**DPC 101**

**FOUNDATIONS OF COUNSELLING**

**Professional Counselling**

A profession is distinguished by having;

* A specific body of knowledge
* Accredited training program
* A professional organization of peers
* Credentialing of practitioners such as licensure
* A code of ethics
* Legal recognition
* Other standards of excellence (Myers& Sweeney,2001)

Counselling meets all standard for a profession and has done so for a significant period of time. It is unique from as well as connected with other mental health disciplines by both its emphasis and its time in history.

Counselling has not always been an encompassing and comprehensive profession. It has evolved over the years from diverse disciplines ‘including but not limited to anthropology, education, ethics, history, law, medical sciences, philosophy, psychology and sociology’ (Smith, 2001, p.570). Some people associate counselling with educational institutions or equate the word ‘guidance’ with ‘counselling’ because they are unaware of counselling’s evolution. Hence they misunderstand the essence of the profession and those who work in it.

Even counsellors themselves who do not keep up in their professional development may become confused as to what exactly counselling is, where it has been and how it is moving forward. Therefore it is important to examine the history of counselling because a counsellor who is informed about the development and transformation of the profession is likely to have a strong professional identity and subsequently make significant contributions to the field.

By understanding counselling’s past, you may better appreciate present and future trends of the profession as it developed in the late 1890’s and early 1900’s and was inter disciplinary from its inception as classroom teachers and administrators were the main practitioners.

One way to chart the evolution of counselling is to trace important events and personal influences through the 20th century.

**The History of Counselling and Psychotherapy**

Throughout the years, human beings have found comfort in sharing their problems or telling their stories to others.The old saying ‘a problem shared is a problem halved’  tells us one universal human truth, that when things get difficult or we have to make decisions in our lives, we sometimes need someone to listen and ‘hear our story’ so we can get a better idea of our options.

Counselling history can be traced back to tribal times where people would come together in a group and share their experiences, and sometimes their dreams. As civilisation developed, religion offered a type of counselling, usually by priests who would listen and advise parishioners on their problems (they still do).

Late 1800’s Frank Parson often referred to as the father of counselling launched out with his book *Choosing a Vocation* which championed the rise of school counselling or guidance counselling. Clifford Beers established emphasis on Mental Health based on his personal experience in a mental clinic and Jesse B. Davis set up a systematic School Guidance program.

In  the 1890’s, Sigmund Freud, a German neurologist, developed a theory later to be called psychoanalysis which allowed individuals to tell their problems to a ‘psychoanalyst’ an individual trained in interpreting the ‘subconscious,’ that part of our psyche that we are not aware of but influences what we do.

 Sigmund Freud whose research into the human mind began in Vienna in 1881 received training to become a neurologist and began working with patients who were classed as hysterical. Freud named his method psychoanalysis and continued to practice his theories until the 1930's.

Although Freud is thought of as the oldest psychological theorist, it was Franz Anton Mesmer, an 18th century physician who discovered animal magnetism (also known as mesmerism) and James Braid who developed hypnotherapy using inspiration from Mesmer's ideas. Hypnosis was a technique Freud adopted in his early work to treat mind disorders but then concentrated on developing his own theories after recognising that hypnotherapy was only a useful technique with certain problems. However, Freud's work remains the most well known in recent times. Freud proposed the division of the mind into ego, superego and id. He also believed that infants pass through oral, anal and phallic stages and becoming 'stuck' in one of the phases could lead to disastrous consequences.

Carl Jung was a close colleague of Freud, but eventually split from Freud to pursue his own school of analytical psychology. His ideas are also widely recognised in recent times. Alfred Adler, Sandor Ferenczi, Karl Abraham and Otto Rank are other influential theorists who worked closely with Freud. Carl Jung, and other descendants of Freud's approach, focused heavily on psychodynamic theories.

Counselling really took off after the Second World War. The 1940's and 1950's marked an important expansion in the field of counselling. The US psychologist Carl Rogers (influenced by Alfred Adler and Otto Rank) established the person centred approach, which is at the heart of most current practice. The person centred approach is now listed under the 'humanistic' branch of psychotherapy. There are now thought to be three general types of psychological therapies;

* [Behavioural therapies,](http://www.counselling-directory.org.uk/behavioural.html)
* [Psychoanalytical and psychodynamic therapies](http://www.counselling-directory.org.uk/psychoanalytical.html) and
* Humanistic therapies.

While Freud and others played an important part in the history of counselling, the actual word “counselling” did not come in to everyday language until the 1960’s.

Counselling began in Nigeria in 1958 at St.Theresa’s College, Ibadan, as vocational guidance as well.

**What is Counselling?**

To understand what counselling is, then we need to know what it is not.

**What Counselling is not**

**Myths abound...**

Although interests in self-development and self-empowerment are steadily growing there are still, unfortunately, many people who have pre-conceived ideas about what Counselling is all about, and what it can and cannot do.

Counselling is often *mistakenly* defined as:

You're mentally sick.

It's a crutch for "weak" people.

It's for people who like nasal gazing (they're too into themselves).

It's for those folks who want to get psycho "analyzed"?

**Common Myths People Believe About Counselling**

Many people don't seek help from a counsellor because they have concerns and misconceptions about counsellors and counselling. The following are some common myths that people have about the process of counselling and counsellors:

**Myth 1**: **Counselling is Only for People who are Crazy and Unsuccessful**

**Reality**: Many people who are in counselling have normal problems that people face every day. Sometimes, the stress from these problems can become overwhelming. These normal, healthy people are seeing a counsellor to work through a specific problem or to figure out why they are not happier with their success. Other common reasons for people to see a counsellor are to get help with depression or anxiety.

**Myth 2**: **Someone Who Doesn't Know Me Can't Help Me**

**Reality**: This is one reason why counselling can be successful. The counselling process depends on the counsellor being unbiased. Counselling involves a unique relationship with an impartial person who can help you figure out how to reach your goals. Most counsellors believe that you are the expert of your own life. Counsellors receive special training to help them know how to assist their clients facing a wide range of life challenges.

**Myth 3**: **Counsellors Can Read People's Minds**

**Reality**: Counsellors are not psychics. However, through their training, counsellors learn to observe their clients and listen to their clients in such a way that counsellors may notice things about their clients that clients did not know themselves.

**Myth 4**: **A Counsellor Can Solve All of Your Problems**

**Reality**: It’s not the job of a counsellor to solve your problems. A counsellor’s job is to help you think through your problems, provide insights, and help you to figure out how best to solve your problems for yourself.

**Myth 5**: **A Couples Counsellor Will Take Sides**

**Reality**: A successful couple counsellor will be committed to your relationship as opposed to siding with one partner or the other. If both partners do not feel that their counsellor is supportive of their needs, then perhaps another counsellor would be a better fit for you. Each counsellor has a different style so do not be afraid to search for one that both of you feel comfortable with.

**Myth 6:Counsellors Never Say Anything**

**Reality**: Most counsellors are very interactive. Don’t let the common picture of Freud “analyzing” someone on a couch distort your entire view of counselling. There are times when silence is therapeutic, but for the most part, counselling is an interactive process.

**Myth 7: Counselling Takes Forever**

**Reality:** Counselling takes as long as it needs to. You cannot put a time limit on the amount of care, thinking space and attention that a client may require. The length of counselling depends on the client’s unique goals and the severity of the challenges they are facing. Short-term counselling generally lasts between eight and twenty sessions. This type of counselling is goal-directed and focuses on specific issues and problems. Longer-term counselling typically focuses on the client’s personal character development and can last a year or more.

**Myth 8: Everyone Will Know I'm Seeing a Counsellor**

**Reality:** The only people who will know you are seeing a counsellor are the ones whom you tell this information. Counsellors are bound to confidentiality and will not discuss your issues with other people. Every counsellor should explain confidentiality to you at the beginning of your time with them; if they have not explained confidentiality, then perhaps you should find another counsellor.

**Myth 9: Counselling Is Unaffordable**

**Reality:** A lot of people do not realize that their health insurance will cover a certain number of sessions. Often, community mental health agencies can work out a payment plan if one is needed. There are also counsellors-in-training and family service agencies that see patients on a sliding scale.

**Myth 10: Counselling Groups are Touch-Feely**

**Reality:** Counselling groups today are not your typical groups that you have seen on movies or television for the last 20 years. Today’s counselling groups help members to maintain appropriate boundaries for themselves to help them work toward their goals.

**Myth 11: You Have to be Near a Divorce to Go to Couples Counselling**

**Reality:** Couples counselling can be beneficial for couples who are experiencing no problems in their relationships and those who notice the early warning signs of problems. Far too many couples do put off seeking help until a divorce seems imminent. Counselling does not guarantee that a divorce will not happen, but it can help you make the best decision.

**Myth 12: A Counsellor Will Turn Me Against My Family**

**Reality:** A counsellor will work with you to help you achieve your goals. In general, counsellors support their clients in creating healthier, more satisfying relationships with their family members.

**Myth 13: Marital Problems can only be Worked on as a Couple**

**Reality:** It is ideal to work on couples issues as a couple. However, one person’s change will affect the couple’s relationship system.

**Myth 14: S/He is the One Who Needs Counselling. Not me!**

**Reality:** We are only able to control our behaviours and our reactions to others. The most powerful way to create changes in relationships is by focusing on how you can change your own behaviours.

**Myth 15: I’m Afraid Counselling Will Change Who I Am**

**Reality:** Change is a constant part of life. Counselling can help you to change in positive ways that are consistent with your goals for life and your relationships.

**Myth 16: The Model is Irrelevant, only the Relationship Counts. The Relationship is Irrelevant, only the Model Counts.**

**Reality:** Research has shown that actively engaging in the process is essential for success, as well as feeling comfortable with the Counsellor. Therefore you need to feel comfortable with both. However, there is a fine balance between taking a risk and remaining in your comfort zone. Growth and change comes from taking a bit of a risk if you can and trying out a new technique or experiment. At this point, it is the relationship with your Counsellor which will support you through any "risky" or challenging processes. A good Counsellor will respect the fact that you may not be "ready" to try out anything too different for a while yet.  
  
**Myth 17: All the very Different Counsellor Styles and Personalities are each Suitable for everyone all of the Time**

**Reality:** Possibly but unlikely! Clearly, a Counsellor's age, manner, sex, or cultural background will all impact on how well you respond to them and them to you. So I suggest you meet a couple (or more) of therapists first and then and choose carefully.  
  
**Myth 18: Counselling is Just About Talking**

**Reality**: If you've been led to believe that, then no wonder you might think it's a pointless and expensive exercise! Of course, talking is involved (obviously) but it's also about being fully heard, received and understood at a much deeper level than normal conversation usually allows. It will take time for trust to build up between you and your Counsellor, but after a little while he or she may offer alternative ways of looking at things and, very gently, challenge your habitual thoughts and behaviours.  
  
**Myth 19: Counselling is just like Talking to a Friend**

**Reality**: Without doubt, many people have some naturally empathic friends whom we all value enormously, but can involved friends really emulate an experienced Counsellor's expert level of focused attention, or their intense listening, insight and appropriate, gentle challenge? Or are they more likely to get caught up emotionally in the drama, reacting and suffering themselves? Could this friend really continue to cope without having had the practice of thousands of hours honing their counselling skills with different people with a variety of challenges? Could the friend manage without some theoretical understanding to get clarity on what's happening to their friend?  
  
**Myth 20: Counsellors Give Advice**

**Reality:** Counsellors support and affirm clients' own choices and help them to arrive at decisions which are comfortable for them. Suggestions may be made, but never imposed.

**Myth 21: Counselling is only for Women**

**Reality:** Sadly, this myth is reflected in the statistics as more women do attend counselling than men. Counselling is equally as beneficial for men. If as a male, you consider talking about and exploring your inner thoughts and feelings emasculating, then what better way confront these issues than a confidential, safe environment with a skilled helper.

**Myth 22: Counsellors or Psychologists are 'strange,' 'peculiar,' or 'crazy' people.**

**Reality:** Most counsellors (or psychologists) are no 'stranger', or 'more peculiar' or 'crazy' than anyone else. You probably wouldn’t be able to pick a counsellor out of a crowd or identify them as such while shopping at your local supermarket.

**Myth 23: I’d have to be pretty far gone to go and see a Counsellor**

**Reality:** It is true that some people, wait until they are pretty desperate before coming for counselling. Many then wish they had come sooner and saved themselves some pain and suffering. Most people come before this, participate actively in solving their problems and leave feeling satisfied with the outcome.

**Myth 24: People in Counselling are Weak.**

**Reality:** There is nothing weak about a person who enters counselling. The individuals who enter counselling are, in fact, taking the first step in solving their difficulties. A lot of people would view this as courageous.

**Myth 25: Counsellors can prescribe Medications, such as Anti-depressants.**

**Reality:** Neither counsellors or psychologists prescribe medications. A psychiatrist or doctor is the only person that can prescribe medication. The counselling service does not dispense any medications. If you need a prescription drug, your own doctor will be able to assist you.

**Myth 26: Change is Simple.**

**Reality:** Change is not always simple and may take some time and effort to put into place. Counselling is not a 'quick fix' cure to your problems, but is part of an ongoing process of change.

Counselling is none of these. More precisely;

**Counselling helps with** *problems in living* **through an interaction with a trained professional.**

* It offers a way to gain perspective on your behaviour, emotions and relationships.
* It provides a means to express your feelings and identify patterns of thinking.
* It alleviates anxiety, depression and anger in their many forms.
* It helps develop communication skills for dealing with conflict and frustration.
* It is a means for addressing pain, working through loss and adding meaning to your life.

And, it may or may not include any of the following methods: advice giving, instruction, skill development, process consultation and/or opinion, recommendation, suggestion, admonition, warning.

That is not all.

**So, what is Counselling?**

**Counselling is a way to be empowered.**

Counselling is for folks who are courageously facing their fears, who want more from their life, who want to expand their lives and achieve goals both personally and professionally.

And, in the process, counselling *can* change your brain.

Here's how...

**Counselling**

Many people think of going to a therapist for answers. This is only part of the equation. What a therapist offers that you cannot get in a book, is an *experience***.**

And, it's *experience* that changes the brain.

* In simple terms, counselling involves one person (the counsellor) helping another person (the client) to work through some difficult or painful emotional, behavioural or relationship problem, difficulty or experience.

Dr John McLeod described counselling like this: "Counselling is a wonderful twentieth-century invention. We live in a complex, busy, changing world. In this world, there are many different types of *experience* that are difficult for people to cope with. Most of the time we get on with life, but sometimes we are stopped in our tracks by an event or situation that we do not, at that moment, have the resources to sort out". If we cannot find ways to sort this out in our family, with our friends, or with a priest or doctor, etc., then "Counselling is a really useful option at these moments". John McLeod, *An Introduction to Counselling*, 2003.

**Counselling is a form of psychological or talking therapy that offers people a chance to change how they feel and to live better**

* Counselling also known as ‘talking therapy’ amount to helping the client to identify the source of their emotional or behavioural problems, *so that they can come to terms with whatever aspect of reality they are resisting*; and/or to refine their understanding of their practical problems; and/or to clarify their goals in relation to some developmental challenge; and/or to overcome their emotional, behavioural or relationship difficulties or problems.

**What more is counselling?**

* Counselling provides a regular time and space for people to talk about their troubles and explore difficult feelings in an environment that is dependable, free from intrusion and confidential.

In addition, we have the concept of ‘therapy,’ which comes from the Greek word for "healing". Counselling and therapy, which overlap significantly, can be said to be in the business of "healing the life" of the client, or helping the client to "heal themselves."

In the UK there are 99 organizations representing counsellors, and each of them varies somewhat in their emphasis on what counsellors do. Forty-six of those counselling organizations are (or have been - directly or indirectly) in negotiations with the British government about professionalization of the field.  
  
One of those forty-six organizations, the BACP, defines counselling as follows:

* "Counselling takes place when a counsellor sees a client in a private and confidential setting to explore a difficulty the client is having, distress they may be experiencing or perhaps their dissatisfaction with life, or loss of a sense of direction and purpose. It is always at the request of the client as no one can properly be 'sent' for counselling.”
* "By listening attentively and patiently the counsellor can begin to perceive the difficulties from the client's point of view and can help them to see things more clearly, possibly from a different perspective. Counselling is a way of enabling choice or change or of reducing confusion. It does not involve giving advice or directing a client to take a particular course of action. Counsellors do not judge or exploit their clients in any way." (Source: BACP website - http://www.bacp.co.uk/education/whatiscounselling .html).

The word ‘counselling’ covers a broad spectrum, from someone who is highly trained to someone who uses counselling skills (listening, reflecting back what you say, or clarifying) as part of another role, such as nursing.

Counselling is concerned with a number of different tasks; which includes giving the client an opportunity to explore, discover and clarify ways of living more satisfyingly and resourcefully.

Simply put, the term ‘counselling’ could be used to mean a talking therapy delivered by a trained professional.

**Who is a Counsellor?**

3 Dimensions of a Counsellor;

* Who the counsellor is
* What the counsellor knows
* What the counsellor can do

**Who the Counsellor is**

A counsellor is (relatively) a wise philosopher who teaches what he has used to heal his own life to facilitate his clients’ exploration of their own issues and needs, and to arrive at conclusions or solutions that resolve their problems and move their lives forward.

Despite the name, counsellors don’t usually offer advice. Instead, they help clients to gain insight into their feelings and behaviour and to change their behaviour, if necessary. They do this by listening to what the clients have to say and commenting on it from their particular professional perspective.

A counsellor respect clients’ viewpoint while helping them to deal with specific problems, cope with crises, improve relationships, or develop better ways of living.

A counsellor is a person trained in the skills of listening to clients, asking supportive questions, discussing various options, giving practical information and important referrals, encouraging clients to make their own informed decisions and suggesting follow-up procedures.

According to WIKIPEDIA; *Counsellors are introspective, cooperative, directive, and attentive. They have a strong desire to contribute to the welfare of others. Counsellors are gratified by helping others to develop and reach their potential.*

*Counsellors often communicate in a personalized manner. They tend to be positive and kind when dealing with others. Counsellors are good listeners and can sometimes detect a person's emotions or intentions even before the individual is aware of them. This ability to take in the emotional experiences of others, however, can lead Counsellors to be hurt easily.*

*Counsellors usually have intricate personalities and rich inner lives. They tend to understand complex issues and individuals. They are generally private people who keep their innermost thoughts and emotional reactions to themselves. This quality can make them difficult to get to know.*

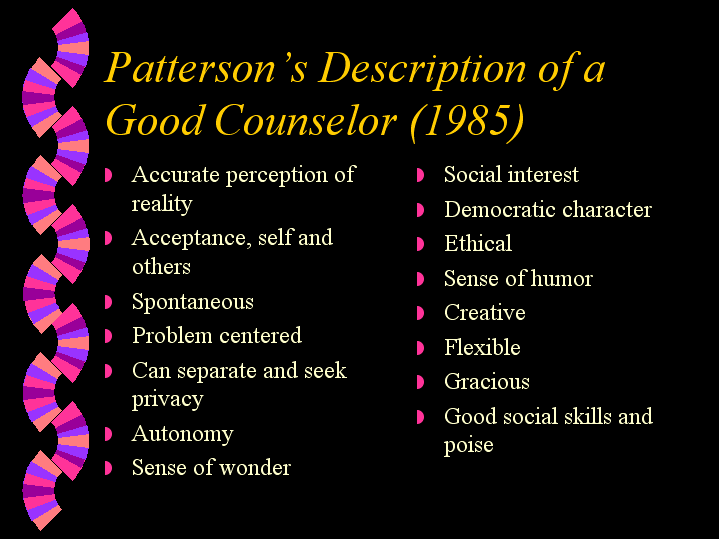
*Counsellors value harmony, which they work to maintain at home and at work. They may lose confidence, become unhappy, and even become physically ill if subjected to a hostile environment. Counsellors may be crushed by too much criticism, though they may not express their feelings to others.*

**What the Counsellor Knows**

* Theories/ Models/ research on personality
* Theories/ Models/research on Human Development
* Theories/Research on Psychopathology
* Assessment Techniques
* Intervention Strategies

**What the Counsellor Can Do**

* Assessment
* Conceptualization of problems
* Systematic intervention – individual, group, family
* Evaluation
* Consultation
* Supervision
* Research

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**A GOOD COUNSELLOR DOES NOT DECIDE FOR HIS/HER CLIENTS**

**APPROACH/TYPES OF COUNSELLING**

There are different approaches to counselling;

-Passive listening forms of counselling;

-More analytical form of the sources of the presenting problem;

-Philosophical form.

**TYPES**

* Crisis Counselling
* Peer Counselling
* Psychotherapy
* Directive Counselling
* Non-Directive Counselling

**Crisis Counselling**

Crisis, as defined in the dictionary of Psychology, is “a decision or event of great psychological significance for the individual.” It is an emergency situation.

In mental health terms, crisis refers not to a traumatic event or experience but to how an individual respond to the situation such as witnessing a violent death or being involved in a car crash.

Crisis counselling is an approach which concentrates on helping a person around the time of a crisis and for a short while afterwards.

This type of counselling is intended to be quite brief, generally lasting for a period no longer than a few weeks and it may involve outreach work within a community as it is not limited to office appointments.

**Elements of Crisis Counselling**

* **Assessing the situation**

Assessing the client’s current situation is the first element of crisis counselling and it involves listening to the clients, asking questions and determining what the individual needs to effectively cope with the crisis.

* **Education**

Clients experiencing crisis needs information on what is happening and informed steps they can take to reduce the damage. During crisis counselling the counsellor is to help the client see that the event is temporary as people in a dire situation tend to think it is forever.

* **Offering Support**

One of the main elements in crisis counselling is to offer support, stabilization and resources. During the crisis, it can be very beneficial for individuals to develop temporary/brief dependency on supportive people. Active and non-judgemental listening, unconditional acceptance and reassurance can help reduce the stress of a crisis.

* **Developing Coping Skill**

In addition to providing support, crisis counsellors also help clients develop coping skills to deal with their immediate crisis. This might involve exploring different solutions with the client, encouraging positive thinking and other stress reduction techniques. Above all, the counsellor should not only teach the client how to get out of the crisis but how to use all he/she is learning in the future.

**Peer Counselling**

In this method of counselling, the counsellor and the person being counselled considered each other’s as peers or equal. The counsellor here doesn’t consider him/her self to be far above the person being counselled.

An example of Peer Counselling is a one-to-one service to disabled people by a counsellor with a disability.

Peer counselling has many advantages to the client, the counsellor and the community.

* The client is given the opportunity to model after someone whom s/he has reached out to.
* S/he is given the opportunity to develop coping skills that presumably work because they work for the peer counsellor s/he is relating to.
* S/he can learn to advocate on his/her own behalf.
* His/her feelings of self-worth can be enhanced because s/he has a counsellor who truly understands.

Peer counselling has been shown to reduce the feelings of isolation, anger and depression.

It gives the time and the opportunity for an individual to express their feelings that they so often keep from family and friends.

**Psychotherapy**

This form of counselling is very deep and is done by skilled and experienced therapists, usually a psychologist or psychiatrist.

It involves listening to people talk about their problems with the aim of improving their mental health.

The central feature of psychotherapy is defined by Holmes and Lindley (1989) as "... *the use of a relationship between therapist and (client) - as opposed to pharmacological or social methods - to produce changes in (thinking), feeling and behaviour*".

These more universal definitions tend to focus upon the relationship. It is a situation where people are offered the rare opportunity to pursue the truth about themselves and their lives. This is without the threat of blame and disapproval and without the risk of offending or hurting the person to whom they are revealing themselves.

Although these definitions emphasise different aspects, all indicate how central the relationship is to any understanding of the practice of psychotherapy.

**Directive Counselling**

Directive counselling is the traditional method of counselling (i.e. father, mother, aunt, uncle) wherein you tell someone what to do.

Without giving outright instructions a counsellor can be directive by pushing the client in a particular direction. This often includes suggesting courses of action and perhaps giving ‘homework’ exercises to clients.

**Forms of Directive Counselling**

* **Rational-emotive behavioural counselling**

This takes the view that people have two main goals in life: to stay alive and to be happy. It aims to remove the obstacles that people place in their own way, and also to achieve a healthy balance between short-term and long-term goals.

* **Cognitive behaviour therapy**

This is concerned with the way people’s beliefs about themselves shape how they interpret experiences. The objective is to change self-defeating or irrational beliefs and behaviours by altering negative ways of thinking.

Clients learn to monitor their emotional upsets and what triggers them, to identify self-defeating thoughts, to see the connections between their beliefs, feelings and behaviour, to look at the evidence for and against these thoughts and beliefs, and to think in a way that is more realistic and less negative.

* **Gestalt counselling**

It encourages people to have an active awareness of their present situation, and also incorporates communication that goes beyond words. A key part of gestalt counselling is the dramatisation, or acting out, of important conflicts in a person’s life. This could involve using two or more chairs, for instance, so that they can physically take up different positions to represent different aspects of themselves.

The counsellor in Directive Counselling usually gives the client tasks or homework to do between sessions. This could mean recording thoughts and feelings, or doing something that test out a basic assumption about themselves. This might mean, for instance, going to the shops when their fear is that they might panic.

**Non-Directive Counselling**

Here the client takes the lead in what’s discussed.

Carl Rogers was the father of non-directive counselling in the USA where he could not practice more active forms of psychoanalysis or psychotherapy, because he did not have a psychology degree. He therefore created a system which depended upon active listening to help the client to clarify their own issues, and extending three core conditions towards the client: **genuineness; empathy and non-possessive caring**.

**Forms of Non-Directive Counselling**

1. **Psychodynamic counselling**

This is based on the idea that past experiences have a bearing on experiences and feelings in the present, and that important relationships, perhaps from early childhood, may be replayed with other people later in life.

The counsellor usually aims to be as neutral a figure as possible, giving little information about him- or herself, making it more likely that important relationships (past or present) will be reflected in the relationship between the client and the counsellor. This relationship is therefore an important source of insight for both parties, and helps the client to ‘work through’ their difficulties. Developing a trusting and reliable relationship with the counsellor is essential for this work.

1. **Client-centred or person-centred counselling**

This is based on the principle that the counsellor provides three 'core conditions' (or essential attributes) that are, in themselves, therapeutic.

These are:

\***Empathy** (the ability to imagine oneself in another person's position)

\***Unconditional positive regard** (warm, positive feelings, regardless of the person's behaviour)

\***Congruence** (honesty and openness).

Again, the counsellor uses the relationship with the client as a means of healing and change.

1. **Transpersonal counselling**

This is an integrative and holistic approach that utilises creative imagination. It assumes a spiritual dimension to life and human nature. It also presupposes the interconnectedness of all beings with a higher spiritual power, and specifically addresses the link between the two.

Transpersonal counselling emphasises personal empowerment. It takes account of the client’s past experiences, but also looks to the future and what is likely to unfold for them, the challenges they may face and the qualities that need to emerge in them to meet those challenges. Its basic belief is that whatever the hardships of human experience, the core essence, or soul, remains undamaged.

1. **Transactional analysis counselling**

Transactional analysis counselling emphasises people's personal responsibility for their feelings, thoughts and behaviour. It believes people can change, if they actively decide to replace their usual patterns of behaviour with new ones.

Here, the counsellor offers:

* 'Permission' (for new messages about yourself and the world)
* 'Protection' (when changing behaviour and thoughts feels risky)
* 'Potency' (to deliver what he or she promised).

Planning the goals of the counselling is part of the process. The focus is on uncovering the 'life scripts' (life plans) that reflect the messages the client was given as a child. The counselling teaches the client to identify in which of the following modes he or she is operating, at any given time:

* the 'child' (replaying their childhood)
* the 'parent' (copied from parents or parent-figures)
* the 'adult' (appropriate to the present situation).

1. **Existential counselling**

This helps people to clarify, think about and understand life, so that they can live it well. It encourages them to focus on the basic assumptions they make about it, and about themselves, so they can come to terms with life as it is. It allows them to make sense of their existence.

The counselling focuses the client on how much they already take charge of their life, and not on what they are doing wrong. At the same time, it takes note of any real limitations, so that they can make choices based on a true view of the options available.

1. **Personal construct counselling**

This is based on the idea that nobody can know absolute truth. Instead, each person constructs their idea of the truth from their own experiences, and this affects the way they see the world. The problem is that people can get stuck with a view of things that prevents them from living life to the full, because they can’t find any alternative ways of seeing things.

Personal construct counselling helps people to look at different ways of behaving that may be useful in changing the way they see the world.

**Other Forms of Counselling:**

* **Telephone counselling**

Telephone counselling is a well-established alternative to face to face counselling. It is obviously better to have face to face contact with your coach or counsellor, but in many situations this is impossible: for examples, when the client is disabled or house-bound; or when the client lives in an area that is not well served by coaches/counsellors/therapists; or perhaps there is nobody from the school of counselling that the client prefer.

This system is very effective, despite the lack of *body language* and *face reading*. It is surprising how nuanced our voices can be in communicating subtleties that normally rely upon body language.

Phone counselling may specialise in bereavement, problems with addiction, serious mental health problems, domestic violence or the aftermath of rape. This offer anonymity, for some people, this feels safer than seeing a counsellor face to face. Calls may be one-off, but clients may be able to speak to one particular counsellor, regularly, by phone, if they wish.

* **Workplace Counselling**

Some employers have an arrangement with an Employee Assistance Programme (EAP.) EAPs employ their own counsellors, who usually have their own consulting rooms. As a rule, the counselling is free to clients because their work-place pays the EAP. It usually runs to 6 or 12 sessions.

Sometimes the organization has the HR trained in workplace counselling so as to handle, more effectively, employees’ issues.

This can be useful for someone trying out counselling, who might decide to pursue something more open-ended afterwards, in which case the EAP counsellor could refer the employee to another counsellor. In other cases, a few sessions may be very helpful in addressing an immediate problem the employee is going through.

**3 Causes of Problems for Workplace Counselling**

* Issues arising **within** individuals caused by the organization or emanating from sources external to both the individual employee and the organization. Problems within individuals could be: (i)Psychological e.g. frustration, lack of job satisfaction, arrogance and inability to succeed (ii) Illness.
* Problems caused by work organization **acting on** the individual, such as; technical incompetence, under utilization, relationship with colleagues and superiors, threat of redundancy or job change.
* Problems from **outside of** the individual and work; may not have importance or effect on the quality of the employees work. i.e. problems around money, family, sexual/marital relationships, behaviours of children, death and loss.
* **Email Counselling**

Email Counselling is a form of Writing Therapy with Professional Support**.**

This service involves an exchange of emails - from the client to the counsellor, describing the problem or concern; and reply from the counsellor, providing analysis, interpretation, commentary and advice, as appropriate.

