's Classical Conditioning, Skinner's Operant conditioning and Bandura's Social Learning theories form the bases for behaviour therapy.
3) Behaviour modification is the change in behavioural patterns through the use of learning principles and techniques like reinforcement.

Self Assessment Questions 2

1) Cognitive therapists explain maladaptive behavior primarily on the basis of irrational or erratic thoughts and beliefs.
2) Aron Beck developed the notion of the cognitive triad to describe how depressed adults tend to think about the self, world, and future. They tend to have negative views in all the three domains.

3) (a) Overgeneralization (since on the basis of a single incidence you are making a conclusive judgment about yourself)

   b) Labelling

   c) Self blame

   d) Emotional reasoning

   e) Dichotomous or polarization (all or none thinking)

Self Assessment Questions 3

1) A-activating event, B- belief, C - consequences, D- disputing interventions, E-Effect of intervention, F - New feeling

2) Cognitive technique - Self correction

   Emotional technique - Rational Emotive Imagery

   Behaviour technique - Language Change

6.10 UNIT END QUESTIONS

1) Discuss the assumptions of behaviour therapy.
2) Descrie the techniques of counseling under behavioural approach.
3) Explain the cognitive distortions with examples.
4) Discuss the techniques under Rational Emotive Behaviour Therapy.
5) Discuss the contributions and limitations of cognitive therapy.
6) Explain the role of client and counselor/ therapist in REBT.

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Web Resources

- https://www.mayoclinic.org/tests-procedures/cognitive-behavioral-therapy/about/pac-20384610
- https://positivepsychology.com/what-is-cbt-definition-meaning/