Email counselling allows the client an opportunity to express thoughts and feelings and explore issues at the time when these are uppermost in their mind. (Emails) can be written at (a time of most convenience) and continued over a period of days or weeks. The client determines the timing of their side of the contract. Putting words down on paper often enables the writer to feel a sense of control over their situation and is often perceived as therapeutic in itself. Knowing someone is there to receive, acknowledge and respond to (emails) can provide those moving through (painful or distressing transitions) with a sense of security and provides a tangible opportunity to chart personal progress.”

* **Narrative Therapy**

What makes a therapy session 'Narrative' is the decision of the counsellor or therapist to focus on the 'story' of the client's life, rather than explore the 'objective facts' of their lives. When counselling and therapy are based on the idea that the client lives inside a socially-shaped story, and their way of helping the client involves exploring the possibility of 'rewriting that story,' then Narrative Therapy is in progress.

Individuals may need to explore and resolve many issues from the past, and this can be done in the form of spoken narratives with a therapist, or written narratives as ‘homework activity' outside of counselling sessions, or even as self-directed narrative writing.

There is a range of options for the structure of therapeutic writing activities. One possibility could involve an individual in writing for 3-5 minutes, about a problem that is bothering them. Then they might edit their work, for 15-20 minutes. In the process they could look for causal links between events; and reflect on their own role in the creation of the problem. They would also be well advised to use more positive than negative words, and to end with some kind of coping self-statement, to avoid feelings of hopelessness and helplessness.

More generally, a therapeutic narrative is any kind of written or spoken narrative/story which promotes physical and/or mental healing.

A therapeutic narrative is a piece of writing (and/or, in its broadest sense, a spoken monologue or dialogue) - normally in the form of a story - which helps to heal the mind of the writer/author/speaker. A great deal of fiction - including novels, plays and short stories - has been written for this purpose - to heal the author; to help them to get over a significant emotional block or deprivation. Therapeutic texts show up in many formats - e.g. personal journals, emails to counsellors, letters written but never sent, etc - and they tackle many different kinds of personal challenges. They are always about some kind of recovery, or growth, or personal liberation from restriction or suffering.

* **Writing Therapy**

Writing therapy, on the other hand, is any system of writing that is designed to promote psychological and physical wellbeing. There are two basic traditions in writing therapy: the cognitive scientific tradition, and the creative/humanities tradition. Both are found to be effective.

Writing therapy is highly effective, compared with drug treatments, but the mechanism by which writing therapy works is still unclear. It may just be that the opportunity to express a problem that has been bottled up is curative in itself; or that it is the thinking through of a problem that has not previously been thoroughly digested that produces the effect. Effective writing therapy seems to involve processing previously unprocessed negative emotions, in a self-reflective way, and identifying causal links between elements of the story. It also normally involves using more positive than negative words, and ending with a coping self-statement.

The question then arises of what therapeutic writing comprises or includes. This was summarized by Bolton and Wright (2004) as follows: "Therapeutic writing employs processes of personal, explorative and expressive writing, which might also be creative or literary, in which patients or clients are offered guidance and inspiration by a clinician or creative writer, and help in choosing a topic for their writing. This might also take the form of approaches similar to ‘guided fantasy', or it might take the form of something more like an ‘essay topic', or structured writing tasks".

**How to start:**

♦ Only 20-30 minutes is needed to do a useful piece of writing: if much longer is set aside, much of it will be wasted in fiddling about without starting to write.

♦ You will write the right thing, no matter what you write; you can't write the wrong thing (by definition).

♦Write without thinking: let the writing hand take charge.

♦ Forget all the rules of grammar, structure, form and spelling ever learned. If these do need sorting out before the writing is shared, it's easier done later.

♦ First write whatever comes into your head for six minutes without stopping, and without thinking. There is no theme or subject for this stage: the aim is to capture those images, which flash in and out of the mind with little or no attention paid to them. This might come out like lists, scattered bits and bobs, or even be fairly incomprehensible.

♦ Now take a theme, such as: *a time I learned something vital; a gift; someone who was very important to me.* Tell a story or write a poem about *a time when...* Write for about 20 minutes or more.

♦ Read it all through silently (including the six-minute scribble). Improve upon the content if that seems right, but give no thought to grammar, construction or spelling yet. Look out for useful connections between the six minutes and the longer writing.

♦ Share it with another, if and when that seems right.

♦ Now this is an exciting stage, if you venture this far: write a fictional story or poem which complements the original one. Write in the voice of the person at the centre of the original account: the patient, the colleague or the relative. Or rewrite giving the account a satisfactory ending instead of a horrid one, or switching the gender of the main characters. Or write in another genre: Mills & Boon (Romantic Fiction), thriller, detective, fantasy. There are many different ways to write another story or poem as there are writers: experiment, have fun. This is a very instructive stage.

This is the essence of what are called therapeutic narratives.

If a novel or a poem, or a conversation with a friend, can be a therapeutic narrative, then there is a distinction to be made between therapeutic narratives *per se*, and the processes of ‘writing therapy’. A therapeutic narrative is clearly *any kind of written or spoken narrative/storywhich promotes physical or mental healing.*

Writing therapy, on the other hand, is *any system of writing* that is *designed to promote psychological and physical wellbeing.*

Writing therapy is seen as positing that, when a person writes about their negative feelings from the past, including traumatic and stressful experiences, the result is an easing of physical and emotional pain, and a strengthening of their immune system

So writing therapy involves writing about emotional traumas, or troublesome emotional stories from the past: in order to stop bottling them up; to begin to digest them; to begin to displace unhelpful dominant narratives, and replace them with more helpful and less disturbing alternative narratives; to integrate conflicting narratives; and so on.

**Who Should Use Writing Therapy?**

We have now defined ‘therapeutic writing' and ‘writing therapy', and shown that writing therapy is highly beneficial to most people in terms of promoting physical and mental well-being, and adaptive behaviour.

However, not *everybody* is likely to benefit equally from writing therapy, and so it is important to try to identify those situations and circumstances in which writing therapy would be seen to be helpful, and also those situations and circumstances in which writing therapy would be contra-indicated.

**(a) Who is most likely to benefit from writing therapy, and in what circumstances?**

Wright (2004:14) has summarized a list of client circumstances in which writing therapy seems most appropriate, as follows:

**Table 1.1 (from Wright, 2004: 14): Circumstances in which writing therapy is beneficial**

|  |
| --- |
| **Clients' circumstances** |
| * + - 1. Time-limited, focused, brief therapy - some of the detail can be dealt with outside the therapy room, on paper in private. |
| * + - 1. With people who have a self-directed tendency to write - journals, diaries, letters - and who have found the process of writing, especially autobiographical writing, (to be) cathartic and clarifying. |
| * + - 1. With people who are or perceive themselves to be powerless. |
| * + - 1. With people who are not using their first language in the face-to-face therapy - they are able to use their first language or a mixture of both first and host language. |
| * + - 1. With people who, for cultural or other reasons, are silenced by shame and feel unable to speak. |
| * + - 1. With people who are in inner turmoil and need to ‘unpack the mind, externalise and organise their thoughts and feelings. |
| * + - 1. With people who need to disclose and exorcise a particular memory of stressful or traumatic experience. |
| * + - 1. With people at particular stages of life associated with experiencing strong feelings (e.g. adolescence or for the dying and those in hospice care.) |

It might also be that this form of therapy is particularly suitable for, or particularly helpful to, males more so than females: Expressive writing is more beneficial for those high in alexithymia (or inability to understand, describe or process emotional states).

**(b) Who should be excluded from writing therapy processes for their own protection?**

Writing therapy is not appropriate in all circumstances. For example: "When the client's experience is pre-verbal (from the first couple of years of life), or when writing is associated with strong negative experiences, for example in English classes at school, clients are unlikely to want to try writing therapy

Writing therapy should also be avoided with clients who are in denial about their problems, and who may seek to divert the therapist at every turn: Some clients bring reams of writing which, if it were read by the therapist at the time, would take up most of the session and avoid the possibility of engagement within the therapy room. It may also mean that all emotional expression takes place outside the sessions, where it can be safely sealed off, rather than being shared and worked with (or worked through). Thus with some clients, or at certain stages in a particular client's therapy, it might be better to stick to face to face encounters.

Also exclude clients who are either: depressed, highly stressed, have negative associations with writing at school or who is suffering from PTSD; Posttraumatic stress disorder (PTSD) is an anxiety disorder that can occur after someone had been through a traumatic event. These events can include:

* Combat or military exposure
* Child sexual or physical abuse
* Terrorist attacks
* Sexual or physical assault
* Serious accidents, such as a car wreck
* Natural disasters, such as a fire, tornado, hurricane, flood, or earthquake

It probably appeals most to people who enjoy writing, and who are self-reflective. So counsellors and therapists should be careful when deciding whether or not to recommend writing therapy to a client.

**For Therapists and Counsellors:**

The following learning points are most relevant to counsellor, psychotherapists, psychologists, psychoanalysts, social workers, etc.:

(1) There is a problem with the stories that clients carry around in their minds. The dominant narratives in their lives may be persecutory or self-downing or otherwise undermining of their self esteem and distorting of their self concept.

(2) Alternative narratives can be developed which are more empowering, and which have a therapeutic effect on the body and mind of the client.

(3) The challenging or dominant or unhelpful narratives can be done verbally or in writing.

(4) Writing therapy is highly effective, relative to drug therapy.

**OUTCOMES OR RESULTS OF COUNSELLING AND THERAPY**

Clients come to counselling because of difficult experiences they have been going through, such as a relationship breakdown, bereavement or redundancy. Or they may want help dealing with feelings of sadness, depression, eating disorder, anxiety or low self-worth that don’t seem to be connected to any particular event.

It can also help clients come to terms with an ongoing physical problem, illness or disability. Counselling can also be a means of coping with physical symptoms or complaints that doctors can’t alleviate.

The main benefits that clients gain from counselling and therapy in general include the following:

1. **A listening ear**. We all know that a problem shared is a problem halved. And being listened to by a professional counsellor can help you to clarify for yourself exactly what is bothering you, and what your goals are in relation to that clarified problem.
2. **Reassurance**: When you consult a reputable counsellor and talk about your problems, you can feel very reassured that your situation is probably not as hopeless as you had thought.
3. **Appropriate advice**: If you go to a cognitive counsellor, you will get advice on how to improve your situation by changing some specific aspect of your thinking, or your behaviour. When you change your thinking and behaviour, your emotions tend to fall in line.

In addition, counsellors help to:

* Identify what went wrong in the clients past.
* Understand how that has affected the client.
* And to complete the client experience of what went wrong, so him/her can digest it and let it go.

You will also get an attentive relationship of care and consideration.

**Here are a further eight aims and benefits of counselling, which are amongst fifteen benefits identified by Dr John McLeod's (2003 book)** *An Introduction to Counselling:*

1. Insight into how emotional disturbances are caused, and how to think your way out of emotional difficulties.
2. Developing the ability to relate better to significant others - to develop relationship skills.
3. Becoming more aware of your own thoughts and feelings, so you can manage them better.
4. Learning to accept yourself with all your faults and frailties as being okay and acceptable.
5. Developing solutions to specific problems, and becoming a more effective problem solver.
6. Learning psychological models to understand and control your behaviour.
7. Learning how to identify and change irrational beliefs, or faulty lenses through which you view your world.
8. Learning how to identify and change maladaptive or self-defeating behaviour

**CONFIDENTIALITY IN COUNSELLING**

Counselling is always confidential, and this is an important part of the contract between client and counsellor, making it safe for the client. There are some exceptions, which allow the counsellor to work responsibly.

1. Counsellors always discuss clients regularly with a supervisor (an experienced counsellor or psychotherapist), who also has to maintain confidentiality. Supervision is an essential part of the work and, indeed, it’s seen as unethical for a counsellor to work without it.
2. If, under any circumstances, the counsellor is concerned about the client’s safety or the safety of a third party, it may be necessary to inform the client’s GP, psychiatrist (if applicable) or someone else. Most counsellors have a policy of informing the client beforehand of any action they intend to take.
3. Many organisations have a policy of confidentiality to the organisation, so that no information goes outside it, but counsellors are free to discuss a case with the manager, when necessary. If a counsellor is working as part of a GP practice, confidentiality may apply to the practice as a whole, rather than to the individual counsellors, and this may mean that information is available to the clients GP. If this is the case, counsellors should make it clear to the client at the start.

Counsellors should tell the clients their policy on confidentiality before counselling begins.

**THE COUNSELLING ROOM**

Counselling takes place in a confidential meeting, in a quiet room, and is subject to a code of ethics which specifies what the counsellor can and cannot morally do in that context.

Items in the counselling room

|  |  |
| --- | --- |
| ITEMS | REASONS |
| Chairs (preferably sofa) | For sitting, to aid comfort, promote relaxation and prevent uptight feelings of facing a panel or judge when the client had to sit upright (especially if the client is a child.) |
| Side stool | For placement of items in use during sessions especially group sessions |
| Mirror | For therapeutic purposes especially “Self Talk” |
| Cabinet/side draw | For safe keeping of all counselling materials, items and reports. |
| Writing materials | Papers, pencils, crayons, pens, erasers, |
| Lightening | For creation of a therapeutic atmosphere |
| Charts | Charts on self-discovery, esteem building, parts of the body, type of touch and other mind enlightening pictorial representations to be hung on the wall for educative purposes |
| Table | For writing purposes |
| Water dispensers | Some clients’ needs to take sips of water during talk to help loosen their tongues. Also water has a calming therapeutic power. |
| Tissue papers | In case of tears |

**HOW LONG DOES IT LAST?**

Counselling can be either open-ended or time-limited, depending on where and who. Most counsellors are funded to offer a maximum of 12 sessions, sometimes 6 or 8, while most private counsellors will take clients on for open-ended work. The counsellor and the client can then decide, together, how much counselling is needed and when it’s right to stop.

**CODES OF ETHICS; Protection against bad practice**

Each professional body has its own code of ethics or ethical framework, and complaints procedure. Codes of ethics vary in their details, but all of them make it clear that a counsellor should never exploit the client financially, emotionally or sexually. They should also endorse a commitment to equal opportunities.

The counsellor should tell a client about the ethics he/she abides by and the complaints procedure of their own professional body.

Here is an example;

**CODES OF ETHICS FROM THE INTERNATIONAL SOCIETY OF PROFESSIONAL COUNSELLORS**

* + 1. I will ensure that all potential clients are fully informed of what would be involved in entering into a counselling/therapy relationship with me, by providing an information pack and background information on REBT/CBT/CENT, and on my own professional training and accreditations, etc.
    2. I will ensure that clients know in advance how much my services will cost them, and that there will not be any attempt to renegotiate fees once counselling/therapy has begun.
    3. The counselling relationship is for the benefit of the client. The emotional well being of the client will be the paramount concern of the Counsellor.
    4. The Counsellor must ensure that they do not abuse the client’s vulnerable situation. The term abuse includes the following: sexual, emotional, psychological, intellectual, financial and physical.
    5. I will restrict my physical contact with clients to formal handshakes; and that not routinely. I will not embrace my clients, so that I can ensure the maintenance of strong barriers against romantic or sexual involvements.
    6. I will work in ways that will promote client autonomy and well-being, and maintain respect for and dignity of the client.
    7. When contracting for psychotherapy, counselling or coaching I will include clear boundaries and conditions for the therapeutic/coaching relationship.
    8. All information given to the client will accurately reflect the nature of my work and of my qualifications and training.
    9. Clients will be informed if records of psychotherapy, counselling or coaching sessions are kept and what degree of access those clients and others have to them.
    10. I will monitor and recognise my own limits of competence through such activities as consultative support, psychotherapy, counselling and coaching supervision and client feedback.
    11. I will maintain high personal and professional standards, and monitor my own effectiveness in the psychotherapy and counselling arena.
    12. I will not practise without regular consultative support and supervision.
    13. I will work within the law and be aware of current legislation affecting the work of psychotherapists, counsellors and coaches.
    14. I will explain the terms of client confidentiality to the client in pre-session information or during initial contracting.
    15. Client confidentiality is normally maintained and only breached without the client’s consent in exceptional circumstances, involving serious legal matters. Any breach will be minimised by releasing only essential information pertinent to the immediate situation.
    16. With regard to research, I accept the following rules: Practitioners using client information for case studies, research, publications, or other purposes, should seek client’s informed consent. In addition, it is important to disguise the clients’ identities to the extent that they cannot be recognised by others.
    17. Two complaints procedures are available to clients, by going to (1) the [Counselling Ltd CCC website](http://www.counselling.ltd.uk); or (2) the [International Society of Professional Counsellors website](http://www.ispc.org.uk) - if they are dissatisfied with my competence, my behaviour or any other aspect of the helping relationship being undertaken.

**The Relationship between Counsellor and Client**

What would help counsellors and therapists to know what to do to help their clients to feel more secure in their relationships, inside and outside of therapy?

Firstly, 2 things are essential for healthy psychological development of every counsellor/client relationship:

(a) counsellor should be *accessible* to the client at all times of need;

(b) Counsellor must be *responsive* as well as accessible.

The client needs to know which of their statements or actions produces which responses in the therapist. The therapist must be transparent in showing the *contingency* (or dependence) of a particular response upon a particular stimulus from the client.

This is what helps the client to construct a model of ‘what is going on' in the mind of the other as reflected in their own mind. If the client cries, the therapist may reflect this by showing a sad face, ‘marked as' a reflection.

Counsellors and therapists, like mothers and fathers, are imperfect and error-prone humans. We cannot always ‘get it right' for our clients. But we should aim high and we should learn how to track down and resolve any misunderstandings that arise between us.

Clients can learn from us that misunderstandings can be resolved, and "distress can be weathered because it can be relieved".

**# R = Rapport**. Build rapport with the client as a basis for a strong therapeutic alliance.

**# C = Contract**. Find out what the client wants to work on, as a contractual undertaking.

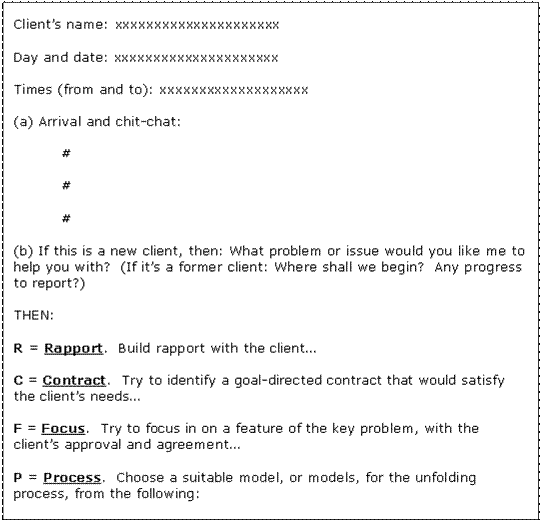
**# F = Focus**. Focus in on an area of work that will assist in the pursuit of the client's goals.

**# P = Process**. Process the client's communications skill.

**# E = Event**. What happened in the client's life, about which they are disturbed.

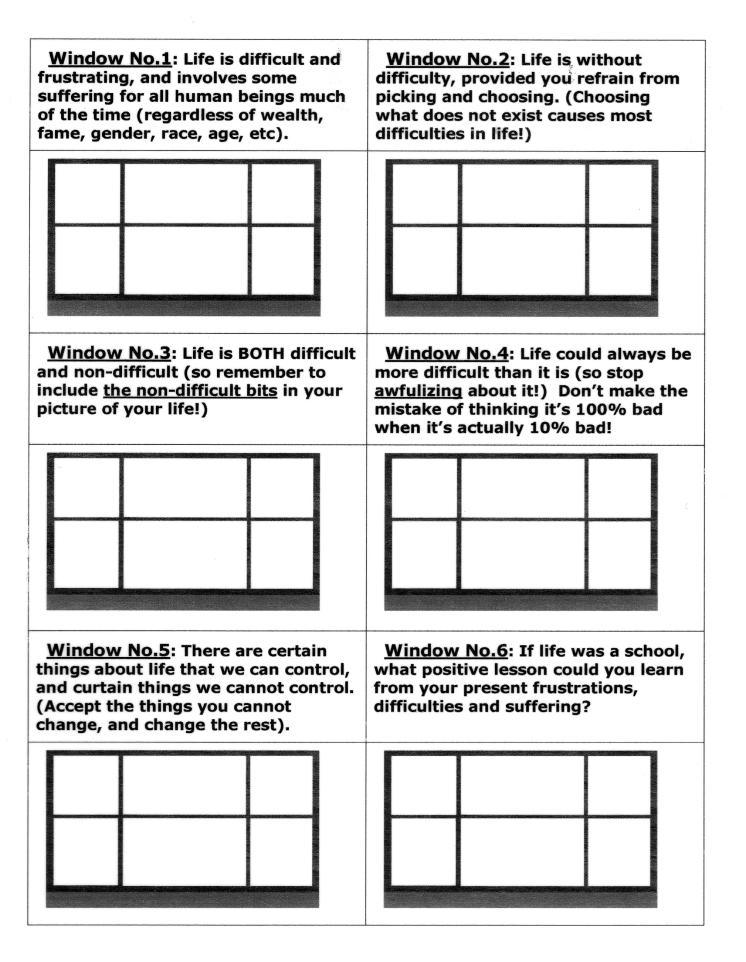
**# F = Framing**. How did the client frame this experience? (They normally will not know this, as it is mainly non-conscious).

**# R = Response**. How did the client respond to their Framing (F) of the Event (E)? What emotion did they feel? How did they act?



The ***Windows Model*** is predicated on ‘frame theory', which suggests that all of our perceptions are ***interpretative***, and that our interpretations are driven by habit-based ‘framings' of incoming stimuli, through our senses.

The Six Windows Model provides six empowering frames through which to view a difficult situation, to allow the client to gain mastery over their problem.



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**DPC 102**

**HUMAN DIFFERENCES & PSYCHOLOGY**

**Introduction: What is Psychology?**

Psychology is the scientific study of the mind and behaviour.  Psychology is a multifaceted discipline and includes many sub-fields of study such areas as human development, sports, health, clinical, social behaviour and cognitive processes.

Psychology is really a very new science, with most advances happening over the past 150 years or so.  However, it's origins can be traced back to ancient Greece, 400 – 500 years BC.  The emphasis was a philosophical one, with great thinkers such as Socrates influencing Plato, who in turn influenced Aristotle.

Philosophers used to discuss many topics now studied by modern psychology, such as [memory](http://www.simplypsychology.org/memory.html), free will, attraction etc.

In the early days of psychology there were two dominant theoretical perspectives.  An American psychologist named William James (1842-1910) developed an approach which came to be known as functionalism.  He argued that the mind is constantly changing and it is pointless to look for the building blocks of experience.

Instead, focus should be on how and why an organism does something. It was suggested that psychologists should look for the underlying cause of behaviour and the mental the processes involved. This emphasis on the causes and consequences of behaviour has influenced contemporary psychology.

Structuralism was the name given to the approach pioneered by Wilhelm Wundt. The term originated from Edward Titchener, an American psychologist who had been trained by Wundt. Structuralism relied on trained introspection, a research method whereby subjects related what was going on in their minds while performing a certain task. However, it proved to be unreliable method because there was too much individual variation in the experiences and reports of research subjects.

Despite the failing of introspection [Wundt](http://www.simplypsychology.org/wundt.html) is an important figure in the history of psychology as he opened the first laboratory dedicated to psychology in 1879, and its opening is usually thought of as the beginning of modern psychology. Wundt was important because he separated psychology from philosophy by analyzing the workings of the mind using more objective and standardized procedures.

Because [psychology is a science](http://www.simplypsychology.org/science-psychology.html) it attempts to investigate the causes of behaviour using systematic and objective procedures for observation, measurement and analysis, backed-up by theoretical interpretations, generalizations, explanations and predictions.

The classic contemporary perspectives in psychology to adopt these strategies were the [behaviourists](http://www.simplypsychology.org/behaviorism.html), who were renowned for their reliance on controlled laboratory experiment and rejection of any unseen or subconscious forces as causes of behaviour.  And later, [cognitive psychology](http://www.simplypsychology.org/cognitive.html) adopted this rigorous, scientific, lab based scientific approach too.

With its broad scope, psychology investigates an enormous range of phenomena: learning and memory, sensation and [perception](http://www.simplypsychology.org/perception-theories.html), motivation and emotion, thinking and language, personality and social behaviour, intelligence, child development, [mental illness](http://www.simplypsychology.org/abnormal-psychology.html), and much more. Furthermore, psychologists examine these topics from a variety of complementary psychological [perspectives](http://www.simplypsychology.org/perspective.html).

Each psychological perspective is underpinned by a shared set of assumptions of what people are like, what is important to study and how to study it.  Some conduct detailed biological studies of the brain, others explore how we process information; others analyze the role of evolution, and still others study the influence of culture and society.

**Fast facts on psychology**

* Psychology is the study of behaviour and the mind.
* We are unable to physically see mental processes such as thoughts, memories, dreams and perceptions.
* Clinical psychology is an integration science, theory, and practice.
* Cognitive psychology investigates internal mental processes such as how people think, perceive and communicate.
* Developmental psychology is the study of how a person develops psychologically over the course of their life.
* Evolutionary psychology examines how psychological adjustments during evolution have affected human behaviour.
* Forensic psychology is the application of psychology to the process of criminal investigation and the law.
* Health psychology observes how health can be influenced by behaviour, biology and social context.
* Neuropsychology examines the how the brain functions in relation to different behaviours and psychological processes.
* Occupational psychology investigates how people perform at work in order to develop an understanding of how organizations function.
* Social psychology is a study of how the behaviour and thoughts of people are influenced by the actual or implied presence of others.

**Psychology - Studying the Mind**

The mind is highly complex and enigmatic. Many wonder how psychologists can study such an intricate, seemingly abstract and extremely sophisticated thing. Even if scientists look inside the brain, as in an autopsy or during a surgical operation, all they see is gray matter (the brain). Thoughts, cognition, emotions, memories, dreams, perceptions, etc. cannot be seen physically, like a skin rash or heart defect.

Experts say that the approach to psychology is not that different to other sciences. As in other sciences, experiments are devised to confirm or disprove theories or expectations. For a physicist, the raw data during the experiments may be atoms, electrons, the application or withdrawal of heat, while for the psychologist human behaviour is the raw data.

For a psychologist, human behaviour is used as evidence - or at least an indication - of how the mind functions. We are unable to observe the mind directly; however, virtually all our actions, feelings and thoughts are influenced by the functioning of our minds. That is why human behaviour is used as raw data for testing psychological theories on how the mind functions.



**Understanding Human Differences**

"Everybody is unique!" is the mantra of the modern era and there is a great deal of truth to this.

The study of human differences has always been a central topic in the discipline of psychology, as it answers to a large extent why and how people do a lot of what they do. Three of the most prominent, salient, and obvious variations among people are differences in culture, gender, and sexuality/sexual orientation.

**Psychology and Culture**

We live in a truly global society. People are more connected than ever, the world seems smaller, and you can encounter an array of differences at a pace and scale never before seen in history.

In the past, you might be lucky if you met someone from a different culture once a month (depending on where you lived); now, you can meet people from all over the world on the bus, at the port, or online.

Psychology as a field would be incomplete without an understanding of how different cultural contexts influence individual minds and behaviour.

Cross-cultural psychology is the study of how culture influences the mind and behaviour. And when referencing "culture," think on a societal level. This can be religious groups, ethnic groups, or even geographic groupings such as "Lagosians"

**Exploring Indigenous Psychologies**

Is there a "Nigerian Psychology"? Is there a "Brazilian Psychology"? Is there a "Chinese Psychology"? The short answer is yes. One of the goals of cross-cultural psychology is to look for variations in "other" cultures that are not present in "our own."

Not all mental disorders are found in all cultures; or, at the very least, the manifestation of specific disorders varies somewhat or to some degree. The hallucinations of schizophrenics, for example, vary by culture (seeing things vs. hearing things, or smelling things).

Indigenous psychology also studies culture-bound syndromes — mental disorders that are only recognized and manifest in specific cultures. Here are some of the more interesting ones:

* Running amok (Malaysian origin): A sudden outburst of aggression or violence and running around wildly.
* Falling out (African American; Caribbean): Alteration in consciousness including passing out in response to stress.
* Susto (Mexico, Central America, South America): Displaced soul resulting from trauma.
* Koro (Asia): A man's sudden grasping of his penis for fear that it will retract into the body. For a women, fear that her nipples may protract.
* Pibloktog (Arctic and Inuit): Seizure, losing consciousness, amnesia, breaking furniture, eating feces, yelling obscenities.

And something can be a norm in one culture that would be considered a disorder in another. For example, grieving in some cultures includes extended periods of mourning, not going out into public, wearing black, not remarrying, and not attending family events. These are expected norms. In Western cultures, this behaviour might be diagnosed as depression.

Other studies have noted other cross-cultural differences. For example, immigrants to North American from Haiti and Eastern Europe are less trusting of others than Western European Americans and African Americans. Asian Americans show fewer outwards signs of depression than European Americans, who clearly smile less and display more negative emotion when depressed.

**Looking For Universals**

Are there psychological universals? Cross-culture studies have been conducted in a wide range of areas, such as developmental psychology, cognitive psychology, and psychopathology. Cross-cultural similarities have been found for such phenomena as theory-of mind, counting ability in infants, and mate preferences (in almost all cultures studied, men value attractiveness and chastity more than women do, and women value status and financial prospects).

Ultimately, the components of the mind and human behaviour can be thought of as (by varying degrees) both universal and variable across cultures.

**Psychology and Gender**

Perhaps the most simple and obvious human differences are sex and gender, male or female, masculine or feminine. Nearly all descriptions of other people when we talk about them, tell stories, describe them, or research them include an accounting of sex and gender.

*Sex* refers to an individual's biological status as either male or female, including anatomy. For the most part, you are born with your sex. *Gender* is not so cut and dry. Gender refers to the behaviour and characteristics defining masculinity or femininity, which is understood to be psychologically, socially, and culturally constructed.

Gender can be correlated with sex to some degree, but we know there are people who are sexually male who are feminine in gender and vice versa.

Gender manifests itself psychologically and behaviourally in what psychologists call gender roles. A *gender role* is a collection of social norms and expectations for a person who identifies or is identified as either masculine or feminine, man or woman. The presence of gender roles in societies gives rise to stereotypes and biases, prejudices, and judgments, of course. However, the world is still very "gendered," and people are still pretty much viewed through the lens of gender role and gender role categories.

Psychologist Sandra Bem developed the Bem Sex-Role Inventory as a way to characterize an individual's gender in relation to a scale. Bem's inventory identifies the following as characteristics typically associated with being masculine, feminine, or neutral:

* **Masculine**: Acts as a leader, aggressive, ambitious, analytical, assertive, athletic, competitive, defends own beliefs, dominant, and forceful
* **Feminine**: Adaptable, affectionate, cheerful, does not use harsh language, gentle to needs of others, soft-spoken, tender, warm, compassionate, and loyal
* **Neutral**: Adaptable, conscientious, friendly, helpful, jealous, moody, secretive, solemn, theatrical, and unpredictable

There is no value judgment associated with Bem's breakdown. Certainly both masculine and feminine traits are valuable in their own right, and certainly their utility and usefulness will vary by situation and context.

**Looking at Gender Differences**

Gender stereotypes abound. “Girls can't do math. Men are uncaring.”

We know that stereotypes are often a shortcut for critical thought and all too often take us down the wrong road. But consistent differences between men and women have been found in research, such as higher rates of aggression and violence in men, higher rates of substance abuse in men, and higher rates of depression in women.

Women's and men's leadership styles vary as well, with women adopting a more democratic and participatory approach and men adopting a more autocratic and directive approach.

Reacting in a stereotype-consistent manner may result in social approval while reacting in a stereotype-inconsistent manner could result in disapproval. It should be noted that what is socially acceptable varies substantially over time and between local cultures and subcultures.

According to research:

|  |  |
| --- | --- |
| * Women are more emotionally expressive. * Women are more emotionally responsive. * Women are more empathetic. * Women are more sensitive to others' feelings. * Women are more obsessed with having children. * Women express their feelings without constraint, except for the emotion of anger. * Women pay more attention to body language. * Women judge emotions from nonverbal communication better than men do. * Women express more love, fear, and sadness. * Women laugh, gaze, and smile more. * Women anticipate negative consequences for expressing anger and aggression. | * Men are more obsessed with sex. * Men are overwhelmed by women's expressions of emotion. * Men express more anger. * Men control their feelings. * Men restrain from expressing their feelings. * Men are stoic. * Men show emotion to communicate dominance. |

While growing up:

**FEMALE or MALE**

What types of activities did you usually participate in with friends?

|  |  |  |
| --- | --- | --- |
| **As a young girl,**  **Most likely you played with dolls of some sort, played house, played "make believe", played board or card games, etc.  You were participating in, and learning, a "*RELATIONAL*" style of interaction.** |  | **As a young boy,**  **Most likely you played different sports, cops & robbers, army, cowboys & Indians, etc. (never "make believe or pretend")  You were participating in, and learning, a "*COMPETITIVE*" style of interaction.** |

So what we are considering is the different way women and men think and behave, and as such,***communicate*** from the position of their individually learned gender perspective.

Consider these communication elements for each style of interaction.

|  |  |  |
| --- | --- | --- |
| **RELATIONAL**   * + Ask more questions   + Make more requests   + Discuss feelings & perceptions   + Higher quantity of speech   + Speech is more polite   + Includes greater level of detail |  | **COMPETITIVE**   * + Make more commands   + Interrupts more   + Limited emotional content   + Quantity of speech limited   + Involves slang or swearing   + Gives information |

**Psychology and Sexuality**

Whom are you sexually attracted to? Sexual attraction is part of what defines a person's *sexuality.*A person's sexuality consists of his or her

* Sexual biology (for example, genitals and arousal)
* Psychosocial functioning (attractions, emotions, and beliefs)
* Behaviour (masturbation and intercourse)
* Clinical aspects (erectile dysfunction and fetishes)
* Cultural aspects (prohibitions of premarital sex or gender roles)

**Laying the Building Blocks of Sexuality**

The development of sexuality is thought to begin in childhood, or at least the roots of adult sexuality are thought to come from childhood.

**Infants, Toddlers, and Young Kids**

Of course, one's sex first becomes evident at birth (or younger if you get a fetal ultrasound), thus marking the early stages of sexuality. A person's sex carries with it biological predispositions (attraction tendencies) and cultural expectations (he's going to be a "ladies' man"). The sexuality development process is just beginning. An infant's closeness with parents (being hugged, cuddled, bathed, and dressed) is a precursor to sexuality and it's possible that disruptions or unhealthy experiences in these interactions can lead to difficulties with sexuality later in life. (These are not seen as "sexual" experiences for an infant but rather precursors to later developed sexuality, as they relate to physical closeness.)

As infants turn into "kids," there is a growing awareness and curiosity about their bodies and genitals. It is not unusual to see children "play" with their genitals and engage in "show" games to others. They may even stimulate themselves by rubbing their genitals against toys or other objects. Simultaneously, there is an awareness of parental reactions and attitudes toward the body in general and genitals in particular. These experiences can range from shaming, to embarrassment, to laughter, to acceptance. Keep in mind that an overly negative tone should be avoided.

**Approaching Adolescence**

As children approach adolescence they have a fairly clear understanding of the anatomical differences between boys and girls. Attitudes toward nudity in the home can change as children become more "mature." Kids may engage in "playing house" or "doctor" as a way to explore their sexual arousal, attractions, and bodies. Experimentation may be with either gender. This type of sex play is not generally considered harmful under ordinary and relatively innocent circumstances.

However, behaviour that appears to be "age-inappropriate" such as overly adult-like actions and adult sexual language use may be a warning sign of possible inappropriate sexual exposure or abuse.

**Puberty and Adulthood**

Puberty marks a significant stage of sexual development. Bodies and physiology go through immense changes. Surveys suggest that the average age of first intercourse is 16 years old for boys and 17 years old for girls. Teen pregnancy and sexually transmitted diseases become real concerns as well. These issues remain ongoing into adulthood.

**Defining Healthy Sexuality**

Having a "healthy sex life" is common fodder for daytime talk shows, books and magazines. Defining healthy sexuality is not about moralizing or upholding any particular set of cultural values per se, but is seen as a "health issue" and is defined in terms of a healthy adult relationship in which the rights, well-being, and satisfaction of all involved is central.

**Getting your Bearings on Sexual Orientation**

There is great variety in sexual attraction, but one determinant that plays the biggest role is *sexual orientation*, defined as an individual's patterns of emotional, romantic, and sexual attractions to men, women, or both sexes. Sexual orientation exists on a continuum with three main orientations: heterosexual (attractions to the opposite sex), gay/lesbian (attractions to the same sex as oneself), and bisexual (attractions to both men and women).

Sexual orientation is considered separate from one's biological sex and gender identity. You could be a feminine (gender) male (sex) who is attracted to women (heterosexual) or a masculine woman attracted to women.

The causes of sexual orientation have yet to be firmly discovered through scientific research. It is considered both biologically determined and environmentally shaped. Research shows the relative influence of such variables as genetics, hormones, and cultural influences, but no one factor has been crowned "the cause."

Some people have judged that being gay, lesbian, or bisexual is a lifestyle "choice" that a person makes, but many gay men, lesbian women, and bisexual men and women report feeling as if they had "no choice" and simply knew how they felt from an early age. They simply were attracted to whom they were attracted to.

Until 1973, being gay or lesbian was considered a mental disorder and was diagnosable by psychiatrists with the aim of providing "treatment." Mainstream psychology now considers these sexual orientations as normal variations of human sexuality. These are not disordered people — just people.

However, in therapy, counsellors would need to be prepared to meet varying people with various perceptions of sexuality and should focus primarily on what the client wants.

**OTHER FACTORS TO CONSIDER IN COUNSELLING**

* **FAMILY OF ORIGIN IMPACT**

The term ‘Family of Origin’ refers to the family that the client grew up in- his/her parents, siblings, grandparents, other relatives and even divorced parents who lived with you during part of your childhood. These people strongly influence who we become.

* **CULTURAL AND ENVIRONMENTAL INFLUENCE**

Many people are ignorant of the influence of culture on their lives or are unwilling to change because changing for them is tantamount to loosing identity.

### UNDERSTANDING PERSONALITY TYPES

### 1. Expressive type personality (Sanguine)-Peter

### 2. Driver type personality (choleric)-Paul

### 3. Analytical type personality (Melancholy)-Moses

### 4. Amiable type personality (phlegmatic)-Abraham

**MANAGING DIFFERENT PERSONALITY TYPES: INTROVERTS AND EXTROVERTS**

There are a lot of different personalities, but almost every personality type will typically fall into one of these two categories: introversion and extroversion.

**The Extrovert**

Extroverts are gregarious, assertive and generally seek out excitement. They enjoy human interactions and tend to lean on the talkative side.

**The Introvert**

Introverts in contrast, are more reserved, less outgoing and less sociable. They are not asocial. However, they tend to have a smaller group of friends to extroverts. Introverts tend to be low-key individuals.

**Temperament and Personality: Who you are, how you got that way, and how to live with others who aren't like you.**

1. Temperament defined: Your temperament is like an artist's canvas. It is your basic inherited style. It is the fabric underlying who you are. Generally speaking, two of the basic temperament types are outgoing or extroverted and two are more inward directed or introverted. This varies based on temperament blend and our individual personality development.
2. Personality defined: Your personality is like the painting on the canvas. It is what you have built on top of your temperament. Two people with like temperament may be very different in actual [behaviour](http://www.selfgrowth.com/behavior_modification.html). Factors that affect personality include socialization, education, birth order, siblings or lack of siblings, and interpersonal pressures will cause us to adapt and change our behaviours.

**The Four "Types"**

Why four? Everyone from the ancients to modern psychologists find that people can be grouped into four basic types of personality. These are:

**A. Sanguine**

Influencing of others, SP - Artisan - The Sanguine is receptive by nature and outgoing. He is usually called a 'super-extrovert'. This temperament is usually thought of as a "natural salesman" but they also tend to enter professions that are outgoing such as acting. He "leads into a room with his mouth" and is never at a loss for words.

**B. Choleric**

Decisive - The choleric is the most forceful and active of the four types. He is strong-willed and independent and opinionated. The choleric thrives on activity. He is the most practical and makes sound, quick decisions. He is not afraid of obstacles and tends to drive right through or over problems. He is probably the strongest natural leader of the four types.

**C. Melancholy**

Conscientious - The melancholy is an introverted temperament type. His natural style is analytical and perfectionist. He is the most moody of types ranging from highly "up" to gloomy and depressed. During his low periods he can be very antagonistic and does not make friends easily. He is the most dependable of the temperaments due to his perfectionist tendencies.

**D. Phlegmatic**

Steady - Idealist - the phlegmatic is best characterized by the words "easy going". He is the calm and steady person who is not easily disturbed. He is the easiest temperament type to get along with. Life for him is happy, unexcited and calm. Underneath the calm exterior, the phlegmatic is the most timid temperament type. He often uses humour to make his points. The phlegmatic is more an observer and does not involve himself in the activities of others.

Phlegmatics make excellent teachers, counsellors and administrators. They are very dependable and organized and, while they never volunteer, they make good group leaders.

**OTHER FACTORS THAT SHAPE PERSONALITY**

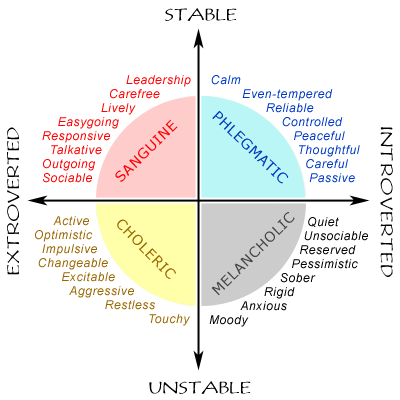
Childhood experiences and [parenting](http://www.selfgrowth.com/parenting.html) will cause differences. A Phlegmatic father may behave differently in raising a child than a melancholy one thereby causing the child to value different behaviours.

A person's level of education and training may affect behaviour as will a person's level of physical health. A healthy PhlegChol may seem more outgoing and aggressive than a choleric with health problems.

In certain individuals there may be parts of three temperament types blended together. While rare, it does happen and makes it more difficult for the person to get a clear picture of their type.

**HOW TO USE TEMPERAMENT TO YOUR ADVANTAGE**

1. Know yourself - knowing your temperament blend can be an "eye-opening" experience. It may help explain why you do certain things and why you don't get along with certain others. Use your knowledge of temperament to guide you in choosing vocations, affiliations, and friendships.
2. Get along with others - [learning](http://www.selfgrowth.com/learning.html) how to spot the temperament of others is invaluable. It takes practice but once you can spot a choleric you know not to try and be "chatty" with them. If you spot a phlegmatic you may understand why they seem quiet and reserved.
3. Work life - This is a key area of understanding temperament. There are so many people in life who are in jobs that do not match their temperament. A sangphleg may not make a good surgeon. A cholmel probably wouldn't be happy teaching kindergartners. Tests of temperament often include suggestions concerning career choices.
4. Relationships - another key area. Cholerics get impatient with sanguines. Melancholies think that phlegmatics "just don't care" about details. And in marriage we more often than not see opposite temperaments together. This can help each individual grow and develop or it can cause anger, resentment and separation. Understanding your temperament and your child's can affect [parenting](http://www.selfgrowth.com/parenting.html) style. A melancholy child needs structure, organization and reassurance. A choleric child needs a big backyard and a large dog to take care of. A phlegmatic mother needs to be firm with a sanguine child.

[](http://thisjourneyismyown.files.wordpress.com/2010/03/eysenck.gif)

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**DPC 103**

**Person of the Counsellor**

**(Self-Concept)**

**Introduction**

The term self-concept is the understanding you have about yourself that’s based on your personal experiences, body image, your thoughts and how you tend to label yourself in various situations.

**Pre-Test**

1. Who are you? “I am a child of God!” “I am a Pretty lady.”
2. How are you conditioned?

**Learning Outcomes**

* To develop the participants’ ability to be aware of themselves and how they relate.
* To enable the participants to explore the importance of self-awareness in counselling.
* To enable participants to explore and evaluate the impact of this training on their development.
* To develop participants’ ability to deepen their personal insight and awareness.

**Importance of Self Concept**

The answer to the question of how to craft a happy, fulfilling life is rooted in Understanding Oneself.

Because, you see, it is only by understanding oneself that we can make the right choices that will guide us to the kind of life and happiness that we seek.

An understanding of self-concept can help clarify and solidify who you are as a person, what you like about yourself, what you don’t like about yourself, and what you need to change.

The development of an understanding of one’s self-concept can help them better understand why they see the world in the way that they do, why they feel the way that they feel, and why they make the decisions that they do

Self-concept is a helpful tool for not only clinicians, but for the average individual who wants to better understand and find happiness with themselves.

A person who believes in themselves and puts forward a strong sense of self-worth is more likely to be treated positively.

The person who emanates confidence in themselves is more likely to inspire confidence in other people, particularly if they can back up their claims with actions and results.

**Your self-concept is an incredibly useful tool for helping you see where things are ‘not quite right’ for you.** An example of this is when we look at our ideal self versus our present self-concept. If you always have an ideal self in mind that is vastly different from your daily self-concept, it is quite likely you have low self-esteem

**Self-concept can also help us see how much a**[lifechange](http://www.harleytherapy.co.uk/counselling/i-hate-change-management.htm)**or**trauma**has affected us.** Sometimes life change strengthens and clarifies our self-concept. But if you feel you’re losing your self-concept, it could be the experience has triggered an identity crisis and it’s time to seek support.

1. **Self-Concept**

Self-concept is the comprehensive or encompassing perception we have about who we are- physically, emotionally, socially, spiritually and in all other aspects that make up who we are (Neill 2005).

Self-concept is built upon perception; upon how you perceive yourself based on the knowledge you have gained over a lifetime of experience.

Important Factors; in Self-concept is a perception you have of your image, abilities, and in some ways a perception of your own individual uniqueness.

It is essentially a mental picture of who you are as a person.

* 1. **Self-concept can include the following:**
* Sexuality (I’m heterosexual)
* Gender (I’m female/male)
* Culture and race (I’m Hausa/Black)
* Physical descriptors and abilities (I am tall, I run fast looks, fitness, health,)
* Mental abilities (I’m good at academics)
* Spirituality and religion (I’m spiritual)
* Social roles (I’m an aunt and a counsellor)
* Personal traits/ character attributes (I’m a loud talker, I’m introverted)
* Beliefs about self (people like me, I’m funny)
* Existential statements (I’m a human being; I am one with all that is).
* Social (how we interact with others)
* Family (how we behave in our family)
* Competence (how we manage basic needs of living)
* Academic (school and intellect)
* Affect (understanding of emotional states).

**Rogers (1951**); Self-concept is fluid. Though it starts to form at a young age, it will change continuously throughout a person’s life as they experience new things, gain new knowledge, and start to figure out who they truly are underneath all of the external influences that have been forced on them throughout their life.

[Carl Rogers](https://www.simplypsychology.org/carl-rogers.html) (1959) believes that the self-concept has three different components:

• The view you have of yourself **(self-image**)

• How much value you place on yourself (**self-esteem or self-worth**)

• What you wish you were really like (**ideal-self**)

1. **Self-image** (*how you see yourself*)

This does not necessarily have to reflect reality. Indeed a person with anorexia who is thin may have a self-image in which the person believes they are fat. A person's self-image is affected by many factors, such as parental influences, friends, the media etc.

Kuhn (1960)

* 1. **Physical Description**: I’m tall, have blue eyes...etc.
  2. **Social Roles**: We are all social beings whose behaviour is shaped to some extent by the roles we play. Such roles as student, housewife, or member of the football team not only help others to recognize us but also help us to know what is expected of us in various situations.

* 1. [**PersonalTraits**](https://www.simplypsychology.org/personality-theories.html): These are the third dimension of our self-descriptions. “I’m impulsive...I’m generous...I tend to worry a lot”...etc.
  2. **Existential Statements** (abstract ones): These can range from "I’m a child of the universe" to "I’m a human being" to "I’m a spiritual being"...etc.

Typically young people describe themselves more in terms of personal traits, whereas older people feel defined to a greater extent by their social roles.

1. **Self-image**: doesn't necessarily coincide with reality. Some people might have an inflated self-image of themselves, while others may perceive or exaggerate the flaws and weaknesses that others don't see.
   1. **Self-esteem** (*the extent to which you value yourself*)

Self-esteem (also known as self-worth) refers to the extent to which we like, accept or approve of ourselves, or how much we value ourselves. Self-esteem always involves a degree of evaluation and we may have either a positive or a negative view of ourselves.

When people respond positively to our behaviour, we are more likely to develop positive self-esteem. When we compare ourselves to others and find ourselves lacking, it can have a negative impact on our self-esteem.

* 1. **High *(Healthy)* Self-esteem:** tend to have positive views of self.

This tends to lead to;

* Confidence in our own abilities
* Self-acceptance
* Not worrying about what others think
* Optimism
  1. **Low Self-esteem:** tend to negative views of self

This tends to lead to;

* Lack of confidence
* Want to be/look like someone else
* Always worrying what others might think
* Pessimism

Even though self-esteem might fluctuate, there are times when we continue to believe good things about ourselves even when evidence to the contrary exists. This is known as the perseverance effect.

1. **Ideal Self** (*what you'd like to be*)

If there is a mismatch between how you see yourself (e.g., your self-image) and what you’d like to be (e.g., your ideal-self) then this is likely to affect how much you value yourself.

Therefore, there is an intimate relationship between self-image, ego-ideal and self-esteem.

A person’s ideal self may not be consistent with what actually happens in life and experiences of the person. Hence, a difference may exist between a person’s ideal self and actual experience. This is called incongruence

According to **Carl Rogers**, the degree to which a person’s self-concept matches up to reality is known as Congruence or Incongruence.

Where a person’s ideal self and actual experience are consistent or very similar, a state of congruence exists. Rarely, if ever does a total state of congruence exist; all people experience a certain amount of incongruence. The development of congruence is dependent on unconditional positive regard. Rogers believed that for a person to achieve self-actualization, they must be in a state of congruence.

***Congruence*** is when self-concept is fairly well aligned to reality.

***Incongruence*** happens when reality does not match our self-concept.

How you wish you could be; in many cases, our self-image and how we would like ourselves do not usually match up.

Rogers believed that incongruence has its earliest roots in childhood. When parents place conditions on their affection for their children (only expressing love if children "earn it" through certain behaviours and living up to the parents' expectations), children begin to distort the memories of experiences that leave them feeling unworthy of their parents' love.

Unconditional love, on the other hand, helps to foster congruence. Children who experience such love feel no need to continually distort their memories in order to believe that other people will love and accept them as they are.

A therapist can also help their client navigate the emotion surrounding decision making processes, because emotional decisions may not align with rationality or reason.

Examining one’s past and previous decisions will also grant clarity on one’s emotional state and future emotional decisions.

A person who lives against who they actually are will be fighting an unending battle against their own mind, trying to square away who they are versus who they believe they need to be.

The person who is able to live in accordance with their ideal self will have far less internal conflict about their place in the world.

1. **ORIGIN OF SELF:** 
   * Body
   * Soul/Mind
   * Spirit
2. **FORMATION OF SELF**: This image develops in a number of ways but is particularly influenced by our interactions with important people in our lives, situations we find ourselves.
   1. **Background & Environment:**

* The formation of self-concept begins as a child, as young as three months old. The baby begins to realize that they are a unique entity by receiving feedback on their interactions with the world.
* These actions begin setting the stage for the development of self-concept.
* **Self-concept tends to change with age.**  As children and adolescents, our self-concept can be flexible, as we are still figuring out who we really are and constantly comparing ourselves to others. As older adults, however, our self-concept is more fixed. We know our personal values and are more self-aware.
  1. **Experiences & Exposures:**

**There are also life changes that can heavily affect our self-concept.** These include things like:

* loss and bereavement
* trauma
* abuse
* major accidents or illnesses.
* Social status
  1. **Culture & Beliefs**

Cultural perspectives usually give insight into the psychological process

* 1. **Religion**

Religiosity has been linked to God-related control attributions.

* 1. **Education & Career**

It involves different roles, responsibilities, positions, development in all life’s endeavours.

1. **Sigmund Freud** believes that personality has three components which works together to produce our complex behaviour.
   1. **Id**: present at birth, it’s instinctive and unconscious. It strives for immediate gratification of desires, needs & libido.
   2. **Ego:** reality, develops from Id which allows the stimulus form of the Id to be expressed in a realistic manner. (conscious, unconscious and pre-conscious.)
   3. **Super-Ego**: provides guidelines for making good judgments. This part holds our moral values, ideals and ability to weigh what's right or wrong.

Freud stated that these three components need to be well balanced to produce reasonable mental health and stability.

1. **ADAPTATION OF SELF**

* **Self-Organization**
* **Awareness of Self**
* **Contact**
* **Assimilation**

1. **Contact Style:**

* **Introjection**
* **Projection**
* **Deflection**
* C**onfluence**
* **Desensitizing**

1. **TEMPERAMENTS**

Refer to those aspects of an individual's personality, such as introversion or extroversion that are often regarded as innate rather than learned.

It influences and is influenced by the experience of individual, and one of its outcomes is the adult personality.

* **Sanguine**
* **Choleric**
* **Melancholic**
* **Phlegmatic**

1. **JOHARI WINDOWS**

HIDDEN

UNKNOWN

BLIND

OPEN

1. **SELF DISCLOSURE**

It is the sharing of personal information by the counsellor to the client. It is different to sharing professional information that is relevant to the client’s treatment.

**TYPES**

* + Deliberate
  + Unavoidable
  + Accidental or Inevitable

**ASSESSMENT:**

**1. According to Carl Rogers, what are the three components of Self Concept?**

**2. Explain one of them.**

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**DPC 104**

**COUNSELLING SKILLS & PROCESSES**

**SETTING THE STAGE: COUNSELLING STAGES**

Counselling process refers to the various stages involve in counselling. These include;

**The Interview stage**

* Provide a warm and comforting welcome
* Introduce yourself and your office/organization briefly
* Establish trust and build confidence
* Explain counselling to the client
* Let client disclose the challenge, listen attentively, don’t interrupt or argue
* Talk generally when you have to; spe ak briefly, pace and lead the client
* Arrange the physical setting as appropriate- Sit facing each other in a relax atmosphere, avoid interruptions and distractions

**The Working stage**

* Use positive body language; a smile, a pat on the hand etc
* Pay attention to clients non-verbal communication; facial expression, tone of voice, eye contact, body motion
* Reflection of clients feeling/body language
* Empathize/ not sympathize with the client
* Show you do not blame client for the situation especially during the first session
* Get client to talk about the problem, fears and feelings; giving details of the situation/ experience/Use metaphors
* Notice resistance/Assure clients not to worry when they forget some details or cannot concentrate.
* Do not judge or condemn the client
* Avoid giving premature advice
* Ask questions when you are not sure what the client means
* Documentation; open a file for each counselee and write in details every session with him or her.
* Summarize important issue raised during or after a session

**The Termination stage**

* Plan for termination at the beginning of counselling
* It could be permanent or temporary termination
* Reasons- if Counselling goals are achieved

-Uncooperative attitude from the client

-Referral to an expert

- Counselee may decide to discontinue

- Emotional involvement with client

**The Follow up stage**

* Individualize your counselling style
* Have a time frame
* Observe how client is adjusting and new problems experienced

**SETTING THE STAGE: COUNSELLING SKILLS**

* **ATTENTIVENESS/RAPPORT BUILDING**
* **ACTIVE LISTENING**
* **EMPHATHETIC LISTENING**
* **EFFECTIVE QUESTIONS**
* **PARAPHRASING/SUMMARISING**
* **FOCUSING /CHALLENGING**
* **BOUNDARIES SETTING**
* **Questioning Skills**
  + Use words like HOW, WHAT, WHEN and WHERE but avoid using WHY because it makes one feel criticized.
  + Use open ended questions like: can you tell me more about....? can you explain....?
  + Do not ask too many questions, so it will not look like court’s cross examination
  + Use open ended questions techniques instead of close ended
  + Don’t be quick to talk when the client is silent, he/she might be thinking of the right word or trying to sum up enough courage to express a difficult experience.
  + When clients derailed during a narration, politely redirect him/her to the original issue
  + Let client be free to express emotions i.e. crying or shouting
  + After questioning reflect the clients feelings back to him/her from the story to be sure you understood him/her.
  + Let clients know ahead the need for you to take notes so it will not look as if you are not listening.
* **Listening Skills**

Listening is the ability of the counsellor to pay attention to the verbal and non-verbal expressions of the client. It involves hearing words, receiving the sounds made by the clients and gaining insights into whatever is uttered.

Listening skill is the foundation stone on which other skills depend in counselling.

* + Eyes on the client
  + Sit up, Lean forward
  + Hands and feet are still
  + Look interested
  + Summarize
  + Paraphrase (focus on each word)
  + Remove bias
* **BOUNDARY SETTING**

Having boundaries is about having an appreciation for the protected nature of the counselling encounter.

It is about self-respect and respect for the client.

Some things are taboo no matter what type of [therapy](http://www.healthcentral.com/depression/therapy.html) practiced:

• Sexual contact of any kind

• Asking the client to invest money in a venture or enter into a business partnership of any kind

• Borrowing anything from the client – money, vacation home

• Not respecting the client’s session – being late, cancelling frequently, taking non-essential phone calls

• Calling client to talk about his or her own life

• Regular social contact such as a book club

Two important boundaries required within a counselling relationship include:

* the setting of time limits.
* working within a structured framework of beginning, middle, and end.

**GENERAL STRATEGIES**

Provide a warm and comforting welcome.

Introduce yourself and your office/organization briefly.

Establish trust and build confidence.

Listen attentively, don’t interrupt or argue.

Arrange the physical setting as appropriate- Sit facing each other in a relax atmosphere, avoid interruptions and distractions.

Talk generally when you have to.

Use lead questions like: Can you tell me more about…? can you explain…?

Use positive body language; a smile, a pat on the hand etc.

Sympathize/ empathize with the client.

Individualize your counselling style.

Show you do not blame client for the situation.

Get client to talk about the problem, fears and feelings; giving details of the situation/ experience.

Assure clients not to worry when they forget some details or cannot concentrate.

Do not judge or condemn the client.

Ask questions when you are not sure what the client means.

Documentation; open a file for each counselee and write in details every session with him or her.

Summarize important issue raised during or after a session.

Plan for termination at the beginning of counselling.

**Further Clarity on some Counselling Strategies Mistakes**

* **Avoid giving premature advice**

Counsellors generally don’t give advice especially at the initial stage of relationship building.

Example: **Counsellor**: what brings you here today?

**Client**: Basically, I’m having trouble with my son

**Counsellor**: Have you tried talking to him?

Instead encourage self exploration.

**Client**: I’m having trouble with my son

**Counsellor**: Tell me about the trouble you are having.

* **Avoid closed questions**

**Client:** I just left after he started to swear at me

**Counsellor:** How did you feel then? (Open)

**Client:** I was really angry. He had no right to speak to me that way

**Counsellor:** Did you lash back? (Closed)

**Client:** No

Open ended questions encourage clients to describe their feelings while closed questions provide no pertinent information. Unless you need specific information, stay with open-ended questions.

* **Listen closely**

**Client:** Debby always disobey me

**Counsellor:** Always?

A word like ‘always’ indicate a distortion of reality. The client didn’t really mean ‘always’. Similarly, counsellors should determine what clients means when they use words like ‘must’ and ‘should.’

* ***Empathy not same as Sympathy or Agreement***

Empathy refers to a deep comprehension of the subjective world of clients. Agreement suggests that the counsellor approve of the clients’ behaviour. Sympathy indicates the counsellor feels sorry for the client.

**Client:** I was really angry when he said I should go home.

**Counsellor**: 1. You felt angry with him. (**Empathy**)

2. Good for you. I’m glad you left (**Agreement**)

3. He is awfully mean to you. (**Sympathy**)

* **Do not assume to know clients’ feelings, thoughts and behaviours**

**Client**: so I just left after we started to argue

**Counsellor**: you were very angry?

**Client:** No, I had to leave for work in 10mins and I knew we’d never resolve anything in that amount of time.

You need to always remember as a counsellor, you do not know everything. Many clients will tell you when you are wrong but it’s wiser to verify your assumptions of clients’ feelings, thoughts and behaviour in a phrase followed by a question.

**Counsellor:** you seem sad as you speak of your father. Is that how you feel? **Client:** No, I didn’t feel sad as much as I felt angry about getting into another argument with him.

**SETTING UP A COUNSELLING TEAM**

You need an administrator, a number of employed and volunteer Counsellors, counselling room, code of ethics, contract, supervision process and periodic training.

What are the skills needed in a counselling team?

1. A good team player, able to get on with different personalities.
2. Loyalty to the church/NGO management.
3. Time management; ability to organise your days between seeing clients, meetings and writing case-notes.
4. Flexibility; able to see the advantages of change rather than only the disadvantages.
5. Commitment and determination - to do all necessary activities, even those you may find tedious, e.g. filing
6. Methodical in completing statistics for monitoring purposes and accurate in keeping data up-to-date.
7. Experience and maturity (professional or spiritual)

**DOCUMENTATION: Counselling Report writing**

As much as possible avoid taking notes during a session, when you have to inform the client ahead.

**Benefits**

* + Records provide support for you in any legal action
  + Records remind you of treatment history and amount of progress
  + Records provides with information to pray with.

**What should you write in your notes/report?**

This depends partially on where you work, but in general you should describe for each session:

1. Principal content
2. Noteworthy counsellor interventions, with client response
3. Client status (behaviour and cognitions)
4. Expected client behaviour during the period leading to the next sessions, including any home work
5. Expected time and interventions still required to meet counselling goals
6. Indications of client expectations of the outcome of counselling.

Your note can also include

* + Tests administered (with results and client’s reactions)
  + Diagnoses
  + Your reaction to the session
  + Questions to ask supervisors or colleagues and relevant persons
  + Relevant client interaction with family and friends.
* Such notes or reports should be securely kept where no one can access them purposefully or accidentally. Computerized record keeping must also have restricted access.

**DPC 105**

**COUNSELLING THEORIES**

**LEARNING OBJECTIVE:**

At the end of this session, you will;

* Understand the concept of theory, counselling theory and approaches.
* Be able to identify the classes of counselling theories
* Be able to identify, describe and deploy the humanistic theories of counselling
* Be able to identify and deploy the Adlerian and Solution Focused Brief Therapy Theories

**INTRODUCTION**

**What is a Theory?**

Basically, a theory involves a gathering together and organizing of knowledge about a particular object or phenomenon. In psychology, theories are used to generate hypotheses about human **thinking,emotions**, and **behavior**. Most of us, as a function of being social creatures, build our own personalized theories about human behavior. These personal theories guide our observations and evaluations of others. This makes all of us theorists (or potential theorists) even though our thinking isn’t as explicit (or as detailed) as most famous psychological theorists.

**Key Features of Theories**

1. A theory needs to accurately describe, explain, and predict a wide range of therapist and client behaviours.
2. A theory also needs to have relevance to its domain and provide strategies for change.
3. A good theory should clearly explain what causes client problems and predict how clients would respond to various therapy techniques.

These predictions should help us know what techniques to use, how long therapy will last, and how a particular technique is likely to affect a particular client.

**Purpose of Theory**

A great task of theory is to provide a clear model or foundation from which they conduct their professional service. To be without a theory, to be a ‘‘vulnerable, directionless creature’’ (Prochaska & Norcross, 2003, p. 4), is something most of us would just as soon avoid. Counselling theories and approaches provide therapists with a frame of reference to analyse client’s and own behaviour

*REF: Counseling and Psychotherapy Theories in Context and Practice Skills, Strategies, and Techniques, John Sommers-Flanagan Rita Sommers-Flanagan, 2015*

**Pre-Test**

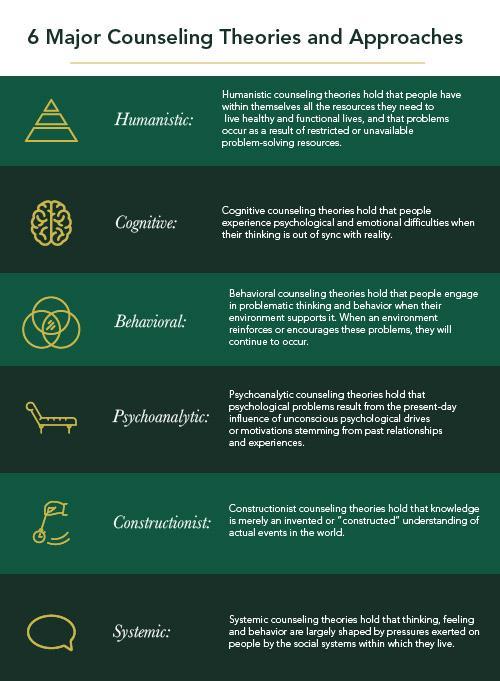
1. When you hear theory, what comes to mind?

2. What is your understanding of counselling theory?

3. What is humanistic theory?

4. What would you say is the counselling implication of theories?

**Key Concepts**



**Theories of Counselling**

**List of Theories**

* Rogerian/Person-Centered Therapy
* Solution Focused therapy
* Adlerian Therapy
* Existential Therapy
* Gestalt Therapy
* Behaviour Therapy
* Cognitive Behaviour Therapy
* Reality Therapy
* Narrative Therapy
* Psychoanalytic Therapy
* Family Systems Therapy

**1.0. PERSON-CENTERED THERAPY - CARL ROGERS (1902-1987)**

**Basic Tenets**

* Adopts a humanistic theory- Each individual has a natural potential that can be actualized and through which s/he can find meaning.
* Emphasis is on self-development and achieving highest potential rather than dysfunctional behaviour.
* Focuses on respect for client’s experience and trust in his/her ability to change.
* Adopts a non-directive approach.
* The counsellor provides a growth-promoting climate and the client is then free and able to discover and grow as she / he wants and needs to.
* The client is encouraged to explore his/her feelings and take responsibility for his/her thoughts and actions.
* The client’s creative instincts may be used to explore and resolve personal issues.
* This approach rejects the role of the therapist as an authority who knows best.
* The client needs to believe that they have the natural potential to actualize.
* Therapist focuses on the constructive side of human nature, on what is right with the client and on the assets s/he brings to therapy.

**Necessary Conditions for Change**

* **Congruence**: genuineness or realness. The therapist’s behaviour is congruent with his/her emotions.
* **Unconditional Positive Regard:** Acceptance and care.
* **Empathy:** An ability to accurately understand the subjective world of the client.

**Therapeutic Goals**

* Aims toward the client achieving independence and integration.
* Its focus is on the person and not the presenting problem.
* By focusing on the personal growth, the therapist assists the client to cope better with his/her current and future problems.
* The fundamental aim of therapy is to provide a conducive environment that will encourage the client to become a fully functioning person.
* To assist clients get rid of the “mask” they have acquired through the process of socialization.
* Clients are encouraged to be increasingly self-actualized, as evidenced by:

1. Openness to experience.
2. A trust in themselves.
3. An internal source of evaluation
4. A willingness to continue growing.

**\* Fostering these characteristics forms the basis for person-centered therapy\***

### The Role of the Counsellor/Therapist

* The therapist is non-directive.
* The therapist focuses on his/her attitudes, rather than on techniques or knowledge in order to facilitate personality change in the client.
* The therapist seeks to encounter the client on a person-to-person level.
* The therapist is required to be present and accessible to clients and also to focus on their immediate experience.

### The Therapeutic Relationship

* The relationship between the client and therapist is everything; both engage in a shared journey in which the therapist and client reveal their humanness and participate in a growth experience.
* The relationship is characterized by equality.
* The process of change in the client depends largely on the quality of the relationship.
* The therapist need not have any special skills or knowledge; the only “techniques” required are active listening, empathizing, understanding and responding to the client.
* Rather than choose goals for the client, the therapist encourages the client to define and clarify his/her goals.
* The client’s self-assessment and assessment of the therapist are of primary importance.
* Growth and change must happen at the client's own pace.
* Goals are expected to change as client progresses through counselling.
* Diagnosis and background history collection is not necessary.

**Limitations and Criticisms**

* This approach does not emphasize the role of techniques that could be used to bring about a change in client’s behaviour.
* There’s a tendency for the counsellor/therapist to be very supportive without being challenging.
* The necessary conditions for change though relevant are not sufficient for change for all clients.
* Limits are placed on the therapist/counsellor’s behaviours, such as their teaching and guiding role.
* Carl Rogers Counsels Gloria - “Coping with divorce”
* Carl Rogers’ Session with Sylvia - “Struggle for acceptance”
* Carl Rogers’ Session - “ Dealing with hurt & anger”
* Carl Rogers’ Interview with Richie

**2.0 EXISTENTIAL PSYCHOTHERAPY**

**EXISTENTIAL PSYCHOTHERAPY** is a supportive and collaborative exploration of clients’ live experiences. It is an aspect of psychotherapy that seeks meaning within a person’s existence.

It focuses on clients’ relationships with themselves and their world in context beyond the counselling room.

Existential psychotherapy believes man’s issues are built around 4 ultimate concerns:

* MORTALITY
* FREEDOM
* ISOLATION
* MEANINGLESSNESS

**MORTALITY**

The death of a loved one or the consciousness of our own death at some unknown time can cause anxiety and make us fail to take decisions that may safeguard or actually enrich our lives.

**FREEDOM**

This practically means responsibility assumption. We all face the consequences of our actions. That’s why you see people wanting you to advise them to shield them from owning up to their errors.

**ISOLATION**

Humans generally crave for belongingness. It helps our esteem and gives us a sense of identity oftentimes, people trade independence for being with others. Isolation also leads to being more vulnerable.

**MEANINGLESSNESS**

As humans, we sometimes struggle to give reason for our daily action. Meaning gives motivation that impels us to act in ways that give sense to our identity and choices in life.

**3.0. SOLUTION-FOCUSED BRIEF THERAPY**

* Steve de Shazer *(1940-2005)*& Insoo Kim Berg *(1935-2007)*

**Basic Tenets**

* Focuses on solutions rather than problem solving.
* Focuses on the present and future rather than the past.
* Therapist focuses on what is possible, with little or no interest in understanding the problem.

**Key Concepts**

**Positive Orientation**

* Optimistic assumption that people are healthy and capable to construct solutions that can enhance their lives.
* SFBT assumes that every individual has the ability to resolve challenges. However, at times we might lose our sense of direction or awareness of our competencies.
* The therapist’s role is to assist the client to recognize his/her competencies.
* The essence of therapy involves building on the client’s hope and optimism by creating positive expectations that change is possible (Corey, 2009).
* SFBT is a non-pathological approach that emphasizes competencies rather than deficits, and strengths rather than weakness (Metcalf, 2001).

**Exceptions:**

* SFBT emphasizes focusing on what is working in the client’s life, rather than on the problem.
* The therapist assists the clients to recognize and pay attention to the exceptions to their problem patterns.
* The therapist promotes hope by assisting the client to discover exceptions.

**BasicAssumptions (Walter & Peller, 1992, 2000)**

1. Individuals who come to therapy have the capability of behaving effectively, even though this effectiveness may be temporarily blocked by negative cognitions.
2. There are advantages to a positive focus on solutions and on the future. If clients can reorient themselves in the direction of their strengths using solution-talk, there’s a good chance that therapy can be brief,
3. There are exceptions to every problem. Rapid changes are possible when clients identify exceptions to their problems.
4. Clients often present only one side of themselves. SFBT invites them to examine another side of the story they are presenting.
5. Small changes pave way for larger changes.
6. Clients want to change, have the capacity to change and are doing their best to make change happen.
7. Clients can be trusted in their intention to solve their problems. There are no “right” solutions.

**The Therapeutic Process**

**Four Basic Steps:**

1. Find out what clients want rather than searching for what they do not want.
2. Do not look for pathology, and do not attempt to reduce clients by giving them a diagnostic label. Instead look for what is already working and encourage them in that direction.
3. If what clients are doing is not working, encourage them to experiment with doing something else.
4. Keep therapy brief, approaching each session as if it were the last and only session.

(Walter & Peller, 1992)

**Therapeutic Goals**

* SFBT therapists focus on small, realistic, achievable changes that can lead to additional positive outcomes.
* The therapist joins with the client by using similar words, pace and tone.
* Clients are assisted to create well-defined goals that are:
* stated positively in the client’s language
* process or action- oriented
* structured in the here and now
* attainable, concrete and specific
* controlled by the client.

**The Role of the Therapist/Counsellor (Walter & Peller, 1992)**

* The therapist views the clients as being the expert on their lives and therefore do not assume the position of the expert.
* The therapist helps to point clients in the right direction of change without dictating what to change.
* Therapists create a climate of mutual respect, dialogue, enquiry and affirmation in which clients are free to create, explore and co-author their evolving stories ( Walter & Peller, 1996).
* The main therapeutic task consists of helping clients imagine how they would like things to be different and what it will take to bring about these changes (Gingerich & Eisengart, 2000).
* The Therapeutic Relationship
* The therapist seeks to establish a collaborative relationship with the client.
* The therapist seeks to create a sense of trust in the client in order to encourage the client to follow through.
* De Shazer (1988) identified three possible relationships that may develop:
* **Customer**: client and therapist jointly identify a problem and a solution to work toward.
* **Complainant:** client identifies a problem and believes that the solution is dependent on someone else’s action.
* **Visitor**: the client comes to therapy because someone else thinks the client has a problem.

**Therapeutic Techniques**

* **Exception Questions**: therapists ask exception questions to direct the clients to times when the problem did not exist or when the problem was less intense.
* **The Miracle Question**: the therapist asks “If a miracle happened and the problem was solved overnight, how would you know it was solved, what would be different?” clients and then encouraged to enact “what would be different.”
* **Scaling Questions**: usually adopted when change in human experiences such as moods and feelings cannot be easily observed. These questions allow clients pay close attention to what they are doing and how they can take steps in the direction of the desired change.

**Limitations and Criticisms**

* The therapist/counsellor must be able to make assessments, help clients formulate goals and effectively apply accurate interventions in a very short time.
* Therapists/counsellors may rely too much on technique, while neglecting the therapeutic relationship.

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**4.0. Adlerian Theory**

**Adlerian psychology/psychotherapy** was developed by [Alfred Adler](https://www.goodtherapy.org/famous-psychologists/alfred-adler.html) (1870-1937). He believed that it was imperative to become closely familiar with a person’s social context by exploring factors such as birth order, lifestyle, and parental education. Adler believed that each person strives to belong and feel significant and this birthed School of Individual Psychology. This emphasized the importance of studying the entire individual.

**ADLERIAN PSYCHOTHERAPY**

Adlerian theory places its emphasis on a person’s ability to adapt to feelings of inadequacy and inferiority relative to others. He believed that a person will be more responsive and cooperative when he or she is encouraged and harbors feelings of adequacy and respect. Conversely, when a person is thwarted and discouraged, he or she will display counterproductive behaviors that present competition, defeat, and withdrawal. When methods of expression are found for the positive influences of encouragement, one’s feelings of fulfillment and optimism increase.

Adler believed strongly that “a misbehaving child is a discouraged child,” and that children’s behavior patterns improve most significantly when they are filled with feelings of acceptance, significance, and respect.

Adler believed that feelings of inferiority and inadequacy may be a result of [birth order](https://www.goodtherapy.org/blog/psychpedia/birth-order), especially if the person experienced personal devaluation at an early age, or they may be due to the presence of a physical limitation or lack of social [empathy](https://www.goodtherapy.org/blog/psychpedia/empathy) for other people. **This method of therapy pays particular attention to behaviour patterns and belief systems that were developed in childhood.**

By examining these early habitual patterns, we can better develop the tools needed to create our own sense of self-worth and meaning, and ultimately create change that results in healing.

**Key Concepts**

**View of Human Nature (a)**

* Adler believed that the individual begins to form an approach to life somewhere in the first 6 years of living.
* Humans are motivated primarily by social relatedness.
* Adler stressed choice and responsibility, meaning in life, and the striving for success, completion, and perfection.
* Inferiority feelings serve as a wellspring of creativity; they motivate us to strive for mastery, success and completion.

**View of Human Nature (b)**

* Adopts a subjective approach to psychology that focuses on internal determinants of behaviour such as values, beliefs, attitudes, goals, interests, and the individual perception of reality.
* Human behaviour is not determined solely by heredity and environment. Instead, we have the capacity to interpret, influence, and create events.

**Subjective Perception of Reality**

* Adlerians attempt to view the world from the client’s subjective frame of reference, an orientation described as phenomenological.
* This “subjective reality” includes the individual’s perceptions, thoughts, feelings, values, beliefs, convictions, and conclusions.
* Behaviour is understood from the vantage point of this subjective perspective.

**Unity and Patterns of Human Personality**

Adler stressed the need to understand the whole person, i.e., how all dimensions of a person are interconnected components, and how all of these components are unified by the individual’s movement toward a life goal.

This holistic concept implies that we cannot be understood in parts, but all aspects of ourselves must be understood in relationship (Carlson & Englar- Carlson, 2008).

**Lifestyle**

* An individual’s core beliefs and assumptions guide each person’s movement through life and organize his or her reality, giving meaning to life events.
* It includes an individual’s characteristic way of thinking, acting, feeling, living, and striving toward long-term goals (Mosak & Maniacci, 2008).
* People are viewed as adopting a proactive, rather than a reactive, approach to their social environment.

**Social Interest and Community Feeling**

* These terms refer to individuals’ awareness of being part of the human community and to individuals’ attitudes in dealing with the social world.
* Social interest is the capacity to cooperate and contribute.
* Our happiness and success are largely related to this social connectedness.

**Birth Order and Sibling Relationships**

* Adler identified five psychological positions, or vantage points, from which children tend to view life: oldest, second of only two, middle, youngest, and only.
* Actual birth order is less important than the individual’s interpretation of his or her place in the family.
* Birth order and the interpretation of one’s position in the family have a great deal to do with how adults interact in the world.

**Inferiority and Superiority**

* Inferiority is not a human weakness unless it develops into an inferiority complex.
* Superiority equals gaining mastery and is a major life goal.
* The striving for superiority or competence is a natural and fundamental motivation of individuals, whereas the superiority complex is not.
* Superiority complex develops when an individual attempts to mask his/her inferiority feelings with an inflated self-importance.

**Basic Mistakes**

This refers to the self-defeating aspects of an individual’s lifestyle. They often manifest as avoidance or withdrawal from others, self-interest, or desire for power and are usually derived from early recollections

**5 Basic Mistakes Identified by Mosak and Maniacci (2006)**

* Overgeneralizations
* False or impossible goals of security
* Misperceptions of life and life’s demands
* Minimization or denial of one’s basic worth
* Faulty values

**Private Logic vs Common Sense:**

* **Private logic** refers to the reasoning invented by an individual to stimulate and justify a style of life.
* **Common sense** refers socially agreed and acceptable behaviours and reasoning, usually to the benefit of all.

**The Therapeutic Goals**

* Focus on helping client develop a healthy life style and social interest.
* Aid client to identify and challenge faulty assumptions.
* To provide information, teaching, guiding and offering encouragement to discouraged clients.
* Help clients overcome feelings of inferiority and discouragement.

**Role of the Counsellor/Therapist**

* Helps the client to explore conscious thoughts, beliefs and logic for behaviours that are not in the client’s best interest or social interest.
* Assists client in better understanding, challenging and changing their life story.
* Conduct a comprehensive assessment (Family constellations & early recollections) of the client’s functioning.
* Encourage clients to explore their private logic in order to correct faulty assumptions.

**The Therapeutic Relationship**

* The relationship is characterized by cooperation, mutual respect, trust confidence, collaboration and goal alignment.
* Counsellor places emphasis on a strong therapeutic alliance for successful outcomes.
* The counsellor continues to model communication and educates client when necessary.

**The Therapeutic Process**

* **PHASE I: ESTABLISHING THE RELATIONSHIP**
* Counsellorsseek a person-to-person connection with clients.
* Counsellor provides support to clients.
* Prioritize client’s subjective experience over techniques.
* Major techniques used are attending and listening with empathy
* Development of clearly identified and aligned goals
* **PHASE II: EXAMINING THE CLIENT’S STYLE OF LIFE**
* Focus is on the client’s social and cultural context.
* Identify clients' faulty assumptions/basic mistakes.
* Use of subjective and objective interviews.
* Use of Family Constellation and Early Recollections for assessment.
* Integration and summary of information gathered from interviews and assessments.
* **PHASE III: DEVELOPING CLIENT INSIGHT**
* Counsellor interprets the findings of the assessment.
* Counsellor helps client to gain understanding of the motivations operating in his/her life. i.e., the hidden purposes of goals are brought to consciousness.
* This understanding serves as a platform for change.
* Disclosure and timely interpretations facilitate the gaining of insight.
* Interpretations are presented as suggestions to the client.
* **PHASE IV: RE-ORIENTATION AND RE-EDUCATION (a)**
* Focuses on helping clients discover a new and more functional perspective.
* Clients are encouraged and challenged to take risks and make life changes.
* Re-orientation involves cognitive and behavioural restructuring.
* Re-education involves teaching, guiding, providing information and encouraging the client.
* Clients are re-oriented to the “useful side of life.”
* **PHASE IV: RE-ORIENTATION AND RE-EDUCATION (b)**
* Counsellor places emphasis on encouragement.
* Clients make decisions and modify their goals.
* Client commitment is an essential part of re-orientation.
* Counsellor and client consider and evaluate possible alternatives and their consequences.
* Success is evident by a change in client behaviour, attitude or perception.

**Techniques**

* Encouragement
* Act “as if”
* “The Question”
* Spitting in the client’s soup
* Creating images
* Avoiding the tar baby
* Catching oneself
* Task setting
* Push button
* Homework

**Limitations of the theory**

* Clients brought up in extended families may not find the birth order and family constellation concepts relevant.
* Some clients may not be open to exploration of past childhood experiences and early memories.
* The approach has limited effectiveness for clients who don’t understand the purpose of exploring a lifestyle assessment in order to address current problems.
* Some clients may feel uncomfortable divulging family information.
* This approach might not work with clients who view the therapist as an expert, rather than as a collaborator

**CLASS TASKS**

**COMPARE AND CONTRAST**

DIFFERENT THE SAME DIFFERENT



TROPICAL

MODERATE TO TROPICAL

THICK PEEL

THIN PEEL

CAME TO EUROPE FROM INDIA

CAME TO EUROPE FROM CENTRAL ASIA

**Conclusion**

There are many factors that contribute to the therapeutic processes.Many researchers have conducted theoretical and empirical analyses of common therapeutic factors (Frank, 1961; J. D. Frank & J. B. Frank, 1991; Lambert, 1992; Wampold, 2001).

Lambert (1992) identified the following four common factors and estimated how much each factor typically accounts for therapeutic change;

1. Extratherapeutic factors (40%).

2. Therapeutic relationship (30%).

3. Expectancy (placebo effects; 15%).

4. Techniques (15%).

Lambert’s estimates are estimates and not designed to be perfectly precise (Beutler, 2009). However, his conceptual frame is strong and meaningful and has become a popular way of thinking about how therapy works—especially within the common factors camp. Theories must be effectively combined with other factors to facilitate therapeutic change.

**Post- Test**

1. What is counselling theory
2. List 5 counselling theories
3. List 2 humanistic approaches to counselling
4. List 2 techniques of Adlerian Theory
5. List 2 techniques of Solution Focused Brief Therapy

**References**

* Counseling and psychotherapy theories in context and practice : skills, strategies, and techniques / John Sommers-Flanagan, Rita Sommers-Flanagan. — 2nd ed.
* <https://counseling.education.wm.edu/blog/counseling-theories-and-approache>

**Suggestions for Further Reading**

Existential Psychotherapy, Dr. Irvin D. Yalom

**DPC 106**

**CHILDREN/TEENAGE COUNSELLING**

This, simply put is, “understanding the child.”

**The World of a Child**

Identifying children who are in needs and how to help them requires a good knowledge of a child’s world and ecology of human development;

**Uri Bronfenbrenner (1979)** was the first to conceive an ecology of human development that consist of a nested arrangement of systems, with each system embed in the other;

**Society**

**Parent network**

**EXO-SYSTEM**

**MACRO-SYSTEM**

**Meso-System:** Settings in which the child is directly involved i.e. home, school and neighbourhood are referred to as micro-systems and interactions between them make the meso-system.

**Exo-system:** Settings in which the child dos not actively participate i.e. his/her parents network of friends or parents workplace relationships are referred to as exo-systems

**Macro-System:** The wider environment in which everything else is embedded is the macro-system

The ecological model helps assess the balance between stresses and supports in a family environment as well as an individual’s own subjective experience of his/her circumstances

**The Child’s World**:

CHILD

Safeguarding & promoting welfare

Child’s developmental needs Parenting Capacity

Family & Environmental Factors

|  |  |  |
| --- | --- | --- |
| **Child’s Developmental Needs**  Health  Education  Emotional and behavioural development  Identity  Family and social relationship  Social presentation  Self-care skills | **Parenting Capacity**  Basic care  Ensuring safety  Emotional warmth  Stimulation  Guidance & boundaries  Stability | **Family & Environmental Factors**  Family history &functioning  Wider family  Housing  Employment  Income  Family social integration  Community Resources |

It is important to know the stages of child-development and to recognise age and how stage-related tasks are achieved as these have the potentials to affect the future outcome in good or bad direction. Deficit or dysfunctional behaviours at one developmental period will lay the ground work for subsequent dysfunctional behaviours. Deficits manifest at one age continues to exercise an influence at the next stage unless an intervention occurs. Example; Malnutrition in infancy having effects in the neurological or medical domain may lead to an impaired intellectual or cognitive functioning in toddlers which in turn may affect IQ and in turn affect school performance in a negative way and in turn lead to impaired performances as an adult.

**DEVELOPMENTAL TASK CHANGES IN CHILDREN**

|  |  |
| --- | --- |
| **AGE PERIOD** | **TASK** |
| Infancy | * Attachment to caregiver(s) * Language * Differentiation of self from environment * Self-control and compliance |
| Middle Childhood | * School adjustment (attendance, appropriate conduct) * Academic achievement (e.g. Learning reading, writing and mathematics) * Getting along with peers (acceptance, making friends) * Rule-governed conduct (following rules of society for moral behaviour and prosocial conduct) |
| Adolescence | * Successful transition to secondary schooling * Academic achievement (learning skills needed for higher education & work) * Involvement in extra-curricular activities (e.g. sport, music, club) * Forming close relationships within and across gender * Forming a cohesive sense of self-identity |

*Examples of developmental tasks. Adopted from Masten and Coatsworth 1998*

**Bentovim(1998) stresses that the key tasks a child should accomplish are:**

* Regulation of feelings
* Development of attachment
* Development of a sense of self
* Forming peer relationships
* Adaptation to school

**Risk factors that impairs children’s development causing childhood disorder;**

* Poor parenting, marital discord and family dysfunction
* Large family size (especially for boys)
* Specific parental psychiatric disorder
* Parental criminality
* Maternal anxiety, mood, attitude
* Exposure to abuse/domestic violence
* Traumatic life event
* Negative teachers
* Social class

**Note:** vigilant supervision of children’s activities and friendships, appropriate parental expectations, positive parent-child interactions, provision of toys and a safe play space can enhance child development even in otherwise high-risk family environments or high crime areas.

**What is Psychology?**

Psychology is the study of human behaviour.

**Understanding the Differences in Children**

* Sexual differences
* Cultural differences
* Age differences
* Personality Differences
* Socio-economic Differences

**THINGS YOU NEED TO UNDERSTAND ABOUT CHILDREN IN ORDER TO TEACH THEM EFECTIVELY**

* They fully experience joy of little things
* They are completely present in the moment
* They have uncensored creativity
* They display unconditional love
* They show happiness, silliness and laughter in all they do
* They notice everything around them
* They believe in play, play, play
* They are always moving
* They day dream and fantasize a lot
* They display endless curiosity

**DEALING WITH PSYCHOLOGICAL SITUATIONS IN CHILDREN**

1. Don’t get mad
2. Observe what is going on at that time
3. Analyse (why is the child acting that way)
4. Find out what the children are thinking
5. Teach them skills on how to handle such emotions and experiences
6. Don’t expect them to get the lesson the first time.

**WHICH CHILD NEEDS COUNSELLING?**

Children with problems such as:

1. Poor self-image/personal identity
2. Excessive attachment to the media
3. Abused (sexual, emotional, physical)
4. Traumatic or dysfunctional experiences
5. Issues with toilet training, homework, academic demands and failure
6. Anxiety and depression
7. A child whose observed emotional distress is distressing daily functioning
8. Career guidance
9. Addiction (drugs, alcohol, sex)
10. Abandonment or lack of attachment

**WHERE SHOULD CHILDREN-COUNSELLING BE DONE?**

1. Never at home
2. Place should be safe and neutral venue for the child
3. If possible, not in the presence of parents but with either their prior permission or subsequent notification.

**WHO SHOULD DO THE COUNSELLING?**

* Professional, trained, and experienced counsellors

**QUALITIES OF A GOOD CHILD COUNSELLOR**

* Reputable and appropriately trained
* Friendly and nice
* Non-judgmental
* Creative and open to new ideas
* Even tempered
* Attentive to the child’s problem
* Ability to give advice and ask questions that don’t sound stupid
* Be open and honest.

**STEPS IN THE COUNSELLING PROCESS**

1. Establish a safe trusting environment
2. Clarify what you think you are hearing
3. Listen attentively
4. Transform problem statements into goal statements
5. Explore possible approaches to goal
6. Develop a plan (help choose one way towards goal)
7. Make a contract to fulfil the plan (to make the next step)
8. Summarize what has occurred, clarify, get verification (evaluate progress)
9. Get feedback and confirmation

**GOALS OF COUNSELLING FOR CHILDREN**

1. To reduce emotional distress
2. To reduce dysfunctional behaviour
3. To promote adaptation
4. To develop potentials
5. To assist in decision making

**DOS OF CHILDREN COUNSELLING;**

1. Parents should meet with the counsellor ahead of the child if they are aware of the need for counselling.
2. Use of words is very important to either draw out a child’s feelings or seal them in for life.
3. The counsellor should assist the child to develop strategies to cope with specific fears and feelings.
4. Give the child an opportunity to explore, discover, and clarify ways of living more satisfactorily and resourcefully.
5. The child needs to know that the counselling is strictly confidential but information gotten can be shared if the child is in any form of danger.
6. Play, activity and talking allows the counsellor to discover how the child actually feels.
7. Provide available options from which the child can choose or decide on the best course of action.

**DON’TS OF CHILDREN COUNSELLING**

1. No matter how funny the situation or problem may sound, don’t laugh at the child
2. Never lose your temper even if the child is annoying or irritable
3. Do not be judgmental
4. Do not discuss your sessions with a third party, except with the consent of the child or in situations of anonymity
5. Counselling is not about giving advice
6. Don’t ever miss a session without prior notice.

**AND FINALLY….**Children are a reflection of the adults around them. When they behave badly or have issues to deal with, they are simply acting HUMAN.

**Child Abuse - Signs and Symptoms**

Although these signs do not necessarily indicate that a child has been abused, they may help adults recognise that something is wrong. The possibility of abuse should be investigated if a child shows a number of these symptoms, or any of them to a marked degree:

**Sexual Abuse**

* Being overly affectionate or knowledgeable in a sexual way inappropriate to the child's age
* Medical problems such as chronic itching, pain in the genitals, venereal diseases
* Other extreme reactions, such as depression, self-mutilation, suicide attempts, running away, overdoses, anorexia
* Personality changes such as becoming insecure or clinging
* Regressing to younger behaviour patterns such as thumb sucking or bringing out discarded cuddly toys
* Sudden loss of appetite or compulsive eating
* Being isolated or withdrawn
* Inability to concentrate
* Lack of trust or fear of someone they know well, such as not wanting to be alone with a babysitter or child minder
* Starting to wet again, day or night/nightmares
* Become worried about clothing being removed
* Suddenly drawing sexually explicit pictures
* Trying to be 'ultra-good' or perfect; overreacting to criticism

**Physical Abuse**

* Unexplained recurrent injuries or burns
* Improbable excuses or refusal to explain injuries
* Wearing clothes to cover injuries, even in hot weather
* Refusal to undress for gym
* Bald patches
* Chronic running away
* Fear of medical help or examination
* Self-destructive tendencies
* Aggression towards others
* Fear of physical contact - shrinking back if touched
* Admitting that they are punished, but the punishment is excessive (such as a child being beaten every night to 'make him study')
* Fear of suspected abuser being contacted

**Emotional Abuse**

* Physical, mental and emotional development lags
* Sudden speech disorders
* Continual self-depreciation ('I'm stupid, ugly, worthless, etc.)
* Overreaction to mistakes
* Extreme fear of any new situation
* Inappropriate response to pain ('I deserve this')
* Neurotic behaviour (rocking, hair twisting, self-mutilation)
* Extremes of passivity or aggression

**Neglect**

* Constant hunger
* Poor personal hygiene
* Constant tiredness
* Poor state of clothing
* Emaciation
* Untreated medical problems
* No social relationships
* Compulsive scavenging
* Destructive tendencies

Note: A child may be subjected to a combination of different kinds of abuse.  
It is also possible that a child may show no outward signs and hide what is happening from everyone

**Suspected Abuse**

If you suspect that a child is being abused, seek advice from the police or social services. It is preferable that you identify yourself and give details. However, if you feel unsure and would like to discuss the situation, ring the Ministry of youth and Social Development help lines or officers of Child Protection units/Social welfare offices. You can speak to these organisations (and the police and social services/NGOs) anonymously. Their numbers are attached to this manual.

Knowing how damaging abuse is to children, it is up to the adults around them to take responsibility for stopping it.

If a child tells you about abuse:

* Stay calm and be reassuring
* Find a quiet place to talk
* Believe in what you are being told
* Listen, but do no press for information
* Say that you are glad that the child told you
* If it will help the child to cope. say that the abuser has a problem
* Say that you will do your best to protect and support the child
* If necessary, seek medical help and contact the police or social services/ counsellor
* If your child has told another adult, such as a teacher or school nurse, contact them. Their advice may make it easier to help your child.
* Determine if this incident may affect how the child reacts at school. It may be advisable to liaise with the child's teacher, school nurse or head-teacher
* Acknowledge that the child may have angry, sad or even guilty feelings about what happened, but stress that the abuse was not the child's fault. Acknowledge that you will probably need help dealing with your own feelings too.

**COUNSELLING TEENS**

Adolescence/Teen-age is the intermediary stage of growth between childhood and adulthood.

The ages, by which children are termed to be a part of adolescence vary by ethnicity and extend from the preteens to nineteen years.

It is a period of CHANGE, GROWTH & DISEQUILIBRIUM.

**Stages of adolescence**

* Early Adolescence 10- 13years
* Middle Adolescence 14- 17years
* Late Adolescence 18- 21years

**Problems of Teenage**

* **Personal/Emotional Problems-**

Depression, Loneliness, Guilt, Anger, Grief, Suicidal

* **Social Problems-**

Love/Dating, Peer pressure, Coping with singleness, Choosing a Partner

* **Educational Problem-**

Dropping out, Underachievement/ Overachievement

* **Vocational Problem**

Knowing God’s will, Choosing a ministry or career, Choosing a college/course

* **Addiction Problem**

Alcohol use & abuse, Drug abuse, Gambling

* **Sex-Related Problem**

Lust, Masturbation, Pornography, Premarital sex, Unplanned Pregnancy, Abortion, Homosexuality, Infections, Soul ties, Abuse, Rape

* **Family related Problem**

Parental (Overprotective, Inattentive, Non-Christians, Divorce, Single & Step parents)

Sibling Rivalry, Rebellion, Abuse (Sexual or Ritual)

**NEEDS OF ADOLESCENCE/TEENAGE**

* Personality needs
* Need for Independence
* Need for Achievement
* Need for Love(Affection)

**Strategies for Teenage Rebellion/Sexuality Counselling**

* **Listen**

Encourage the teen to talk openly and honestly about his/her sexual urges and struggles.

Assure him or her of confidentiality.

Initially speak only to make it easier for the teen to speak, never express shock, outrage, condemnation, or revulsion.

Ask questions designed to provide useful information, not to satisfy your curiosity, i.e. how long has this being a struggle for you? How it started and possible reasons he turned into it.

* **Empathize**

Try to remember your own experience as a youth and the troubles you may have faced coping with hormonal changes and sex drive.

Understand that the teen may be embarrassed discussing such matters with an adult

You (same sex adult) can communicate empathy by;

- facing the young person directly,

- leaning forward in your seat,

-appropriate touch,

-nodding your head,

-making eye contact without starring

-reflect the young person’s statements (“You feel..” or “it sounds like you are saying”...)

-waiting patiently through tears or silence

* **Affirm**

Help them understand the confusion they feel as well as the sex drives are normal.

Give frequent messages of affirmations and assurance of appreciation (e.g. “You are not the only one struggling with these things”, “you are normal”, “I love you”, etc)

Gently lead him, her to confession and repentance

Guide the youth to understand God’s love

Reinforce his/her positive traits and abilities

* **Direct**

-Subtly and sensitively direct the young person in a strategy that will most help his/her specific situation.

-Help him, brainstorm ways to address and counter those needs or struggles in other ways (exercise, proper diet, relationship with God, memorizing scripture etc)

* **Enlist**
* Help them formulate their own plan, with action steps to serve as a program or guide for the struggle.
* Encourage ownership of both the problem and solution.
* **Refer**

In sexual matters particularly, it is critical that adult/counsellor of same sex offer the comfort and guidance.

Referral to another professional biblical counsellor when;

-problems are complicated,

-when counselee is getting emotional involved with counsellor,

-when suicidal tendencies are noticed.

**DPC 107**

**UNDERSTANDING A CHILD’S PERSONALITY & CAREER COUNSELING**

**INTRODUCTION**

* Every personality type will fall into two categories: ***INTROVERSION & EXTROVERSION***
* Research has it that we also have “EXTRAVERSION” personality, which is a blend of both introversion and extroversion. But this type is usually discovered as growth & development occurs.
* For children, a close observation and sound EQ by an adult will give a lead into what personality type a child is.

**Shy, Exuberant, Intense, or Laid Back?**

Temperament is what we’re born with. It is what makes us unique,

* It is powerful
* Determines how we react to the world
* You were born with it



**Defining TEMPER-ament**

There are many ways to define temperament, but with children we look out for;

* Intensity of reaction
* Activity level
* Tolerance for frustration
* Response to change
* Reaction to new people

**When to Tell**

* Between 6 & 9 months you begin to see patterns for clues
* But temperament becomes more apparent in toddler (2years upward) years as they become more verbal and social.

**PUTTING ALL THE PIECES TOGETHER**

Temperament is not created, chosen.

No right, wrong, worse or better temperament.

Children must be accepted for who they are.

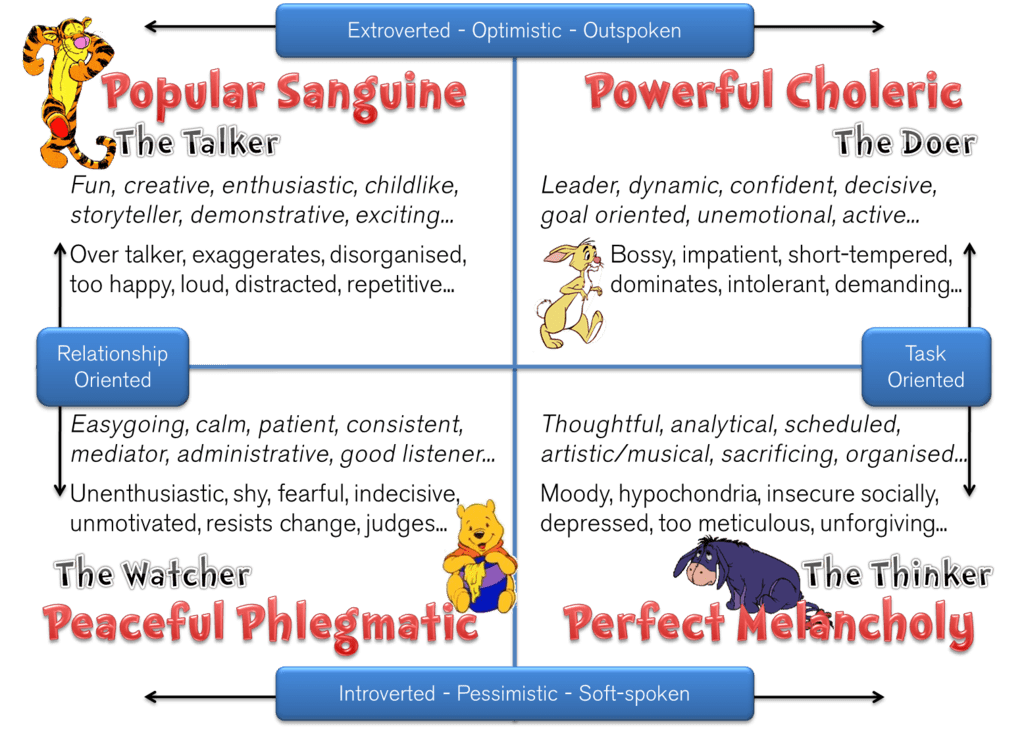
Key note:

* Recognize patterns in your child
* Watch out for unguarded moments/behaviors in your child
* Their untailored responses

**Four primary TEMPER- aments D I S C**

* THE HIGH D (Choleric)
* THE HIGH I (Sanguine)
* THE HIGH S (Phlegmatic)
* THE HIGH C (Melancholy)

**Personality D-I-S-C Grid**



**HORMONES & TEMPERAMENTS**

* Hippocrates described the four temperaments, which he considered to be linked to various predominant body fluids, or humours:
* The sanguine: optimistic & energetic (EXPLORER)
* The melancholic: moody & withdrawn (BUILDER)
* The Choleric: Irritable & impulsive (DIRECTOR)
* The Phlegmatic: calm & slow (NEGOTIATOR)

**THE HORMONE/BRAIN BEHIND YOUR TEMPERAMENT**



**HORMONES**

* **TESTOSTERONE (DIRECTORS**): Systems-thinking, tough minded & direct.
* **ESTROGEN (NEGOTIATORS**): Empathetic & inclusive, contemplative, ponder over & over.
* **SEROTONIN (BUILDERS)**: Prudent & principled, concrete & methodical. Not interested in theory; they want facts! Details, step by step, careful & not risk-takers.
* **DOPAMIN (EXPLORERS):** Curious, energetic, inventive, future oriented

**The Sanguine Strengths, Weaknesses & Possible Careers**

The sanguine nervous system is strong, balanced, and mobile.

* **(Strength)**  
  Lively, optimistic, buoyant, carefree, adventurous, sociable, entertainer, creative, optimistic, energetic, bold, etc.
* **(Weakness)**  
  Unstable mood, chronically late, forgetful, talkative, disorganized, cannot keep secret.
* **(Ideal Career)**

Marketing, travelling, fashion, cooking, acting, sporting, etc.

**The Phlegmatic Strengths, Weaknesses & Possible Careers**

Their nervous system is inert, strong, balanced, and sedentary.

* **(Strength)**  
  Loyal, hospitable, teachable, kind, quiet, friendly, shy, don't easily get angry, hate conflict, don't like open confrontation, don't like arguing, trustworthy, understanding, etc.
* **(Weakness)**  
  Don't keep to time, lazy, can become selfish cause of self-desire, can be stubborn at will, prone to grudge holding, can be destructive when angry.
* **(Ideal Career)**  
  Nursing, teaching, psychology or counselling, child development, or charity services.

**The Choleric Strengths, Weaknesses & Possible Careers**

Their nervous system is unrestrained, strong, unbalanced, and mobile.

* **(Strength)**  
  Goal oriented, social, enjoy deep and meaningful conversations, charismatic, good leader and planner, keep to time, self-confident, courageous, very good at arguing, love challenge
* **(Weakness)**  
  Dictatorial, dominate the phlegmatic, desire to be in control, easily angry, harsh in words, proud, aggressive, override others.
* **(Ideal Career)**Management, technology, statistics, engineering, programming, business and politics.

**The Melancholy Strengths, Weaknesses & Possible Careers**

Their nervous system is weak, unbalanced, and immobile.  
**(Strength)**  
Love traditions, sociable, contributors to the community, orderly, accurate, fantastic people managers, sacrificial, self-reliant.  
**(Weakness)**  
Slow eater, not social, too analytical, hard to please, moody, introvert.

**(Ideal Career)**  
Management, accounting, social work, administration.

**DPC 108**

**MARRIAGE & FAMILY COUNSELLING**

**DEFINITIONS**

* Branch of psychotherapy that works with families and couples in intimate relationships to nurture change and development.
* The family is viewed as a system.
* Change is viewed in terms of the systemic interaction between family members.
* Family relationships are emphasized as an important factor in psychological health.

**BASIC ASSUMPTIONS**

* A change in one family member influences the entire system and each member individually.
* Illness in one family member may be a symptom of a larger family.

**The Etiology of Problems**

Problems are assumed to be as result of;

* A dysfunction in family characteristics, such as structure and nature of interactions.
* A disruption in the stability (homeostasis) of the family.

**Systems approach**

* In working systemically the central focus should be upon the system rather than the individual.
* The system may usefully be thought of as the household or a wider family system, and may include friends, people in institutions (school, work, church).
* A consistent view is that these difficulties do not arise within individuals but in the relationships, interactions and language that develop between individuals.

**Family characteristics**

* **Boundaries**:

These are implicit family rules that regulate family interaction.When there are no rules, members behave and interact as they like. When this happens, families become fused or enmeshed.When the rules are too rigid, families become disengaged.

**Boundaries: Fusion/Enmeshment:**

People are fused or enmeshed when they are unable to think or act independently.

People who are not fused are autonomous and have emotional separation from their family. They are said to be differentiated.

A person’s level of differentiation is often related to his or her parents’ level of differentiation. It tends to be trans-generational.

People with low levels of differentiation are more reactive to environmental stressors. When under stress they are more likely to try to resolve it by:

* Withdrawal
* Conflict
* Dysfunction
* Triangulation

**Boundaries: Disengagement:**

Family members are withdrawn from each other emotionally and psychologically.

Family members don’t react to one another.

**Diagnosing family dysfunction**

* Good family functioning is based on diversity.
* Poor family functioning is a result of rigidity and narrowness.
* Pathology is looked at in the pattern of interactions among people.
* Counsellors look for circular causality and not linear causality.
* Feelings are not as relevant as actions.

**Family life cycle stages**

* Single young adult leaves home.
* Formation of a family through marriage.
* Families with young children.
* Families with adolescents.
* Launching children. Children move out.
* Empty nest.

**Family life cycles & family functioning**

* Family dysfunction often is a result of unmet family developmental tasks.
* Family life cycle changes are a major source of stress and disequilibrium for families.
* As families grow, there are developmental tasks that are required; when a family negotiates these successfully family roles and structures change.
* When the family does not, or cannot accommodate these changes, stress and symptom pathology will occur.
* It is not the normal difficulties that create the problem but rather the chronic mishandling of problems over time.
* Denying the need for change and treating normal family development as a problem or striving for perfection are all catalysts for family dysfunction.

**Dysfunctional patterns**

* Family dysfunction can be caused by behavioural patterns that are rigid and repetitive.
* Unless something breaks up the dysfunctional pattern, it can continue indefinitely.
* There is no blame on any one family member; everyone has a role to play.
* Problems occur when there is no hierarchy or if it is ambiguous or culturally inappropriate.
* Unclear, inadequate, confusing, incongruent communication creates problems.
* Problems arise when marital partners both have low self-esteem and are intolerant of each other’s differences and seek to raise their self-esteem through their children.

**How does change occur?**

**Change takes place when:**

* Family members are able to gain insight into their dysfunctional dynamics.
* Modifications are made to the repetitive behaviours that hinder family development.

E.g.:

* + - developing healthy boundaries
    - developing effective ways of communicating
    - adjusting family roles

**Essential Skills and Attributes of the Couples Counsellor**

1. Counsellor self-awareness
2. Capacity to tolerate intensity
3. Ability both to validate and to challenge
4. Recognition that relationships are full of contradictions
5. Understanding relationships in the context of cultural values and norms

**Class activity**

1. a) List your top 5 values.

b) Identify 3 beliefs that guide/drive you.

c)Identify 2-3 stereotypes that you have consciously or unconsciously judged/perceived others by.

1. How can the self-awareness issues you identified influence how you interact with clients?
2. How can you prevent these issues from negatively influencing your counselling sessions?

**Importance of Counsellor Self-Awareness**

Being self-aware allows counsellors to:

* Provide high-quality services to all couples.
* Ensure that their values, beliefs, and experiences do not influence their interaction with couples. In other words, self-awareness helps the counsellor remain non-judgmental.
* Reduce the potential for biasing the couple’s decisions.
* Understand that he or she is not responsible for the couple’s relationship.
* Hear and understand the couple’s concerns.
* Offer genuine empathy and support.
* Skillfully and effectively manage the couples counselling session.
* Consequently, through self-awareness, counsellors are able to focus unbiased attention on the couple and effectively engage and empower them.

**Issues That May Influence the Counsellor’s Ability to Provide Quality Services to Couples**

* Counsellor’s experience, values, and feelings relating to couple relationships, including gender roles and expectations.
* Dreams and aspirations the counsellor has for his or her relationship, family, and future.
* Counsellor’s relationship with his or her partner.

**Additional skills for the couples’counsellor**

**The marriage counsellor must be able to:**

* Demonstrate balanced and equal concern for both partners.
* Convey respect for the couple’s relationship.
* Facilitate balanced participation of both partners during the session.
* Model appropriate listening and communication skills.
* Facilitate dialogue between the couple.
* Raise difficult issues that the couple may need to address.
* Ease tension and diffuse blame

**Forming Alliances**

* Definition: An alliance is a partnership between the counsellor and the couple.

With this in place, couples are encouraged to:

- engage in the session

- be willing to explore deep seated issues

- be willing to disclose and address challenging issues

**Strategies for Forming Alliances**

* The acronym, A.C.E., explains three important steps to building an alliance:

1. **Acknowledgement**—Describes the couple’s awareness that the counsellor acknowledges their strengths, courage, and experience.
2. **Competence**—The Couple senses that the counsellor has the skills and experience to guide and support them through the process.
3. **Empathy**—The couple senses that the counsellor genuinely understands and appreciates their experiences and feelings.

**Identifying Important Alliances**

There are four important alliances that the counsellor needs to establish, foster, and maintain.

1. The alliance between the counsellor and the wife.
2. The alliance between the counsellor and the husband.
3. The alliance between the counsellor and the couple as a collective unit representing more than two individuals (for example, the family unit, the community, and society).
4. The alliance between the couple as partners.

**The Counselling Process**

* **The Initial Interview:**
* **Pre-session Planning**:The therapist determines in advance who will attend the session.
* **The Joining Stage**: The therapist joins with the family, taking on their affective tone, tempo, language and structure.
* **The Problem Statement Stage:**Who gets to initially frame the “problem”? Sometimes the person who has the least involvement with the problem is addressed first.
* **The Interaction Stage:**The therapist focuses on determining the patterns of interaction sustaining the problem.
* **Goal Setting Stage:**The therapist reaches an agreement with the family on a solvable problem, stated in a behavioural term so that all involved will know when the problem has been solved.
* **Ending Stage:**The therapist sets the next appointment and indicates which family members will be present.

**Family Therapy Assessment Tools**

* ***Family Interview***
* ***Reenactment:***Asking the family to act out a situation rather than describe it verbally.
* ***Genogram*:** Gives a picture of three or more generations (like a family tree) and notes important family dynamics, rules, patterns, mental health issues, etc.
* ***Circular Questioning:*** The same question is asked of each family member.
* ***Family Sculpting:***Examines power and closeness in a family by asking each family member to physically arrange all other family members in order of relationships.
* ***Family Apgar*:** Used to assess each family member’s level of satisfaction and the family’s functionality.

**Family Therapy Intervention Techniques**

* ***Reframing*:**  Stating the problem in solvable, behavioural terms. Referencing it as a family problem and not just the problem of one family member, and putting in positive terms.
* ***Giving Directives*:**Creating or selecting an intervention that will impact the presenting problem.
* ***Rituals:***Symbolic acts that help the family move. (e.g. burying a box that contains family anger.)
* Assignments that interrupt patterns.
* Challenge unproductive assumptions.
* Parent training
* Communication skill building
* Decrease emotional reactivity and increase thoughtful responses.
* De-triangulation
* Conjoint family drawings
* Restructuring

**Major Family & Family Therapy Models**

* *Strategic family therapy:* developed by Jay Haley & Cloe Madanes
* *Conjoint family therapy* : developed by Virginia Satir.
* *Structural family therapy*: developed by Salvador Minuchin.
* *Bowen family therapy*: developed by Murray Bowen.
* *Experiential family therapy:* developed by Carl Whitaker
* *Solution-Focused Brief Family Therapy*: developed by Insoo Kin Berg and Steve de shazer.
* *Narrative Family Therapy:* developed by Michael White
* *Cognitive Behavioural Family Therapy*: Albert Ellis, Albert Bandura.
* *Emotion Focused Therapy-* Sue Johnson

**DPC 109**

**UNDERSTANDING MENTAL HEALTH   
(Service Group)**

**Introduction**

***“A human being is a constitution of mental and physical states. Hence, total health and wellbeing of any individual is ultimately dependent on the inter-relationship that exist between these two states”***

**(Kolappa et.al 2013)**

**Pre-Test**

* What is your understanding of mental health?
* What are your perceptions of mental health and are you aware of where those perceptions originate from?

**Learning Outcomes**

* To expose the students to prevalence of mental health problems.
* To identify and change any possible misconceptions about mental health.
* To expose the trainee to the difference between mental health and illness.
* For the trainee counsellors to understand their roles when faced with mental health cases.
* To test students understanding of the modules.

1. **Prevalence in Nigeria**

*An estimated 30% of Nigerians are believed to suffer from mental health disorders, this implies about 60millions Nigeria. 80 cases of suicide have been reported in the last one year, with Lagos state leading with 15 cases within the period under review. Not taking into account unreported cases*. *(AbdulazizAbdullahi, Perm. Sec. Fed. Min. Health, 2018).*

Dr Blessing Chukwukwelu stated; *only one-fifth of those with depressive episode receive any treatment, and only one in 50 receives treatment that is minimally adequate*.

Nigeria has only 150 psychiatrists to care for the population; that’s one psychiatrist to 1.3million Nigerians. Nigeria has 5 mental health nurses to 100,000 Nigerians with only 8 Psychiatrist Hospitals in the country.

1. **Discrimination/Misconception**

In the absence of a Mental Health Act passed by law and with a lack of adequate mental health infrastructure, low numbers of professional personnel, training and research, Nigerians suffering from mental illness are at risk of being subjected to prejudices, discrimination, stigmatization and abuse.

Those statistics suggests that Nigeria is not yet ready to address mental health issues. No clearly defined mental health policy has been implemented.

The 2006 WHO-AIMS report on mental health system in Nigeria made some telling revelations. It reports that “*there is considerable neglect of mental health issues in the country. The existing Mental Health Policy document in Nigeria was formulated in 1991. Since its formulation, no revision has taken place and no formal assessment of how much it has been implemented has been conducted……No desk exists in the ministries at any level for mental health issues and only four per cent of government expenditures on health is earmarked for mental health.*” It also unearthed other issues related to mental health. These include unavailability of essential medicines at health centers, unavailability of physicians to run primary health care centers and the lack or restrictions to the prescription of psychotropic medications. It also identified that there are only a few nongovernmental organizations involved in individual assistance activities such as counselling, housing, or support groups.

Although a bill for the establishment of a Mental Health Act was introduced in 2003 and re-introduced to the National Assembly in 2013, this is yet to be passed into law, and only 3.3% of the federal government’s health budget goes to mental health.

In addition to this lack of political will where mental health is concerned, numbers of trained and specialised mental health care professionals in the country are also low.

In emergency situations such as conflicts, wars and disaster as Nigeria is currently witnessing in Northern parts and the Middle Belt of Nigeria, “rates of mental disorder tend to double,” widening the inequality gap “in the distribution of skilled human resources for mental health.”

* 1. This lack of policy and regulation for mental health has also created an avenue for a variety of different professions currently concerned with the treatment of mental illness in Nigeria, including traditional and spiritual healers, counsellors, life-coaches, psychiatrists and psychologists, to flourish. Although an increase in services to treat mental illness is generally welcome, there is a danger of malpractice that comes with the lack of standardized and evidence-based diagnoses and treatment.

The implication, therefore, according to WHO, is that the *“poor often bear the greater burden of mental disorders, both in terms of the risk in having a mental disorder and the lack of access to treatment. Constant exposure to severally stressful events, dangerous living conditions, exploitation, and poor health in general all contributed to the greater vulnerability of the poor. The lack of access to affordable treatment makes the course of the illness more severe and debilitating, leading to a vicious circle of poverty and mental health disorders that is rarely broken”*

1. **Misconception & Stigmatisation**

What we need to be aware of is that, it’s not only the insane man on the street who talks to himself and sleeps on dirt is not the only one with mental disorder. There are also many who appear ‘normal’ yet may be having serious mental illness.

For example, individuals who show symptoms of psychosis (hearing voices or seeing things that are not there) are often labelled as “crazy”, publicly beaten and deprived of rights essential to dignified living. Individuals suffering from mental illness are generally seen as dangerous, regardless of their type or diagnosis of mental illness.

Sadly, the stigma around mental health in the country has often meant that the individuals we see are more severely ill before they access help through services.

Understanding mental illness in Nigeria is something that has to be taken contextually and historically. There is a large misconception and misinformation on the context of the subject amongst Nigerians. The general belief is that preternatural or supernatural forces, witches, evil spirits and even God cause mental illness. These beliefs have influenced the attitude of Nigerians towards the mentally ill.

Historically, people with mental illnesses were burned, hanged, mutilated, abandoned and restrained with chains, all in the bid to save their souls, or bring redemption to their families and curb the iniquities causing mental illness within the families. These beliefs on the etiology of mental illness shape attitudes and have been shown to have a huge impact on the acceptance of the mentally ill amongst Nigerians.

* 1. [**Stigmatization**](https://www.omicsonline.org/searchresult.php?keyword=%20Stigmatization) deprives victims of mental illness their full measure of human dignity and participation in wider society by undermining social support and compromising opportunity for treatment. And this is done by individual and institutional discrimination resulting from misconception, prejudicial stereotypes and negative public and professional attitudes about mental illness.

A national survey on stigma and mental illness among nursing professionals in Nigeria conducted in the six geopolitical zones of the country by Obembe et al. reported that 40% of their studied population viewed mentally ill individuals as violent, 26.5% would distance themselves from the mentally ill and a third associated mental illness with lack of self-discipline and will power but generally they held less negative views about mental illness. Another study conducted by Abasiubong on stigmatizing attitudes towards the mentally ill in a Nigerian university teaching hospital among the hospital population found that 52% of the respondents believed witches were responsible for the causation of mental illness, 44.2% thought it was due to demon possession, and close to one third felt it was due to the consequences of divine punishment. The respondents generally held strong negative views about the mentally ill. Most of the respondents believed being authoritarian and restrictive in their attitudes towards the mentally ill and placing emphasis on custodial care is the best approach to treatment.

A report by Audu et al. in a rural community in Northern Nigeria found widespread ignorance about causation, mode of transmission and remedies available for mental illness as a cause for stigmatizing the mentally ill, with only 0.9% of respondents attributing mental illness to brain disease. The others attributed mental illness to spiritual attack, punishment for evil doing and illicit psychoactive substance use, among other things. Negative views about the mentally ill were also widely expressed resulting in discriminatory practices.

1. **GLOBALLY**

By WHO data, at least *“one in four people in the world will be affected by mental or neurological disorders at some point in their lives,” placing the total number of people currently suffer from such conditions at 450 million worldwide”.*

The implication being mental disorders is “among the leading causes of ill-health and disability worldwide.”

1. **Mental Health:**

It is the state of someone who is functioning at a satisfactory level of emotional and behavioural*adjustments* to fit the *dynamic environment* wherein he or she co-exists with others.

* It also helps determine how we handle *stress*, relates to others, surrounding and make choices. That is, ability to *adapt* to internal and external stressors.
* Refers to one’s emotional and psychological well-being.
* This state of well-being is essential at all stages of life.

1. **MENTAL ILLNESS/DISORDER;**

This is a condition which causes serious disorder in a person's behaviour or thinking.

Mental illness is any disease or condition that influences the way a person thinks, feels, behaves, and/or relates to others and to his or her surroundings. Although the symptoms of mental illness can range from mild to severe and are different depending on the type of mental illness, a person with an untreated mental illness often is unable to cope with life's daily routines and demands.

* 1. **MENTAL DISORDER:**
* Refers to issues in the mind that have negative effect on the way a person thinks, feels and behaves.
* An illness that can affect a person’s thoughts, perceptions, mood or behaviour.
* A mental health becomes illness when on-going signs cause frequent stress and affect one’s daily functionalities.
* It can make it difficult for someone to cope with work, relationships and other demands.
  1. **TRIGGERS/STRESSORS**
* **Heredity (Genetics):**

Many mental illnesses run in families, suggesting they may be passed on from parents to children through genes. Genes contain instructions for the function of each cell in the body and are responsible for how we look, act, think, etc.

* **Biology**:

Some mental illnesses have been linked to an abnormal balance of brain chemicals called neurotransmitters. If these chemicals are out of balance or are not working properly, messages may not make it through the brain correctly, leading to symptoms of mental illness.

* **Experiential/Psychological trauma**:

Some mental illnesses may be triggered by psychological trauma suffered as a child, such as severe emotional, physical, or sexual abuse; a significant early loss, such as the loss of a parent; and neglect.

* **Environmental stressors**:

Certain stressors -- such as a death or divorce, a dysfunctional family life, changing jobs or schools, and substance abuse -- can trigger a disorder in a person who may be at risk for developing a mental illness

* **SUBSTANCE MISUSE:**

Evidence has shown that there is a clear connection between mental disorders and substance misuse.

Problems with substance and mental disorder are known as dual diagnosis or co-morbidity.

## Types of Mental Illness

* 1. **Psychotic Disorders:** Psychotic disorders involve distorted awareness and thinking. Two of the most common symptoms of psychotic disorders are hallucinations -- the experience of images or sounds that are not real, such as hearing voices -- and delusions, which are false fixed beliefs that the ill person accepts as true, despite evidence to the contrary. Schizophrenia is an example of a psychotic disorder.
  2. **Mood Disorders:** These disorders, also called affective disorders, involve persistent feelings of sadness or periods of feeling overly happy, or fluctuations from extreme happiness to extreme sadness. The most common mood disorders are depression and bipolar disorder.
  3. **Anxiety Disorders:** People with anxiety disorders respond to certain objects or situations with fear and dread, as well as with physical signs of anxiety or panic, such as a rapid heartbeat and sweating. An anxiety disorder is diagnosed if the person's response is not appropriate for the situation, if the person cannot control the response, or if the anxiety interferes with normal functioning Anxiety disorders include generalized anxiety disorder, panic disorder, social anxiety disorder, and specific phobias.
  4. **Eating Disorders**; e.g. Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder.
  5. **Impulse Control and Addiction Disorders**: Pyromania (starting fires), kleptomania (stealing), and Compulsive Gambling are examples of impulse control disorders. Alcohol and Drugs are common objects of addictions.
  6. **Dementia**:

According to WHO;Worldwide- 47.5million people;

* There are 7.7m yearly
* Countries like Nigeria accounted for 5.77m cases.

According to Adeloye, D (2015);there is 400% increase in 20yrs in Nig.

1995 – *63,500*

2015- *318,000 mostly amongst 60+*

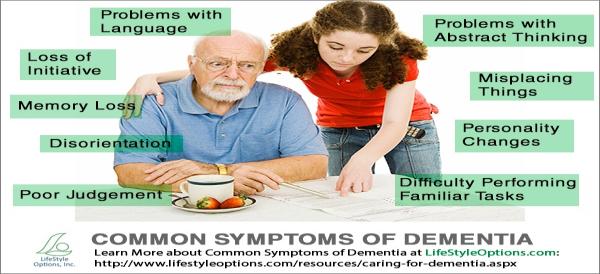
Highest in *North-Central,*

Followed by *North-West*

Then *South-West*

Higher in urban settings than rural areas.

Dementia is not a specific disease. It's an overall term that describes a wide range of symptoms associated with a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities.



**8.0. INTERVENTIONS:**

* Pharmacology
* Medical
* Therapy

1. **MODULE ASSESSMENT:**

* *Have your perceptions about mental health been changed?*
* *If yes, what’s your new understanding of mental health?*
  1. **Assignment**

Pick one of the two case studies and treat it.

1. Abigail is a student of University of Lagos. She presently feeling very overwhelmed in her mood, feeling continuously unhappy in the past few month. Whenever she remembers the sexual abuse she suffered from the hand of her uncle while growing she experiences the following;

* Feeling demotivated, lost interest in her studies
* She feels like binging on diets
* She thinks she may not be able to achieve much in life.
* Sleep has also been erratic

Abigail has come into therapy and examples of her statements are; “the world has been unfair to me”, “I don’t see myself achieving something tangible in life”.

As a counsellor, from your initial assessment of Abigail,

1. Identify what mental health diagnosis that she may be suffering?
2. Identify the symptoms of Abigail’s mental illness?
3. Identify the triggers for her psychological problems?
4. Philip has lost his job as a result of the COVID-19 pandemic, and he is the breadwinner of his family. He also has so many extended family members he’s taking care of.

Due to this adverse life experience, Philip continues to ruminate on his loss. It was noted that he’s being behaving abnormally. Family reported that he’s been talking to himself lately, believing that some people are after his life and threatening violence to his family.

Family also added that he is awake most night because he’s suspicious that some people will attack him and also expressing that he has some supernatural power to know what will happen in future.

As a therapist, Philip’s family has consulted you for help, from your initial assessment,

1. Identify what mental health diagnosis that he may be suffering?
2. Identify the symptoms of Philip’s mental illness?
3. Identify the triggers for his psychological problems?

**References;**

1. Obembe A, Yunusa M, Adeniyi F, Uwakwe R et al. (2013) *National survey on stigma, mental illness and nurses in Nigeria: A preliminary report.*
2. Abasiubong DI (2010) *Stigmatizing attitudes towards the mentally ill: A survey in a Nigerian university teaching hospital*. South African Journal of Psychiatry 16: 56-60.
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**DPC 110**

**CRISIS/ TRAUMA COUNSELLING**

Trauma refers to the body or mind being overwhelmed by traumatic events. Psychological trauma in particular occurs as a result of a distressing event that leads the sufferer to question their beliefs while destroying their assumptions of trust. If you have experienced a traumatic event, you may feel socially disconnected and somewhat numb, leading to feelings of isolation. On top of this, you may find yourself feeling more afraid and vulnerable than before the event.

Psychological trauma is the mind's reaction to an event and not everyone will react to the same event in the same way - for example, some people would find falling from a height traumatic, while others choose to jump out of planes for fun. Trauma also affects people in different ways and for some, the symptoms take weeks, months or even years to surface.

Regardless of its source, an emotional trauma contains three common elements:

* It was unexpected;
* The person was unprepared; and
* There was nothing the person could do to prevent it from happening.

**What is Psychological Trauma?**

Psychological trauma usually occurs after a particularly distressing event or a series of enduring events. The result of this can lead you to feel totally overwhelmed and unable to cope. These events are typically so far outside what we expect and what we believe that our reactions can seem somewhat unusual or even disturbing. Reactions like this are normal though, and should be expected after trauma.

The most common term used to describe the symptoms of psychological trauma is [post traumatic stress disorder](http://www.counselling-directory.org.uk/ptsd.html), or PTSD. Categorised as an anxiety disorder, PTSD occurs after a traumatic event and refers to ongoing, severe symptoms such as flashbacks and insomnia. Not everyone who experiences a traumatic event will go on to develop PTSD.

There are different severities of psychological trauma, some symptoms are mild and may go away with time, while others can be more severe (such as PTSD) and will require professional treatment. When it comes to trauma, the sooner you seek help the better.

**Causes of Trauma**

As previously mentioned trauma is subjective and can have a multitude of causes. The common factor for events that lead to trauma is that they are not anticipated and are outside the realms of what we deem to be acceptable - physically, emotionally or socially. Below are some examples of events that could lead to psychological trauma.

**Abuse**

This can refer to physical, emotional, sexual or verbal abuse. Anything that can be described as improper treatment that leads you to feel violated in some way constitutes abuse. The traumatic event could be a one-off attack or a recurring form of abuse that takes place over long periods of time.

**Accidents**

Being involved in an accident can lead to a traumatic response. Examples include car accidents, a bad fall and accidentally harming someone else. Even if you were not physically harmed by the accident in question, being involved and experiencing the event can still lead to traumatic feelings.

**Brain Tumour and Brain Injury**

Injuries and [cancer](http://www.counselling-directory.org.uk/cancer.html) of the brain can be catastrophic for both the person affected and those around them. In some cases, such injuries and illness can alter personalities or affect key motor skills - both of which can lead to symptoms of psychological trauma.

**Catastrophic Events**

This can relate to natural disasters such as earthquakes, tsunamis and hurricanes as well as man-made events like war and bombings. Being involved in these kinds of events can affect you both directly and indirectly.

**Physical Injury**

Some physical injuries can change your life forever. You may have had a limb amputated and need to learn to cope with your new [disability](http://www.counselling-directory.org.uk/disabilities.html), or you may be left with physical scarring and [chronic pain](http://www.counselling-directory.org.uk/chronic-pain.html). Either way, this kind of trauma often requires a great deal of emotional support alongside physical rehabilitation.

**Terminal Illness/Bereavement**

Whether it's yourself or someone close to you who has been diagnosed with a terminal illness, traumatic symptoms are often experienced. Equally, when someone close to you passes away (whether it's expected or unexpected) you can start to question your belief system and shut down emotionally.

**Violence**

Experiencing violence in any way can be traumatic. Whether you have been the victim of physical violence, threatened with violence or even witnessed violence - you could find yourself suffering from symptoms of psychological trauma.

**Symptoms of Trauma**

Symptoms of trauma vary from person to person and depend on the severity of the event. These symptoms can last anything from a couple of days to decades if treatment isn't sought. Some people also find that they do not notice any symptoms immediately after the event as they can often occur some time later.

Common symptoms of psychological trauma include:

* **Flashbacks** – When clients re-experience the traumatic event mentally or physically.
* **Insomnia** – After a traumatic experience it is common to have difficulties sleeping due to nightmares or due to mentally going over details of the event.
* **Anxiety** – Feeling constantly anxious after a trauma is very common. Sometimes these feelings turn into anxiety disorders such as PTSD or panic attacks.
* **Stress** – Even if client handled stress very well before their experience, many people find stress harder to manage after a traumatic event.
* **Anger** – Feeling angry after a trauma is very common. Client might be angry at the person who traumatised them, at the event itself or even at the world. This can lead to outbursts and other anger management issues.
* **Depression** – Many people fall into a depression after experiencing something very distressing. Client can be left wondering why the event happened to them - leading to dark moods and in severe cases, [suicidal thoughts](http://www.counselling-directory.org.uk/suicidal-thoughts.html).
* **Loss of self-esteem** – It can be easy to lack self-belief and self-confidence after you have experienced something traumatic. Client can be left questioning their identity and what they have to offer the world.
* **Self-medication** – For some, the only way they feel they can deal with what happened is by self-medicating with alcohol or drugs. This leads to very self-destructive behaviour and can isolate them from friends and family.
* **Emotional detachment** – For some, the emotions brought up are so severe that they cannot deal with them at all. This can lead to emotional numbness, also known as [dissociation](http://www.counselling-directory.org.uk/dissociation.html). They may refuse to deal with any psychological issues they have and could appear cold and distant to others.

The longer the trauma symptoms go untreated, the more psychological damage they could cause. Therefore it is important to encourage trauma victims to seek professional help.

**Treatments**

There are many different treatment options for those going through psychological trauma; the key is finding a treatment that works best for each person. Treatments generally involve acknowledging and processing trauma-related memories while releasing any pent up 'fight-or-flight' energy. Learning how to regulate strong emotions and building an ability to trust again is also essential.

The type of treatment counselee receives will depend on a number of factors, including the kind of trauma experienced, their personality and the counsellor. These three treatment options are some of the most common when dealing with psychological trauma and are often combined.

**Somatic Experiencing**

This technique utilises the body's unique ability to heal itself by focusing on bodily sensations as opposed to thoughts and memories. The therapy looks at what's happening in the body by getting in touch with trauma-related tension. At this point, natural survival instincts take over and the participant releases pent-up energy by crying, shaking and other physical reactions.

[**Cognitive Behavioural Therapy**](http://www.counselling-directory.org.uk/cognitive-behavioural-therapy.html)**(CBT)**

One of the most popular therapies used by counsellors today, CBT looks at changing the way individuals think and how they react to these thoughts. With psychological trauma, CBT helps to process and evaluate thoughts and feelings about the trauma. This treatment is often paired with other physiological therapies such as Somatic Experiencing to ensure all elements of the trauma are addressed.

**Eye movement desensitisation and reprocessing (EMDR)**

EMDR incorporates CBT with eye movements and other rhythmic left to right stimulation. These motions help by 'unfreezing' traumatic memories, letting you then resolve issues as they surface. Particularly helpful for those who have repressed any traumatic memories, EMDR addresses both psychological and physiological issues.

* **NEUROLOGICAL REDESIGN**

Neurological Redesign process using sub-modalities could be considered a pattern interruption or scramble. Using some Neurological Redesign Techniques works effectively also with extreme emotional tension or trauma associated with a past event. The techniques involve;

* Interrupting an existing neurological link between a trigger and its response
* Simultaneously creating a positive association with a new desired behaviour, state or belief

**EXAMPLE:**

1. **Shifting sub-modalities**
   * + Determine the unwanted state or behaviour to be changed
     + Chose the preferred state or behaviour to replace the one being changed
     + Elicit the Internal Representation (I/R) and their sub-modalities for both the unwanted and the preferred.
     + Determine the ‘drivers’ those critical sub-modalities that differ between both I/Rs
     + Change the sub-modalities of the unwanted state or behaviour with those of the preferred
     + Test and link new response to future

**Keys**: \*Speed

\*Find the ‘drivers’ (The critical sub-modalities that create the most change when they are replaced)

\* Utilize universally generalized experiences

**Ask:** How is it a problem for you now?

Is it alright with your unconscious mind to make this change today and for you to have conscious awareness of it?

Can you do it now?

So, you would know if it disappeared, right?

1. **Behaviour Destroyer**

* This process is used specifically for behaviours NOT non-behaviours i.e. “I eat too many sweets” OR “I get mad at my kids when they are late.”
* It is less useful for unconscious behaviours such as nail biting, hair pulling etc.
* Consider your words are embedded commands… use ONLY positive I/R (Internal Representations)

**STEPS**

1. Elicit unwanted behaviour
2. Elicit intention of unwanted behaviour. Chunk up only 1-2 levels by asking:

“For what purpose?”

1. Mind read or elicit opposite of the problem behaviour
2. Plug words into the behaviour destroyer formula:
3. **“Anything less than \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Opposite of the problem behaviour)**

**Isn’t \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, isn’t it?**

**(Intention of problem behaviour)**

1. **“It’s not just about \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, isn’t it?**

**(Intention or other useful words)**

1. Repeat several times, going back and forth across boundary conditions

(What were you pretending not to know in order to have thought that you had that problem?” “How do you know you have this problem?” “How do you know when you no longer have this problem?”

1. **Cartesian Logic**

This gives you the privilege to see a problem through four (4) different quadrants

|  |  |
| --- | --- |
| CONVERSE  #AB  What wouldn’t happen if you did? | THEOREM  AB  What would happen if you did? |
| NON-MIRROW IMAGE  A#B#  What wouldn’t happen if you didn’t? | INVERSE  A#B  What would happen if you didn’t |

**3-PHASES OF S.T.A.R (STRATEGIC TRAUMA & ABUSE RECOVERY)**

1. Safety & stability
2. Reprocessing & grieving
3. Reconnecting & integrating

**HEALING TIPS FOR STRUGGLERS:**

* Acknowledge you are wounded; expose the wound to open air
* Get accountability
  + Detach YOUR Person from Act
  + Track first experience
  + Grieve your loss
  + State your gain
  + Track your triggers
  + Create New Coping Mechanism/Response
  + Plan to fall & rise again
  + Forgive yourself, forgive yourself, forgive God
  + Discover the purpose of your pain. Every pain has a purpose
  + Use your pain to comfort others

**4-LEVELS OF TRAUMA CARE**

* Be trauma informed; be deliberate to understand and recognise
* Adopt a trauma informed approach; active shift in your thinking and approach with client i.e. ‘What’s wrong with you?’ to ‘What happened to you?’
* Adopt &practice trauma specific intervention; interrelations between trauma and trauma symptoms
* Be a trauma expert; education is the key to recovery (use assessment), engage the flip side (coping mechanism)

**Remember the connection to the original trauma as the circle increases; distorted identity.**

**GROUP-WORK**

**Treatment Strategies:**For victims of Loss/Grief, Suicide, Sexual Abuse, Sex addicts

**GRIEF COUNSELLING**

***For victims of Loss/Grief***

* + Establish which stage client is in:

**Stages of grief**

Shock Denial &Isolation

Denial Anger

Anger Bargaining

Depression Depression

Acceptance Acceptance

* + Emphasize strengths-note even minor strength or acts.
  + Encourage reading, writing, and talking—no isolation
  + Go through realistic remembering together e.g. looking through wardrobe or belongings of the deceased, looking at old pictures etc
  + Moving On:
    - * 1. Accepting new role i.e. single parent, singlehood
        2. Focusing on people alive. Don’t grief at the expense of others, especially children.
        3. Recognizing God has a plan.
        4. Reconnecting and beginning new relationships.
  + What NOT to say
    - 1. “God just wanted your...”
      2. “Well it happens to everyone...”
      3. “Yeah, I remember when ... died of the same thing”
      4. “Don’t worry, it will be just fine...”
  + What to DO
    - 1. Be available
      2. Listen
      3. Be flexible with the grieving person’s moods

NOTE: Your job as a counsellor is not to help people ignore or put away their grief but to help them go through it.

**SUICIDE COUNSELLING**

***For victims of suicide***

1. Follow up on any mention of suicide or indication that clients have thought about harming themselves.
2. Do not worry that you will be giving clients a new idea if you ask about suicidal thoughts. For example;

**Client**: I have been depressed for so long now that I’ve just about given up hope.

**Counsellor**: You seem so hopeless that I wonder if you have thought about hurting yourself.

**Client**: Oh no, I do never do that.

1. If confirmed, the more specific, accessible and concrete the method the greater the likelihood the client will attempt suicide.

**Client**: Yes, I want to die (don’t shut him/her up or dissuade him/her from saying such)

**Counsellor**: Have you thought about a way to kill yourself?

**Client**: Yes…

**Counsellor**: Please tell me about it

**Client**: I have thought about hanging myself

**Counsellor:** You have had serious thoughts about this. Have you thought about where this will take place?

**Client:** No, not really

Here, we could estimate that the client’s lethality risk as moderate to high. A method is available but additional action is necessary before suicide would be imminent.

1. Elicit information about the existence and nature of previous attempt

**Counsellor:** Have you tried to commit suicide before?

**Client:** Yes, I slashed my wrists. My sister found me and they rushed me to the hospital

The information about a previous serious attempt however combined with an available method would increase the assessment of the client’s lethality to ‘serious’. In such a case, counsellors ethically and legally have a responsibility to take action to preserve a life.

Even when suicide is unlikely, counsellors should take action.

Such action ranges from…

* + Particularly with suicidal clients, Counsellors should create structure that promotes order and predictability. In most cases here, the client had lost control so the counsellor takes the lead.
  + Counsellors should consult with a supervisor/professional if suicide is a possibility
  + Confidentiality may be broken to save the client’s life
  + Further immediate counselling to the client’s voluntary or involuntary hospitalization.

**SEXUAL ABUSE COUNSELLING**

***For victims of Sexual Abuse***

1. Have patients DO things
   * 1. Artwork
     2. Letter Writing
     3. Journaling
     4. Role Playing
2. Establish trust in the therapeutic relationship
3. Obligations to the perpetrator should be eliminated and NO demands for reciprocity- only focus on recovery
4. Survivorship should depend on the victim, not on others.(counsellors past experience are not important. His/her role is to help client heal themselves)
5. Establish a process- (small steps towards a goal)
6. Educate client; teach sexual and non-sexual touch(may have skin memories)
7. Prevention of future occurrence (abused people are often victims again)break the circle
8. Externalization is important- may be return to the scene with friends or safe people and tell what had happened
9. A resolution scrape book may help-discussion about healthy sexual relations separating abusive sex helps clarify the differences.
10. Move from victim to survivor
11. Rebirth of positive attitude
12. Explanation of the abuse--- selfishness, character disorder of the perpetrator- broken rules and discounted child’s rights
13. Teach “i have been misused- not used up”

NOTE: Counsellors respond must be creative and adjusted to each client.

**SEXUAL ADDICTION COUNSELLING**

***For victims of sexual addiction***

1. Establish the reason for seeking therapy
2. Reasons for tendencies
3. Teach the right attitude
4. Teach requirement for change
   1. Must take responsibility
   2. Must demonstrate understanding of the cycle of sexual offending behaviour
   3. Must develop a viable plan for prevention strategies: recommendation of accountability partner etc
5. Must assess possibility of other options
6. Heterosexual,
7. celibacy

**5 practical things when working with sex addicts**

\* Your own view of God (very important );your understanding of God will rub off on your counselees

\* Trace first event; you need to go back to when addiction started (a) they have to forgive the people associated to that 1st event (b) to have compassion on them

\* Break soul ties; if they can remember names of past partners let them mention it to break ties. Sex is much more than physical.

\* Close the doors; close the door against demonic spirits of lust etc. Clients need to verbalize this, hence they will feel more in charge. There is a physical, emotional and spiritual part of coming out of sexual addiction.

\* What to do next;- start new patterns

- Healthy good friendships/accountability partners.

NOTE: counsellors must be comfortable in their sexuality to help others

**PCOUN 111**

**CHRISTIAN COUNSELLING 1**

**Introduction**

Christian counselling, also known as biblical counselling, Christian psychology and faith-based counselling, combines your faith with the principles of psychology to improve your mental health and relationships. More specifically, this therapy approach uses scripture and biblical teachings to help you deal with life’s challenges.

The ultimate goal of Christian counselling is to help Christians identify behaviours that are inconsistent with God’s teachings, so they can become more accepting of God’s will – even when it’s not their will. Christian counsellors believe that the bible is the ultimate guide on how people, especially Christians, should think and behave. In other words, they view this holy book as the one and only truth.

Through the power of the Holy Spirit, believers are saved, filled, sealed, and sanctified. The Holy Spirit reveals God’s thoughts, teaches, and guides believers into all truth. The Holy Spirit also helps Christians in their weakness and intercedes for them.

**Pre Tests**

* What Qualities should a Christian counsellor have?
* Is the Bible enough for Christian counselling or other texts are required.
* Is it important for a Christian Counsellor to first deal with his own issues or is it okay to go on with the as long as it does not interfere with his/her work?

**Key Concept**

* Christian counselling focuses on your spiritual health, personal relationship with God, and the belief that, with therapy, personal problems, mental health issues, and emotional distress can be replaced with increased self-worth and spiritual fulfillment.

The term ‘counselling also often referred to as guidance, admonition, encouragement, advice giving etc. is usually a life-long duty of a pastor towards building a strong foundation for his parishioners emotional, behavioural and spiritual growth. Christian counselling can be defined as that;

*…activity which seeks to help people towards a constructive change and growth in every aspect of their lives. The aim is to achieve this through a caring relationship and within agreed boundaries according to Biblical truths, aims and practices within a frame work of Christian commitment, insights and values*[[1]](#footnote-1)

Christian counselling accepts the Bible as the final source of authority. Relying on the Holy Spirit to guide them through the Bible, Christians are not dependent on their own conscience to direct their behaviour. If conscience agrees with the word of God then it is valid, if not it is invalid.

The Bible not only gives insight into human behaviour but also put everything into proper perspective. It tells who we are, where we come from and our nature and purposes. The Bible addresses every human challenge, the root and the solution. Hence, the Christian counsellor refers to it.

*Christian counselling focuses on a few main principles that are different from traditional counselling. It focuses on the care of the whole person, body, soul and spirit as it is also sometimes named "soul-care", and maintains the values taught in the bible. The aim of Christian counselling is to help people regain a sense of hope for their life that is found in* Jesus Christ*.*[[2]](#footnote-2)

It depends not solely on the human will to be responsible but also on the indwelling power of the Holy Spirit to conquer human problems. Through God’s power, we no longer need to be slave to weak will, to situations or past experiences. Although accepting Christ does not mean that problems would disappear automatically but we gain new power to deal with problems. Christians, through faith receives the Holy Spirit, who enables Christians have victory over their sinful nature. (Rom 1:28-32).

**Christian counselling** deals effectively with counselees past. Offering forgiveness for past events, enable them to be guilt- free (1john 1:9) and look forward to the future (Phil 3:13-14). Even if past events require insight or specific prayers to deal with bitterness and resentment, believers have a secured position in Christ.

**Christian counselling** is unique because it is based on God’s love. God loves us (1John 4:10) as His love flows through us, we love others and care for them.(Romans 12:9-21) A Christian counsellors feels a spiritual relationship with other Christians and helps them to grow in Christ as they solve their problems. Gary Collins having described counsellors as people-helpers had explained that Biblical writers do not present people-helping as an option in Christianity but a responsibility for every believer and that while counselling may seem sometimes too difficult or a waste of time, ‘it can be an effective, important and necessary part of any ministry’.[[3]](#footnote-3)

**Types/Approaches to Christian Counselling**

Some Christian counsellors had argued that there are three major approaches to Christian counselling; Even within these three approaches there can be a great deal of difference depending on the training and background of the therapists. These three categories as described by Matthew McDonald[[4]](#footnote-4) are:

1. **Counselling** by a counsellor who also identifies himself as a Christian, but provides standard psychological interventions without integrating his understanding of the Christian faith into these interventions. In this case, the client would be seeking the comfort of knowing that his counsel or shared a common faith, but not seeking for an element of that faith to be influenced or regularly discussed as a part of treatment. (Most counsellors, whether they identify as Christian or not, should be accepting of a client’s spiritual beliefs and respect the influence that it has on the client’s life, but some clients feel more comfortable in this relationship if the counsellor shares the same religion.)
2. **Counselling** by a counsellor who not only identifies himself as a Christian, but allows core principles of this religion to influence and inform standard psychological interventions. This counsellor intentionally integrates core Christian values with understanding of research-based human psychology. This counsellor does not integrate these beliefs into the counselling interventions or discussions with the client unless the client shares or requests this religious/spiritual element be a part of treatment.
3. **Counselling** by a counsellor who claims to provide “Nouthetic” or “Biblical” counselling approaches treatment from an understanding or belief that pain, turmoil, and suffering in a person’s life are a result of the presence of sin. The interventions provided by this counsellor would be grounded predominantly in an understanding or conviction that the Bible is a sufficient guide for counselling most, or even all issues. Counsellors providing this treatment attempt to confront what they see as sin in the life of the client. They would provide this intervention believing that it is done out of care for the client and that biblical mandates for living, if followed, would correct the symptoms in the life of the client.

Three models are also suggested: Non-directive, Directive and Holy Spirit-led

**Non-directive**

* Not give advice/not telling the person what to do.
* Person centred/ or Rogerian approach (after Carl Rogers)
* Helping people see a range of options
* Allows the troubled person to talk/think problem(s) through/ consider options/ retain ownership of problems/take responsibilities for working through solutions

**Directive**

* Offering advice or direction to the clients
* Can confront and challenge
* Can be used to sensitively confront sin issues
* Recognizes the final authority of the Word of God, that is living and active- Jesus could be directive in His style of counselling (e.g. go and sin no more)
* Recognize the centrality of Jesus and not the person
* Example of Christian directive approach is Jay Adams
* Example of secular directive approach could be Rational Emotive Therapy

**Holy Spirit-led**

* Need to pray and ask God for discernment, guidance and wisdom, and for Jesus to intervene in every situation
* Remember the need to operate by God’s power and love
* Recognize Him as the wonderful counsellor

As Christian counsellors, we are free to use all 3 models as appropriate and be careful not to focus too much on either the directive or non-directive. Always remember that the Holy Spirit needs to be the power base.

Christian counsellors counsel for the glory of God, not for the glory of their clients nor themselves. Another perspective is Biblical Counselling.

**BIBLICAL CHANGE**

Welcome to Dynamics of Biblical Change. This is a course about the things that really matter. God is in the process of making right everything that goes wrong. So the working vocabulary of Scripture is all about *changing* things: redemption, grace, repentance, turning, mercy, wrath, deliverance, justice, reconciliation, peacemaking, salvation, regeneration, making disciples, sanctification, the coming of a kingdom, and the like. Of course, such good words often get layered over by distorted religiosity (another wrong that needs righting). But at heart these things are not ‘religious’ words. They operate in the domain of life lived, of everyday human experience.

Our Redeemer rights all wrong. All true and lasting change in individuals works with the answers to a series of questions. These are simple questions. But they are endlessly adaptable.

* What are you facing? What influences affect you? What is the meaning of your hardships (and your felicities), your troubles (and your opportunities)?
* What should you be like? What’s going wrong, becoming bent and darkened both inside and out?

The Dynamics of Biblical Change seeks answers to such questions. This is a course about people. It is about how people change into the “image-in-action” of Jesus Christ.

* No other model of change or approach to counselling—besides a biblical one—has worship as the goal. The end of everything you seek to do is to love and adore God.

Psalm 23, for example, deals directly with your deepest, grittiest, most pressing problems. Consider the comparison between the psalm and the ‘anti-psalm’.

**CASE STUDY**

You have an important appointment that you have to get to. Traffic comes to a grinding halt. You left your cell phone at home.

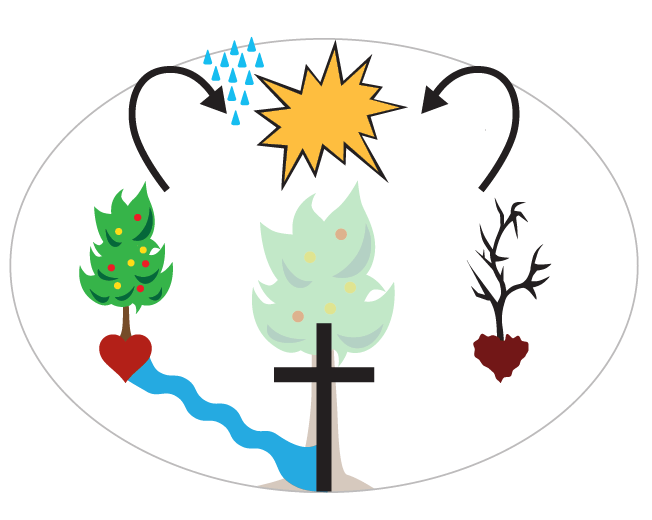
In such an instance what do you do?

**THE 8 QUESTIONS**

These eight questions will help you walk through the change process

* What happens to you that brings pressure, temptation, trouble, beguilement? When, where, and with whom do you struggle? In other words, what is the significant context, situation, or circumstance that pushes your buttons?
* How are you reacting? What do you typically do? Thoughts, words, actions, emotions, choices, relationships? How are you tempted to react?
* What rules you, hijacks your heart, replaces God as the chief object of your affections and focus of attention? I want\_\_\_? I fear\_\_\_? I functionally believe\_\_\_? I trust\_\_\_? What are your ‘buttons’?
* What are the consequences and ripple effects? How do your reactions affect relationships, work life, mood, finances, situation, health, etc.?
* Who is God – relevant to this struggle? What does He say? What does He promise? What does He do? His person, words, and actions intend to enter, address, and change how you see your situation, how you react, and the reasons for your reactions.
* Respond to God from the heart. Stop. Listen. Ponder. Turn. Trust. Come. Seek. Ask. Talk. Transact with Him. How will you have a candid, intelligent, pointed conversation with God?
* Respond constructively into your situation. Speak. Act. Do. Don’t do. Choose. How will you show intelligent love for others (the opposite of every sin)?
* What are the consequences? How do God (#5) and faith (#6) and love (#7) create ripple effects in relationships, work life, mood, finances, situation, health, etc?

**The Three Trees diagram**



* The three trees are as follows: the tree on the right is a thorn bush; the tree on the left is a fruit tree; the tree in the middle is our Redeemer.
* The heat (baking sun) is our circumstances. !e heat is both the voices that beguile us and the threats that assail us.
* The triune God is present in the world he created.
* Our diagram represents God’s world where there are consequences: we ‘reap.’
* We use this picture to orient us. We talk in metaphors because God made us to understand things by analogy and to think pictorially.

**SELF COUNSELLING**

The Christian life is like a yo-yo held in the hands of a man who is walking up stairs. There are ups and downs but, in the long haul, you are going somewhere. As time passes, the downs do not remain the same as they were in the past.

The goal is not to get God to throw the yo-yo to the second floor; the goal is to shorten the string.

If the goal is to shorten the string, then what defines growth?

* Learning to ask for forgiveness more intelligently
* A quickness to repent
* Lessening frequency of outbursts
* Lessening intensity of outbursts
* Appreciating the grace of Christ
* A willingness to do the repair work in relationships

2 Corinthians 1:1-12 is a perfect passage of scripture which will help us during self-counselling and when counselling other people.

Verse 4 has an astonishing promise: You are able to manifest effective counselling wisdom that will help you deal with other people’s troubles. (Question 7)

* Paul begins with his own personal troubles, the hardest troubles he had experienced. (Question 1)
* Usually when people speak of their own troubles, they tend to grumble and complain. Complaining thereby allows troubles to become excuses for wrong living.
* Paul sets a radically different example here. Paul shows he gained wisdom, and how he learned joy and perseverance of faith.
* Counselling wisdom is gained through suffering. !e mishandling of suffering is how we show ourselves to be fools.
* Paul uses the same words over and over again to describe his troubles: suffering, affliction, and comfort.

a. Affliction means extreme pressure in life: “It’s hard.”

b. Suffering means you are in pain: “It hurts

Paul moves from general (verses 4-7) to particular (verse 8). He expresses the experiential weight of his burden; he does not leave it at generalities.

The ‘wisdom of the ‘flesh’ manifests when fallen people instinctively respond to pressure and pain. (Question 2) Examples of horizontal ‘fleshly responses:

* 1. Grumbling and complaining
* 2. Anger, fighting, and conflict
* 3. Confusion, anxiety, and fear
* 4. Escapism—ranging from those escapes that appear innocent to those that are obviously guilty.

There are consequences when we react to suffering out of ‘fleshly wisdom (Question 4). In the very least, it sabotages your ability to help another person.

* There are consequences when we react to suffering out of fleshly wisdom (Question 4). In the very least, it sabotages your ability to help another person.
* Horizontal responses reveal the vertical dimension of what rules a person (Question 3).The instinct of our foolish wisdom is to trust ourselves and control our situation.
* There is a sovereign God who is over and in all things (Question 5). Our sufferings fundamentally have meaning. God is with us in our suffering and he is up to something good: “these things happened in order that…”
* The fundamental shift from a foolish response to a wise response is, when your life is threatened, to trust in the God who raises the dead. This is not an abstract promise. It is a relevant promise that meets the need of the moment (Question 6).
* Understand the relationship between behaviour and the heart (Question 7).
* The fruit of trusting God is joy, gratitude, endurance, and counselling wisdom (Question 8).

**THE HEAT**



The hand is the situation. When you knock the glass of water, why do you think the water falls on the floor? The knock was like being attacked, sinned against. In classic Christian philosophy, this is called the instrumental cause. Why is water on the floor? The answer ultimately is because the cup was filled with water. If the cup had another substance in it, then the other substance would have fallen on the floor instead of the water. The situation is significant but not determinative.

The situation does not make us who we are. The situation reveals who we are.

This story should profoundly impact your counselling ministry toward others. We learn that the situation is significant, and that the situation is not determinative. When you put these two truths together, you walk through the minefield where contemporary culture gets confused.

* 1. Secular culture tends to overemphasize situational factors.
* 2. Christian culture tends to overlook situational factors.

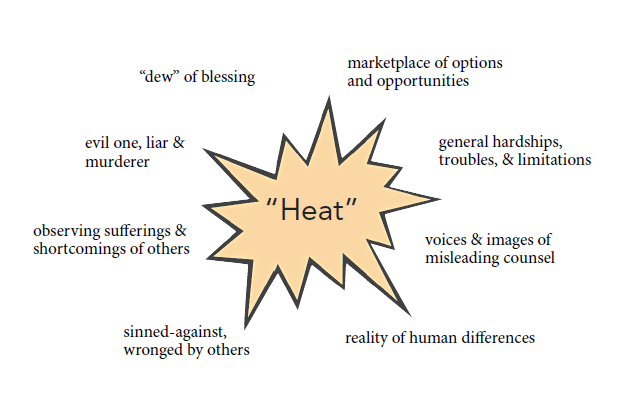
The million-dollar question: Why do certain things bring out good or ill responses?

1. If another person violates me, how will I respond?

* Will I forgive or be filled with wrath? (the issue of rage)
* Where will I take refuge? (the issue of escapism)
* Is there a basis in which to have courage in the face of evil? (the issue of despair)
* What will it mean to have hope? Where does hope come from? (the issue of fear)

1. Scripture acknowledges that if we treat a child badly then it will result in certain responses in and by the child. There is a reason Scripture tells parents not to provoke their children. (See Ephesians 6 and Colossians 3.)

This life, therefore, is not righteousness but growth in righteousness, not health but healing, not being but becoming, not rest but exercise. We are not yet what we shall be, but we are growing toward it. The process is not yet finished but it is going on. This is not the end but it is the road. All does not yet gleam in glory but all is being purified.

**EIGHT ASPECT OF THE HEAT**

**SUFFERING**

Katharina von Schlegel, “Be Still My Soul,” Hymn #689, Trinity Hymnal (Philadelphia: Great Commission Publications, 1990). Based on Psalm 131: “Surely I have composed and quieted my soul.”The Hymn is about suffering.

1. Be still, my soul: the Lord is on your side;  
   bear patiently the cross of grief or pain;  
   leave to your God to order and provide;  
   in ev'ry change he faithful will remain.  
   Be still, my soul: your best, your heav'nly Friend  
   through thorny ways leads to a joyful end.
2. Be still, my soul: your God will undertake  
   to guide the future as he has the past.  
   Your hope, your confidence let nothing shake;  
   all now mysterious shall be bright at last.  
   Be still, my soul: the waves and winds still know  
   his voice who ruled them while he dwelt below.
3. Be still, my soul: when dearest friends depart,  
   and all is darkened in the vale of tears,  
   then shall you better know his love, his heart,  
   who comes to soothe your sorrow and your fears.  
   Be still, my soul: your Jesus can repay  
   from his own fullness all he takes away.
4. Be still, my soul: the hour is hast'ning on  
   when we shall be forever with the Lord,  
   when disappointment, grief, and fear are gone,  
   sorrow forgot, love's purest joys restored.  
   Be still, my soul: when change and tears are past,  
   all safe and blessed we shall meet at last.

Notice there is only one specific suffering mentioned by the writer: “when dearest friends depart.” The rest are general categories and metaphors.

This hymn, like the psalms, speaks in metaphors. Katharina invites us to personalize the experience with our own specifics.

Vivid metaphors evoke the experience of torture and sheer anguish:

* a. “the cross”
* b. “thorny ways”
* c. “the waves and winds”
* d. “all is darkened in the vale”

2. General categories of human experience in this hymn:

* a. Grief
* b. Pain
* c. Change
* d. Mystery
* e. Tears
* f. Sorrow
* g. Fears
* h. Things taken away

3. There is no mention of sin in this hymn because the focus is on sorrow

**THE HEAT**

1. So far in our class, the heat has been the main door into the heart. There are two reasons for this: the heat is often the first thing people are aware of and the theology of the situation is a weakness of the church (though the Bible teaches a rich view of the situation). We have seen that the heat, the situation, is significant but not causative or determinative. The wellspring of life and the wellspring of death both emerge out of the heart and not from the situation.
2. Scripture has a rich view of people. The thorn bush and the fruit tree each have a vertical and horizontal dimension. What happens in one dimension affects the other; they are intimately connected to each other.
3. We want you to have many doors in to understand the issues of the heat. Do not simply think that everything is unbelief, or idolatry, or false love, etc. The measure of our wisdom is the ability to not get hung up on one particular way of seeing heart struggles. Rather, you need the flexibility to understand what the concept points to. Ask ultimate questions like, “What masters you?” or “What is in the control room of your life—the living God or god substitutes?”

The essential nature of sinfulness;

* 1. Unbelief erases God.
* 2. Pride exalts self.
* 3. Fear of man exalts others.
* 4. The lust of the flesh and desire language lets you get specific because desires have an object. Our desires are open-ended: You desire (fill in the blank). What did you want? What were your expectations? What were you after?

Galatians 5 has a rich description that links our heart to how we live. This chapter describes the opposition between the desires of the flesh and the desires of the Spirit. The works of the flesh express obedience to the desires of the flesh. The fruit of the Spirit expresses submission to the desires of the Spirit. Our fundamental anthropology is captured in this passage. Similar passages:

* 1. Titus 2:11-13, 2 Timothy 2:22, James 1:14-15, Romans 13: 12-14.

**SUFFERING & SHORTCOMINGS OF OTHERS**

1. Scripture says a lot about the sufferings and shortcomings of others that you observe but do not directly affect you. What you do in these cases is revelatory of who you are. Our fundamental call is redemptive engagement that brings mercy and light. Think of these examples in the Bible:

* 1. The Good Samaritan...what are you doing about someone else’s suffering?
* 2. The human high priest deals gently with the ignorant and wayward (Hebrews 5:2-3).
* 3. The prayers of Daniel and Nehemiah over the sins of others
* 4. What do you do when you see your brother’s fault (Matthew 7:1-5)?

1. Satan, the evil one

* 1. In the Bible, demonization is linked almost exclusively to physical affliction.
* 2. In a way, our entire course has been about spiritual warfare. Satan is the liar behind the lies, the luster behind the lust, the murderer behind the sinning against, and the slave master behind the things that enslave people.
* 3. World, flesh, and devil are portrayed as intimately interwoven with each other.

1. The dew of blessing

* 1. Everything is revelatory, including blessings.
* 2. Scripture captures the sense that the situation is significant but never determinative. Good and bad situations always reveal our master. (See Proverbs 30:8-9.)
* 3. Deuteronomy 8:2-20 warns that both the deprivations of the desert and the blessings of the land are equal occasions for our heart to be either grateful or lustful.
* 4. Any situation can serve as a crucible in which good or evil comes out of the heart.

**SINNED AGAINST**

* + - 1. To be sinned against is expected in a fallen world. It is ‘normal’ in that it always happens. It is suchan important topic that entire books of the Bible are dedicated to this issue of being wronged:

1. The book of Psalms (people are out to get you and wrong you)
2. 2 Corinthians
3. 1 Peter (comes at the Christian life through the lens of being wronged)
4. Hebrews (largely a book on suffering)
5. Chapters 5 & 8 of Romans
6. Revelation (deals with false teachers and the overall theme of facing malice)
7. We see it in Jesus’ life and in his battles with those who wrong him.
   * + 1. God engages the situation of being sinned against in a multivalent way.
8. God is exceedingly tender to sufferers of wrong. He is a Refuge and Deliverer of the poor, afflicted, oppressed, innocent, orphan, and weak.
9. God is hostile to the cruel. In the Bible, mercy to the oppressed and wrath against evildoers appear hand-in-hand. !e wrath of God in this context is that he rights wrongs, which is a hope for his children who are suffering. We do not have to be vengeance takers because we know he will deal fairly—and sometimes mercifully—with evil.

c. God is tough-minded toward us when we return evil for evil. !at tough mindedness is transformative; it is a redemptive warning.

* + - 1. God is in it and he is up to something good. This reality is seen in multiple places in the Bible:

1. Even the evil of persecution purifies our faith because it makes us set our hopes on the only place our hope can be set (1 Peter 1).
2. In the story of Joseph, a long-term good comes out of the situation.
3. We learn to counsel and comfort others because of the way we receive comfort in our situations (2 Corinthians 1:4-7).
4. In the context of suffering, we gain a settled hope and a transformed life. In the context of being wronged, we learn that God is for me (Romans 5, 8).
5. In Job’s story, Job grows in wisdom when God’s glory and Satan’s shame emerge.
6. In the book of Psalms, refuge is sought and found.
7. In the book of James, wisdom and endurance are learned in the context of suffering.
   * + 1. How you treat your enemies is a litmus test of your heart.
8. Are you a vengeance-taker or are you transformed to do courageous good in the context of evil (Romans 12:14-21)?
9. Matthew 5:9-11, 38-48
10. Luke 6:20-49
    * + 1. Biblical teaching on how to deal with brothers and sisters who sin against us and act enemy-like:
11. Luke 17:1-10
12. Matthew 18:15-39
13. Matthew 7:1-5
14. Colossians 3
    * + 1. How will you react to being sinned against? Two dominant themes:
15. Refuge
16. Repentance—the transformation and dynamic of biblical change. The instinctive way we express displeasure is transformed into the constructive displeasure that glorifies God and expresses the person and character of Christ.
    * + 1. A time is coming when there will be no more evil. Good will triumph.
17. 2 Corinthians 4:16-18
18. Romans 8
19. Revelation 21:4

**Benefits of Practicing**

There are many people who can benefit from seeing a Christian counsellor. Those with addictions, mood disorders, mental health problems, family issues, marital breakdowns, loss or grief can all benefit.

Christian counsellors can help individuals to navigate the challenges of life in a hopeful and healthy way. They can promote healing through spirituality for a more positive approach to the here and now. Whether you are a practicing Christian or want to take a spiritual approach to counselling, a Christian counsellor can help.

**Conclusion**

Christian counselling may be most beneficial for Christians and those who have a strong faith or spirituality – although you don’t have to be religious or spiritual to benefit from this therapeutic counselling approach.  In fact, anyone – religious or non-religious can partake in Christian counselling. If you struggle with grief and/or relationship problems, and can no longer cope with these issues alone, Christian counselling will most likely benefit you.

In addition, if you have a strong faith and belief in God, this type of therapy will most likely benefit you because it centers on biblical teachings. The hope is that by sharpening your knowledge of the Bible, strengthening your connection with God, and understanding God’s commandments, you will be able to turn your life around and conquer your problems.

You may benefit from Christian counselling if you are experiencing the following issues:

* Anxiety that prevents you from completing everyday tasks
* Panic attacks
* Insomnia or being unable to fall asleep and/or stay asleep all night long
* Social isolation or avoiding spending time with friends and family
* Sudden extreme weight loss or weight gain
* Feeling hopeless, helpless, and/or overwhelmed, or feeling unable to manage your problems on your own
* Out-of-control, irrational [anger](https://therapytribe.com/therapy/anger-management-counseling/)
* A loss of interest in activities you used to enjoy
* Feeling disconnected to your faith or God

**Post Test**

1. What are the characteristics of a good Christian counsellor?
2. What are the models of Christian counselling?
3. How do we measure change in Christian counselling?
4. What is the Benefit of self-counselling to a Christian counsellor?

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**DPC 112**

**REPORT WRITING /PROGRESS NOTE**

**NOTE**

**Introduction**

***SHORTEST PENCIL IS BETTER THAN THE LONGEST MEMORY***

**Pre-Test**

* What are your thoughts about report writing in Professional Counselling?

**Learning Outcomes**

1. The trainee to be exposed to the importance and needs for report writing in professional counselling.
2. For the trainee to be aware of the ethical need for report writing and safeguarding clients’ notes.
3. Students to learn how to write client’s note.
4. **Counselling Reports**

* Counselling report contains the record of a counselling session.
* It provides the “what, why, where and how” of the client’s interaction.
* It also serves as an official record containing the assessments, interventions and results of the counselling session.

1. **IMPORTANCE OF REPORT WRITING**
2. It’s professional
3. Better and quality service.
4. Accurate record of information for future use
5. Protection in-case of legal issues
6. Ethical
7. **Usefulness**

* To work more effectively with clients
* To enhance planning and review
* For Accountability
* Helps to remember what has been done
* To provide relevant information for other practitioners for action or follow up when needed.

1. **Counselling Notes Contains:**

* Opening notes: like the demographic information of your clients (name, age, sex, etc).
* Primary problem: as stated by the clients.
* Signs: client’s reaction the problem.
* History: length of/or trend of signs.
* Agreement that client had made with the counselor
* A summary of issues discussed with client.
* Any information, suggestions, encouragement given by counselor to do particular things.
* Any letter including poems that client has given the counselor.

1. **Progress Notes**

* Use for ongoing care of client
* To document that the care planned for the client has been established
* To document the effectiveness of the care planned for the client
* To document any changes in the care plan
* To document responses to counselling
* To review with a counseling or clinical team for a particular client.

1. **Characteristics of Case Notes**

* Notes must be made within 30mins-24 hours of contact with client
* Must indicate all contacts with or regarding the client
* Must document dates of contacts
* Must be signed by the counselor
* Must contain assessment notes
* Can be hand written of computer typed
* Must be legible;
* DO NOT ALTERED
* DO NOT TIP-EX

1. **Benefits include the following:**

* A better quality service
* Less repetition of information
* An accurate record of information for future use

1. **Counselling Notes Contains:**

* Agreement that client had made with the counselor
* A summary of issues discussed with client
* Any advice, information, encouragement given by counselor to do particular things
* Any letter including poems that client has given the counselor.

1. **Who Can See The Case Note?**

* It’s a confidential document meant to be locked in a file room.
* *Counsel ling note is a confidential document, therefore it must be safeguarded.*
* *Whosoever the client consented to.*
* *Anyone that maybe involve in client’s care*
* *Limitation to confidentiality can be observed*

**INFORMATION ABOUT CLIENT IS CONFIDENTIAL AND SUBECT TO LEGAL CONSTRAINT.**

* Limitation to Confidentiality:
* Client is danger to self and others
* If client is under 18 years or had told counselor of a child under 18 being abused or at risk of abuse.
* Notification of some sexually transmitted infections.

1. **The Soap Format**

* A format of recording information regarding counseling sessions
* Documentation of sessions is extremely important partof counseling process.
* SOAP notes are one of the most important format for counselors

Soap note consist of the following:

* 1. **SUBECTIVE**
* These are statements made by the client, this can contain direct quotes.
* This is where counsellor record all the information the client tells you about how they are doing
* Counsellor must only record only things relevant to counselling
  1. **OBJECTIVE**
* Record here measurable and observable information such as
* *Behaviors, but not behaviors that you are targeting*
* Use “ice breaker” to elicit information
* Provide general comment on appearance
* Address progress or relapse of treatment here
  1. **ASSESSMENT**
* Assessment of the situation, the session and the client regardless of how obvious it might be based on the subjective and/or objective statements.
  1. **PLAN**
* Final section of SOAP notes
* Plan for the future therapeutic work.
* Should reflect interventions, including home works.
* To reflect follow up needed or completed

**Sample of Report Forms:**

**THERAPY FROM**

**Date**………………………………..

**Client’s Name**……………………………………………………………………………….

**Tel.No**…………………………………………………………………**Emai**l…………………

**Address**:……………………………………………………………………………………

**SITUATIONAL REPORT**

....................................................................................................................................................

**UPDATE/PROGRESS REPORT**

**Date**…………………

**Client's Name…………………………………….............................**

**……………………………………………………………………………**

**…………………………………………………………………………….**

**PLAN:**

**………………………………………………………………………………………………**

**Next Appointment Date**……………………………………………

**Therapist’s Name**……………………………………………………………………………….

**Signature**……………………………………………………………**Date**………………

**Assessment**

1. Briefly explain the importance of safeguarding clients’ documents?

**DPC 113**

**INTRODUCTION TO PREMARITAL COUNSELLING**

**Learning objectives**

To equip students with the understanding of premarital counselling and skills for rendering quality professional counselling to intending couples.

**Module Overview**

A.      Define the term premarital counselling

B.      Understand relationship stages to premarital counselling

C.      Background influences to premarital counselling

D.      Important and benefits of premarital counselling on family life

**Trainer’s Cover Notes**

We will consider the essential factors in premarital counselling through questioning beliefs and life experiences as it affect the success if pre and post marital outcomes.

**Pre-test**

What does premarital counselling mean to you?

What role does premarital counselling plays in building the society?

**Introduction**

Premarital class is the systematic and strategic approach to marriage preparation aimed to guide the marital choice of a person, provide depth of understanding and purpose of marriage and to raise marriages and families that will give our World rest.

* Premarital counselling and relationship education are associated with higher level of relationship satisfaction and marital success.
* Premarital counselling gives huge benefits and can assist an individual to gain clarify to make informed decisions that are critical to marital happiness and fulfillment.

**WHEN ROMANCE TAKES THE CENTER STAGE**



**Is love blind ?**

When a guy meets a lady and fall in love. The heat of the moment can overshadow their reasoning and time is of no essence.

**THE ESSENTIALS ARE NOT CHECKED.**

**ESSENTIALS….**

* Purpose
* Family background.
* Values.
* Beliefs
* Personality
* Patterns
* Past relationships
* Health profile
* Financial /Debt profile

**HOW DID YOU GROW UP?**

**WHO ARE YOU**?

Many factors combine to make us who we are. A person is the product of his family birth order, his neurological structure, and interactions with his mother, father, and siblings and so on, but the atmosphere of a home, and specially the relationship with parents, has a significant impact on shaping identity and behaviours.

* Singleness test
* Relationship test

**THE FAMILY YOU ORIGINATE FROM IS SIGNIFICANT TO THE MARRIAGE YOU WILL BUILD.**

**Background Check**

* Describe the family you came out from.
* Describe who a wife and a husband are in that family.
* If there’s anything you can change in that family, what will it be?

**Understanding Marriage: Question and Answer**

* Why do you want to marry?
* Why do you want to marry this person?
* How did you conclude on your mate selection?
* How do you hope to handle marital crisis?
* What are the roles of husband and wife in marriage?
* What kind of marriage and family do you want?
* Who are your relationship mentors?

**Essentials of Marriage**

* Sex in marriage.
* Money before wedding and money matters in marriage.
* In-laws interference
* Parenting.
* Personal dreams and accomplishment.
* Family vision and constitution.
* Expectations.

**Class Task**

In Africa, what premarital education practices do you know that should be encouraged or abolished?

**References**

John Gottman, Neil Clark Warren.

**Suggestions for Further Reading**

* The Premarital Counselling Handbook - H Normal Wright.

**DPC 114**

**ETHICAL CONSIDERATION IN PROFESSIONAL COUNSELLING**

**Introduction**

*“What makes an action right is the principle that guides it.”* (Remley & Herlihy, 2007).

In professional counselling, ethics underpin the nature and course of actions taken by counselling. Professional counsellors are expected to practice in an ethical way.

**Pre-test**

* What is code of ethics?

**Learning Outcomes**

1. To enhance students’ ethical considerations in counselling practice.
2. To guide the trainee counsellor to being ethically mindful and be willing to be accountable for the ethical basis of practice.
3. For trainee counsellors to understand the code of ethics of their practice and the need for it.
4. For the students to be exposed and learn to manage some ethical dilemma they may experience in practice.
5. **ARE THERE ETHICAL GUIDELINES FOR PROFESIONAL COUNSELLING IN NIGERIA?**

African Network of professional Counsellors (ANEPCO) is a newly founded organization created to set code of ethics that will standardize counselling practice in Nigeria.

1. **Ethical Codes:**

According to Akinade (2005), ethics are normative in nature and focus on principles and standards that govern relationships between individuals, such as counsellors and clients. Ethics are;

* Established principles guiding behaviour.
* Guidelines developed by a regulating body for what a counsellor can and cannot do.
* Moral principles of what are right or wrong and which will bring the greatest benefit for most people.

Ethics are “rules” to be complied with for common good.

* 1. **Values-Based Ethics:**
  + Ethics apply to professional behaviour only
  + Ethics are “rules” to be complied with for common good
  + Ethical behaviour is a lifestyle
  + Ethics guides professional’s work and personal life.
  + Common good emphasizes both client and social welfare.

1. **Purpose of the Ethical Code**

* Provide framework for ethical behaviour
* Set standards for practice
* Protect clients, communities, and the profession

1. **Reasons for Ethical Codes**

* Therapeutic relationships are unbalanced (Who has more power)
* Therapeutic relationships are complicated
* Clients’ issues are complicated
* The nature of the relationship itself is complicated
* Counsellors are human, therefore they are fallible
* Ethical guidelines provide guidance and accountability.
* To inform and educate counsellors
* To safeguard welfare of clients and society
* A way to promote professional growth

1. **Morality**

Recognition of the distribution between good and evil, right or wrong, respect for and obedience to the rules of right conduct, the mental disposition or characteristic of behaving in a manner intended to produce morally good results. It also refers to keeping a set of social rules, customs, traditions, beliefs or practices guiding principles (Kitchener, 1986)

1. **Law**

The body of rules and standards issued by a government or to be applied by courts and similar authorities (1999 Constitution of the Federal Republic of Nigeria).

Law is the specialized form of social control familiar in modern, secular, politically organized societies.

The profession of counselling is governed not only by ethical standards but by legal ones as well. Legal refers to “law or state of being lawful, and law refers to “a body of rules recognized by a state or community as binding on its members (Shertzer& Stone, 1980).

1. **Nigeria Factors**

When we talk of ethics, morality and the law in the counselling profession, there is more to be done in Nigeria. Each society’s ethics is formulated with consideration of their;

 Environment

 Culture

 Morals

 Values

1. **Origin of Ethical Codes**

* Created by flagship professional groups (ANEPCO)
* Are required to be followed by members of professional organizations
* Are requirements of most state licensing boards

1. **Things Counsellors Need to have Dealt with before Therapy**

***Ethically, counsellors need to be aware of their –***

* Own needs
* Areas of unfinished business,
* Potential personal conflicts and defences
* How this may affect the clients
* Responsibilities to work actively toward expanding own self-awareness and recognize areas of prejudice & vulnerability
* Personal power is an effective quality of the therapist
* Counsellor need to nurture

1. **Common Ethical Dilemmas in Practice**

* Multiple-Role Relationships
* Informed Consent
* Confidentiality
* Privileged Communication
* Legal cases
* Expert testimony

1. **DIMENSIONS OF ETHICAL PRINCIPLES**

**TWO DIMENSIONS**

1. General Principles
2. Morals

**11.1. GENERAL PRINCIPLES**

General principles are inspirational in nature. Their intent is to guide and inspire counsellors toward the very highest ethical ideals of the profession.

Corey et al. (2006) and BACP (2010) described the basic moral principles that form the foundation at the highest ethical level as a professional. The detail descriptions of these principles are as follows:

1. **Autonomy** – This principle refers to the promotion of self-determination, or the freedom of clients to choose their own direction.

* This principle reflected in the Humanist Theory promoted by Carl Rogers (1961). He suggested that human being is an organism that constantly moves independently to find homeostasis in life, and therefore gained independence and autonomy.
* To display respects for autonomy, the counsellor must acknowledge the right of clients to choose and act in accordance with their wishes, and a professional counsellor must behave in a way that promotes autonomy.
* The counsellor's ethical responsibility is to encourage client independent thinking and decision-making, and to deter all forms of client dependency
* However, autonomy opposes the manipulation of clients again their will, even for beneficial social ends. Stadle (1986).

1. **Beneficence**– a commitment to promoting the client’s well-being

* It directs attention to working strictly within one’s limits of competence and providing services on the basis of adequate training or experience.
* . There is an obligation to use regular and on-going supervision to enhance the quality of the services provided and to commit to updating practice by continuing professional development
* An obligation to act in the best interests of a client may become paramount when working with clients whose capacity for autonomy is diminished because of immaturity, lack of understanding, extreme distress, serious disturbance or other significant personal constraints.
* By nature, counselling profession contributes to the growth and healthy wellbeing of the clients within their own cultural context.
* But what is morally acceptable in a culture sometimes is not acceptable to another culture. Therefore, although the counsellor’s intention in helping is good, but due to cultural differences, it can cause more harm than good. For instance, following a behavioural approach, a very passive client is asked to be more assertive towards his or her parents which can be quiet unfitting and thereby raising family conflict between children and parents.

1. **Non-malfeasance** – a commitment to avoiding harm to the client

* Avoiding sexual, financial, emotional or any other form of client exploitation; avoiding incompetence or malpractice; not providing services when unfit to do so due to illness, personal circumstances or intoxication.
* Practitioners have personal and professional responsibility to challenge, where appropriate, the incompetence or malpractice of others; and to contribute to any investigation and/or adjudication concerning professional practice which falls below that of a reasonably competent practitioner and/or risks bringing discredit upon the profession.
* Counsellors should be more careful when handling information (or transferring client’s information to a third party via electronic mode) given by clients so as to promote confidentiality.
* Counsellors must at all times review their behaviours to identify patterns that might suggest inclination towards development of dual or multiple relationship or even behaviours that could suggest bartering (exchanging goods with services) that could harm the clients.
* Counsellors must also be very careful when developing treatment plan to ensure that it will benefit the clients (and not the counsellors).

1. **Justice** – a commitment to be fair and impartial.

* The principle of justice requires being just and fair to all clients and respecting their human rights and dignity.
* It directs attention to considering conscientiously any legal requirements and obligations, and remaining alert to potential conflicts between legal and ethical obligations. A commitment to farness requires the ability to appreciate difference between people and to be contrary to their legitimate personal or social characteristics.
* Practitioners have a duty to strive to ensure a fair provision of counselling and psychotherapy services, accessible and appropriate to the needs of potential clients (Gumaer and Scott, 1985).

1. **Fidelity**– honouring the trust placed in the practitioner

* Fidelity means that the professional counsellor must make honest promises and honour their commitments to those they serve.
* This entails fulfilling one’s responsibilities of trust in a counselling relationship
* When counselling is initiated… the counsellor must inform clients of the purpose, goals, techniques, procedures, limitations, potential risks, and benefits of services…”

1. **Self-respect**– fostering the practitioner’s self-knowledge and care for self

* It means that the practitioner appropriately applies all the above principles as entitlements for self. This includes seeking counselling therapy and other opportunities for personal development as required.
* There is an ethical responsibility to use supervision for appropriate personal and professional support and development, and to seek training and other opportunities for containing professional development.
* Guarding against financial liabilities arising from work undertaken usually requires obtaining appropriate insurance.
* The principle of self-respect encourages active engagement to life-enhancing activities and relationship that are independent of relationships in counselling or psychotherapy.

1. **CONFIDENTIALITY**

Client having a feeling of safety and security and the chance to talk to someone in a safe environment and without fear of repercussion is part of what makes therapeutic relationship special.

* Confidentiality is a cornerstone of therapeutic relationship
* Practitioners, from the onset, must inform clients of the concept of confidentiality
* Counsellor must create an atmosphere of confidence and trust in which the client is willing to make a frank and complete disclosure of facts, emotions, memories, and fears.
* Confidence must create an atmosphere that allows client to make disclosure of confidential communications during counselling sessions may cause embarrassment or disgrace to the client.
* Confidentiality extends to records. Counsellors have an ethical duty to secure their records in a safe place with restricted access.
  1. **Limit to Confidentiality;**• Sometimes it is permitted to share client information with others with the goal of promoting client welfare, and client has given consent, these situations include:

• When therapist consults with experts or peers

• Information may also be shared with clerical or other assistants who handle confidential information. Child abuse• Clients, who may be physically dangerous to self and others

• Legitimate concern for public danger

• Clients who are involved in a lawsuit involving their mental state health• Clients in group therapy• In counselling supervision• Under certain circumstances reports may need to be given to employers• Evidence in court cases• Illegal action• Mental health issues

1. **PERSONAL MORAL QUALITIES**

The practitioner’s personal moral qualities are of the utmost importance to clients. Many of the personal qualities considered important in the provision of services have an ethical or moral component and are therefore considered as virtues or good personal qualities.

It is inappropriate to prescribe that all practitioners possess these qualities, since it is concerned and developed out of personal commitment rather than the requirement of an external authority. Personal qualities to which counsellors are strongly encouraged to aspire include;

* **Empathy:** The ability to communicate understanding of another person’s experience from that person’s perspective.
* **Sincerity:** A personal commitment to consistency between what is professed and what is done.
* **Integrity:** Commitment to being moral in dealings with others, personal straight forwardness, honesty and coherence. To promote accuracy, honesty and truthfulness in the science, teaching and practice of counselling. In these activities, counsellors do not steal, cheat or engage in fraud, subterfuge or intentional misrepresentations of fact.
* **Resilience:** The capacity to work with the client’s concerns without being personally diminished.
* **Respect:** Showing appropriate esteem to others and their understanding of themselves.
* **Humility:** The ability to asses accurately and acknowledge one’s own strengths and weaknesses
* **Competence:** The effective deployment of the skills and knowledge needed to do what is required.
* **Fairness:** The consistent application of appropriate criteria to inform decisions and actions.
* **Wisdom:** Possession of sound judgment that inform practice.
* **Courage:** the capacity to act in spite of known fears, risks and uncertainty

1. **Contracting a Client**: A contract deals with individual rights and responsibilities.

* A covenant: addresses commitment to a relationship
* A framework for a contract
* The duration and frequency of sessions
* The keeping and cancelling of sessions
* The use of phone calls or contact outside appointment times
* Payment procedures
* Expected outcomes
* Treatment strategies
* Qualifications of counsellor
* Informed consent
* The client must have the capacity to make a rational decision; he/she must be able to comprehend the therapy.

1. **LEGAL CONSIDERATION**

The obligation here does not have only an ethical connotation but even a legal implication. What the law appears to require in this case is that the professional is not to disclose information shown to him under the setting of one-to-one counselling and also to maintain the professional confidence reposed on him in such relationship. The counsellor is not to disclose such a confidential information (even where accurate) to individual not entitled to it. Also everything about the relationship in written records must be accurately done and strongly safeguarded

**The law about libel and slander in counselling:** A counsellor should know that there are certain things he may do or say in counselling which would usually be actionable by the aggrieved clients. Among these are; the misconduct of libel and slander which is a form of defamation. This involves exposure of the victim to hatred, ridicule and contempt; arid also damaging of reputation.

**CONCLUSION**

“A customer is the most important visitor on our premises. He is not dependent on us.

We are dependent on him.

He is not an interruption to our work. He is the purpose of it. He is not an outsider in our business. He is part of it.

We are not doing him a favour by serving him. He is doing us a favour by giving us an opportunity to do so”.

-**MAHANDAS GHANDI**

**ASSESSMENT**

**Case Study:** kindly treat;

Grace is a school counsellor who has been assigned a trainee from Attitude Development International (ADI). As she observes Bosun work with primary school children, she is increasingly impressed with his skills. She asked him to work with Peter, a 9year old, who has not adjusted well to his parents’ recent divorce.

Again, she is impressed with Bosun’s skills, his warmth and understanding, and ultimately, with the success he has in working with Peter. Grace is a single parent who is concern about her 9year old son. She decides to ask Bosun to see him; Bosun is complimented by her confidence in him.

Nkiru’s son attends a different school, but she arranges to have Bosun see him after school hours.

**Questions**

1. What are the main issues in the case?
2. What ethical issues are of concern in the case?
3. Are there particular breaches of ethical principles? What are they?
4. What can at the supervisor do, if anything, to resolve the ethical problem(s) presented in the case?
5. What could have been done to prevent the ethical problem from occurring in the first place?

**DPC 115**

**UNDERSTANDING THERAPY**

**Some Tools:**

NLP –Neuro Linguistic Programming

EFT- Emotional Freedom Techniques

FSE- Family System Engineering

Aromatherapy

A Therapist Heart

**PROFESSIONAL DRESS SENSE FOR COUNSELLORS**

The dressing of a counsellor goes a long way to determine the level of confidence a client would have in the counsellor. How you look tells the client how you feel about yourself and makes a difference in how the client will respond to you.

No one moves ahead without the right clothing even with all the professional qualification. These are essential tips for personal grooming as a counsellor;

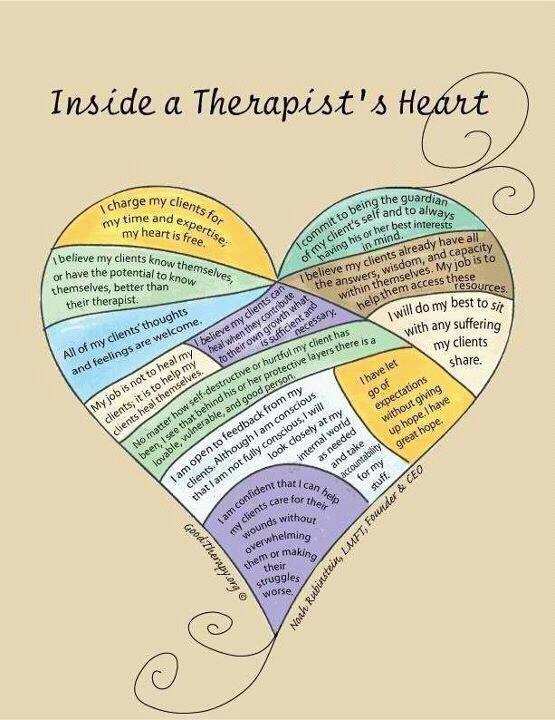
* + Keep make up light and simple
  + Hair should be neatly combed and styled. Female counsellors should avoid coloured or overwhelming styles
  + Keep nails neat and trimmed
  + Avoid exposing armpit, keep it shaved and use deodorant
  + Be conscious of body odour; always have body spray/perfumes nearby.
  + Do not spray minutes before you enter for a session
  + Avoid food that will give mouth smell or stain your teeth during your work hours
  + Avoid having eyes bag or tired eyes due to sleeplessness. Keep your eye brows well groomed.
  + Jewellery used must not be distracting. Make it simple during work hours.

**Counselling** in view is simply;

* Discovering the person of the counsellor; that is healer heal thyself first.
* A sense of assessment; to know how to ask vulnerable questions and to know what to do per time.

15% only has to do with techniques

85% has to do with relationship between counsellor and counselee.



**DPC 116**

**EMOTIONAL INTELLIGENCE: SELF AWARENESS & EMPATHY**

**Class Objective:**

**Dealing with:**

* Disturbing emotions like fear, anger, worry, tension, anxiety, depression, hatred, jealousy, insult, frustration and conflict
* Mastering temperaments &personality types
* Self Awareness& Empathy

**WHAT IS EQ?**

It can be defined as being skilled in awareness of your emotions, understanding your emotions and managing your emotions in a wise and empathetic way.

**QUESTION: What negative emotion(s) are you struggling with?**

Growing your EQ begins with intentionality around awareness… paying attention to the cues and clues your heart, your mind and your body gives you… as well as mastering same with others.

**4 SIDES OF EQ…**

|  |  |
| --- | --- |
| **Self Awareness** | **Self Mastery / Control** |
| **Social Awareness** | **Social Mastery** |

**Self & Social Awareness …**

Self Intelligence is understanding and having a clear perception of your personality, strengths and weaknesses, thoughts, beliefs, motivation, and emotions. *(SA allows you to understand people and your responses to them in the moment).*

Social Intelligence is paying attention to other people’s emotions and feelings and how we respond to such situations.

EQ means that we have an insight into our own and other peoples PERSONALITY (strengths& weaknesses) how it affects our abilities to deal with challenges as they arise.

* WHAT PERSONALITY IS YOURS? WHO ARE YOU?
* PERSONALITY TYPES: Phlegmatic, Sanguine, Choleric, Melancholy

**SELF CONCEPT…**

* Sexuality (I’m heterosexual)
* Gender (I’m female/male)
* Culture and race (I’m Hausa/Black)
* Physical descriptors and abilities (I am tall, I run fast looks, fitness, health,)
* Mental abilities (I’m good at academics)
* Spirituality and religion (I’m spiritual)
* Social roles (I’m an aunt and a counsellor)
* Personal traits/ character attributes (I’m a loud talker, I’m introverted)

SELF CONCEPT…

* Beliefs about self (people like me, I’m funny)
* Existential statements (I’m a human being; I am one with all that is).
* Social (how we interact with others)
* Family (how we behave in our family)
* Competence (how we manage basic needs of living)
* Academic (school and intellect)
* Affect (understanding of emotional states).

**SELF Contact Style:**

* Introjection
* Projection
* Deflection
* Confluence
* Desensitizing

**EMPATHY…**

Empathy is the capacity to understand or feel what another person is experiencing from within their frame of reference, that is, the capacity to place oneself in another's position.

**Empathy** comes from a German word, Einfühlung, meaning “feeling in.” And just as there are many ways to feel; there are multiple ways to experience **empathy**. The **three** forms of **empathy** that psychologists have defined are;

**Cognitive empathy**is the ability to understand how a person feels and what they might be thinking. Cognitive empathy makes us better communicators, because it helps us relay information in a way that best reaches the other person.

**Emotional empathy**(also known as affective empathy) is the ability to share the feelings of another person. Some have described it as "your pain in my heart." This type of empathy helps you build emotional connections with others.

**Compassionate empathy**(also known as empathic concern) goes beyond simply understanding others and sharing their feelings: it actually moves us to take action, to help however we can.

**WAYS TO MASTER EQ IN RELATIONSHIPS**

* Build Your Emotional Vocabulary
* Make Friends With your Feelings
* Master Communication Style for each personality
* LOVE!

**DPC 117**

**SEX THERAPY**

**WHAT IS SEX THERAPY**

Sex therapy is a form of psychotherapy that is used to help individuals and couples address sexual problems. Sex therapy is talk therapy, not hands on therapy. In a sex therapy session, everyone in the room remains fully clothed, and there is no touching.

Sex therapy helps sexual difficulties, such as difficulties relating to **Sexual desire, Arousal, Ability to orgasm, Sexual abuse/trauma, Sex addiction etc**. The major treatment method is talk therapy, designed to help clients explore issues that may affect their sexuality.

Current approaches to sex therapy is a 3 pronged approach, typically informed by a bio-psychosocial framework, that is, a framework which recognizes that biological/physiological causes (e.g. hormone levels), psychological (e.g. self esteem and body image) and socio-cultural (dictates of social and cultural environment e.g. the degree of social acceptance of women playing an active role in sexual encounters) factors all influence an individual’s sexual functioning.

As such the various treatments which comprise sex therapy address biological, psychological and socio-cultural factors which may underlie a particular sexual complaint.

Sex therapy aims not only to help couples or individuals overcome difficulties relating to their sexual functioning but also to increase their pleasure, skill, comfort and confidence in sexual experiences.

Individual therapists will vary in their approach to sex therapy. However, as a group, sex therapists take a **NON-JUDGMENTAL STANCE** (they do not judge individuals because of their sexual desires or fetishes, but rather recognize that all individuals are different and will desire different sexual experiences).

The goal of sex therapy is to help people move past physical, psychological and emotional challenges to have a satisfying and pleasurable sex life.

Sex therapy is about bringing a sexual problem into the open but safe space of a therapy session and then beginning to deal with it. Often we don’t acknowledge our sexual difficulties to ourselves, let alone our partners. We internalize them. Sex therapy is about externalizing them, taking a step back and asking: what can be done to improve things?

Sex therapists are health professionals who have specialized training in helping people with difficulties relating to sex.

A well-qualified sex therapist has done intensive research on sexual problems and sexual dysfunction, and truly understands how to help individuals faced with these issues.

**COMMON PROBLEMS**

* Lack of sexual desire
* Lack of arousal (inability to get or maintain an erection, or female frigidity)
* Inability to orgasm (inability to climax or control ejaculation)
* Erectile dysfunction
* Premature Ejaculation
* Sexual inhibitions
* Painful intercourse
* Sexual relationships that have become stagnant
* Differences in what sexually arouses each of you
* Communication breakdowns when it comes to discussing sex
* Enhancing your sexual relationship
* Difficulty in establishing sexual boundaries
* Inability to control Sexual behaviours
* Sex Addiction
* Sexual Abuse/Trauma
* Distressing Sexual thoughts
* Unwanted Sexual Fetishes
* Couples struggling with sexual communication

**WHY DO YOU NEED SEX THERAPY**

A fulfilling sex life is healthy and natural. Physical and emotional intimacy is essential parts of your well-being. When sexual dysfunction occurs, having that fulfilling sex life can be difficult.

Many people may think that you must have severe sexual problems before seeking help from a sex therapist, but this isn’t so. Many sex therapists deal with couples with general sexual problems, such as lack of effective communication about sexual dynamics in their relationships. It's therefore not necessary to wait for a massive sexual issue to develop before seeking professional help.

A fulfilling sex life is healthy and natural. Physical and emotional intimacy are essential parts of your well-being. When sexual dysfunction occurs, having that fulfilling sex life can be difficult.

Many people may think that you must have severe sexual problems before seeking help from a sex therapist, but this isn’t so. Many sex therapists deal with couples with general sexual problems, such as lack of effective communication about sexual dynamics in their relationships. It's therefore not necessary to wait for a massive sexual issue to develop before seeking professional help.

Sex therapy helps to reframe sexual challenges, deal with a variety of physical and emotional issues that can interfere with sexual satisfaction, thereby improving sexual satisfaction and can help individuals and couples work through these issues in a supportive and educational environment.

Individuals or couples who experience sexual difficulties might need sex therapy. There is no archetype for the person who will benefit from sex therapy. Instead, sex therapy can help individuals of various ages, cultural backgrounds, beliefs, sexual orientation and abilities.

**WHO NEEDS SEX THERAPY**

Individuals or couples who experience sexual difficulties might need sex therapy. There is no archetype for the person who will benefit from sex therapy. Instead, sex therapy can help individuals of various ages, cultural backgrounds, beliefs, sexual orientation and abilities.

The sexual difficulties for which couples or individuals may seek sex therapy can be specifically identified as **Sexual problems** or **Sexual dysfunctions**.

Sexual dysfunctions are impairments, either physical or psychological, of one of the three phases of the sexual response cycle, i.e. desire, arousal and orgasm. Additionally, there are the pain disorders such as Dyspareunia, Vaginismus, Vulvodynia etc.

Aside from these dysfunctions, people experience a wide range of other sexual difficulties for which they may like to seek sexuality counselling. They are referred to as sexual problems and range from dissatisfaction with Sexual frequency, Sexual boredom, Sexual incompatibility with respect to sexual activity and lack of sexual fulfilment.

**HOW DOES SEX THERAPY WORK?**

Sex Therapy sessions can either be done online or physically.

Typically, Sex therapy will involve a number of sessions with a therapist to facilitate the disclosure and discussion of the sexual problems which have led the individual (or couple) to seek therapy.

In couples Sex Therapy, ideally, the couple are treated together although certain aspects of the treatment may involve only one member of the couple. In some instances individuals will also seek therapy and be treated as individuals.

Sex therapists are often involved in the ongoing treatment of sexual difficulties & dysfunction, particularly when treatment involves psychosocial (as opposed to medication-only) therapies.

In addition to assessing the situation, the therapist’s role is to help the client(s) come up with the motivation to change their sexual behaviours to achieve a more fulfilling Sex life.

A therapist also tries to help the client unravel the difficulties underlying their sexual difficulties and develop strategies which might help to overcome them. With the therapist’s assistance, client(s) engage in discussions about their sex life and sexuality and the factors which influence these.

Together with the therapist, client then works out coping mechanisms to help improve their responses in the future so that they can have a healthier sex life.

They may also practice physical exercises often as “homework” tasks (for example sensual touching exercises).

The therapist may also recommend counselling for broader issues affecting sexual functioning (e.g. marital counselling for couples with marital difficulties).

If the therapist suspects the dysfunction experienced is the result of a physical sexual concern, they may refer client to a medical doctor.

The therapist and the doctor can consult about signs and symptoms and work to help find any physical concerns that may be contributing to greater sexual problems. However, Sex Therapist would not recommend medications or carry out physical examinations themselves.

**Initial Assessment**

Initial assessment of a couple visiting a sex therapist or other health professional with complaints of sexual difficulties generally includes taking client's history (with a particular focus on the history of the sexual difficulty) and if required, physical examination. A diagnosis of the complaint will then usually be made.

**History Taking**

In order to assess the nature, severity and underlying causes of a sexual difficulty, a therapist or other health professional may ask the individual (or couple) questions regarding the:

* When they first became sexually active (or history of the relationship, if it's a couple's session)
* Onset of sexual difficulties;
* Nature of the sexual difficulties;
* Client’s explanation for why they are having sexual difficulties;
* Attitudes towards sexuality; and
* Previous treatment for sexual difficulties and response to that treatment.

Discussing the sexuality may be a difficult process, as many individuals are not open to discussing such. They may experience a range of negative emotions including shame, guilt and anger.

Negative emotions will interfere with the treatment, and the sex therapist will therefore encourage couples to discuss events of the past and move on from them, leaving any negative emotions behind.

Therapists may also ask about childhood experiences which may be influencing their sexuality today, including questions regarding:

Their parents’ marriage, details of their parents’ level of intimacy, attitudes to sexuality, separations and extra-marital affairs; and childhood experience of incest or sexual abuse.

**Physical Examination**

Physical examination also plays an important role in the assessment of sexual difficulties. However, it is important to note that a physical examination cannot be conducted by a Sex Therapist who is not a GP, medical doctor, nurse or physiotherapist. A physical examination is generally considered essential in cases where the presenting complaint is:

* A sexual pain disorder (e.g. vaginismus, dyspareunia);
* Erectile dysfunction; or
* Thought to be caused or influenced a neurological or physiological disorder.

For other presenting complaints, while not essential, physical examination often provides important insights into the underlying causes or nature of a range of sexual difficulties. It can also assist the doctor to select the most appropriate laboratory tests and other investigations to assist with diagnosis. For example:

* Degeneration of the genital tissues in women may indicate oestrogen deficiency or a connective tissue disorder;
* Erectile dysfunction in men might indicate cardiovascular problems, diabetes or a lower urinary tract problem; and
* The emotional or physical response to pelvic and/or genital examination of a man and woman, may provide insights regarding psychological issues underlying the sexual dysfunction.

**Investigations**

Laboratory assessment of hormone levels is often performed in the assessment of sexual disorders although such tests are not essential.

For women, the hormones best known for influencing sexual functioning are testosterone (which affects sexual desire) and estrogen (which affects sexual arousal, in particular vaginal lubrication and elasticity).

Testosterone is also the key hormone affecting sexual desire and function in men. However, there is also evidence that psychosocial factors, in particular satisfaction with the relationship and partner, are more important determinants of sexual function than hormone levels.

**Diagnosis**The information generated through history taking, examination and investigations is used to develop:

* A preliminary diagnosis regarding the causes underlying the couple’s sexual difficulties (particularly a determination of whether the difficulties are primarily underpinned by biological or psychological factors);
* A strategy for resolving the sexual difficulties based on the above diagnosis; and
* A strategy for resolving any related problems which may influence sexual difficulties (e.g. Marriage or couples therapy to resolve relationship issues such as intimacy and trust).

**Treatment**

In cases where medication alone is required to treat a sexual problem, it may be administered solely by a medical doctor.

If the sexual difficulty does not require any form of medication, a purely psychosocial approach is employed.

Combined approaches to sex therapy involve a combination of cognitive-behavioural and systemic interventions including:

* Sexual education;
* Sexual permissiveness training (teaching individuals or couples to freely express their sexual feelings and behave in ways which they may previously thought of as unusual);
* Non demand pleasuring (sensual activities between a couple which occur for their own sake, not as a lead up to sexual intercourse);
* Physical awareness and sensuality exercises;
* Exploration of past traumatic events that may influence current sexual experience;
* Treatment of psychological problems (e.g. depression);
* Treatment of other health issues such as obesity and overweight, fatigue, eating disorders, self esteem and body image difficulties, sedentary lifestyle etc
* Surgical interventions to rectify congenital or other abnormalities of the genitals which may underpin sexual difficulties. E.g. In cases where a woman is unable to have sexual intercourse due to having an imperforate hymen.

**The exact combination of therapeutic measures will depend on the nature of the sexual difficulties and the individuals involved. Sex therapists will usually be familiar with many different treatment options and combine them to suit the particular needs of the couple being treated.**

The Sex therapist also helps motivate and guide the couple throughout the treatment.

Typically sex therapy involves numerous visits to a therapist’s office, in which education and training are undertaken, issues discussed and response to medicines and other aspects of the treatment monitored.

The couple may also be introduced to pleasuring exercises and asked to practice these as homework.

Such homework might include the following:

• **Experimentation**. Couples who feel they’re in a sexual rut may try different activities, such as role playing or using sex toys, to increase their desire. Other couples may need to adjust their sexual routine or positions, especially if one partner has a health condition that requires such changes.

• **Sensual Exercises**. This technique for couples is designed to build trust and intimacy while reducing anxiety. Couples progress through three stages, starting with non-sexual touching, progressing to genital touching, and, usually, ending with penetration.

• **SexualEducation**. Sometimes, clients do not receive adequate sex education while they are growing up. As a result, they may not be aware of anatomy and how the body functions during sexual activity. Therapists might assign books or web content to read or videos to watch. They might also suggest that clients use a mirror to learn more about their body.

• **Communication strategies**. Clients may practice asking for what they want or need sexually or emotionally in a relationship.

Success with sex therapy often depends on how committed clients are to the process. If clients are willing to put in the effort, either alone or with a partner, they are more likely to reach their sexual goals.

The frequency and duration of sex therapy sessions will vary depending on the couple being treated. However, to prevent the reoccurrence of sexual difficulties, it is recommended that sessions continue even after improvements in sexual functioning are seen.

Clients are also more likely to experience greater improvement if they continue with “homework” exercises after the conclusion of sex therapy sessions.

**Follow Up to Prevent Relapse**

Individuals who experience improved sexual functioning during sex therapy may still relapse into sexual difficulties once sex therapy sessions terminate.   
  
Ensuring that sex therapy is comprehensive and effectively addresses the biological, physical, psychological and social factors underpinning sexual difficulties tends to reduce the potential for difficulties to re-arise once therapy stops.

However, it is also important that the client:

* Has realistic goals about their future sexual performance, for example that they do not expect to have “perfect” sex every time;
* Is prepared to deal with sexual “failures”, that is, sexual experiences which were difficult or less than satisfactory than was hoped;
* Continues to practice some of the techniques learnt during sex therapy, for example non-demand pleasuring sessions without intercourse and using alternative sexual scripts to consciously expand their sexual repertoire; and
* Has follow up visits with the sex therapist every six months for one to two years after the treatment is complete.
* Additionally, resistance to treatment and relapse may be signs of other sexual dysfunctions in the individual or couple, problems with communication, or relationship conflict.

**ASSESSING THE OUTCOMES OF SEX THERAPY**

There are a number of approaches which can be taken to measure the effectiveness of a sex therapy program.

Evaluation typically focuses on objective, physical measures, such as achievement of orgasm or erection in an individual who previously had difficulty.

This is partly because it is more difficult to assess subjective measures in circumstances where same outcomes may indicate either success or failure, depending on the couple. For example, in some cases sex therapy may result in the realisation that the relationship is deeply troubled. In such a case ending the relationship may constitute a more successful treatment outcome than achieving sexual performance within it.

It is generally recognised that the main measure on which the success of sex therapy should be measured is in terms of whether or not the therapy assisted the couple to achieve greater sexual satisfaction, regardless of whether, or in spite of the fact that, sexual performance actually changed.

Achieving an orgasm is not necessarily a success, unless the couple perceive that achievement to have enhanced their sex life.

In some cases expectations may change as a result of sex therapy rather than sexual performance. For example, sex therapy may teach couples not to expect “perfect” sexual performance at every encounter, and that imperfect sexual performance does not necessarily constitute unsatisfactory sex.

**ETHICAL PRINCIPLES OF SEX THERAPY**

Some people wonder if sex therapy entails talk therapy only or whether treatment will involve sexual contact with the therapist or even between the couple while in the therapist’s office.

**NO SEXUAL CONTACT BETWEEN THERAPISTS AND THE COUPLE OR INDIVIDUAL IS PERMISSIBLE.**

Although, couples or individuals are often given homework assignments to practice at home and then to discuss in the following session, it would be unethical to have couples engage in sexual activity or touching with the therapist present.

Additionally, issues such as integrity and confidentiality are non-negotiable in Sex therapy, as with other forms of Psychotherapy.

**DPC 118**

**GRIEF COUNSELLING**

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**Introduction**

Most people will experience loss at some point in their lives. Grief is a reaction to any form of loss. Bereavement is a type of grief involving the death of a loved one.

Bereavement and grief encompass a range of feelings from deep sadness to anger. The process of adapting to a significant loss can vary dramatically from one person to another. It often depends on a person’s background, beliefs, and relationship to what was lost.

**Pre Test**

What is the difference between Grief, Loss, and Bereavement?

Mention some thoughts and behaviours surrounding grief?

Explain what the Kubler Ross Model of Grief is about.

What are the Tasks of Mourning?

What are the Steps to grief recovery?

Explain the Relationship between Bereavement and Culture.

What are we not to say to a person in grief?

What can we say to a person in grief?

**GRIEVING THOUGHTS AND BEHAVIOURS**

Grief is not limited to feelings of sadness. It can also involve guilt, yearning, anger, and regret. Emotions are often surprising in their strength or mildness. They can also be confusing. One person may find themselves grieving a painful relationship. Another may mourn a loved one who died from cancer and yet feel relief that the person is no longer suffering.

People in grief can bounce between different thoughts as they make sense of their loss. Thoughts can range from soothing (“She had a good life.”) to troubling (“It wasn’t her time.”). People may assign themselves varying levels of responsibility, from “There was nothing I could have done,” to “It’s all my fault.”

Grieving behaviours also have a wide range. Some people find comfort in sharing their feelings among company. Other people may prefer to be alone with their feelings, engaging in silent activities like exercising or writing.

The different feelings, thoughts, and behaviours people express during grief can be categorized into two main styles: instrumental and intuitive. Most people display a blend of these two styles of grieving:

Instrumental grieving has a focus primarily on problem-solving tasks. This style involves controlling or minimizing emotional expression.

Intuitive grieving is based on a heightened emotional experience. This style involves sharing feelings, exploring the lost relationship, and considering mortality.

No one way of grieving is better than any other. Some people are more emotional and dive into their feelings. Others are stoic and may seek distraction from dwelling on an unchangeable fact of living. Every individual has unique needs when coping with loss.

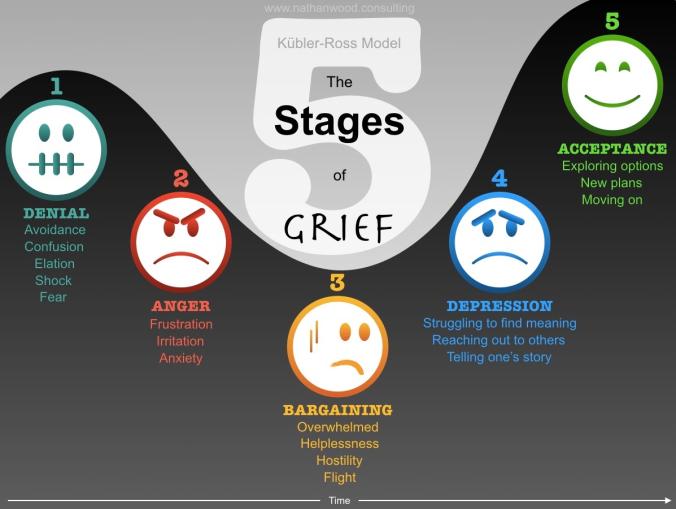
**MODELS OF GRIEF**

Grief can vary between individuals. However, there are still global trends in how people cope with loss. Psychologists and researchers have outlined various models of grief. Some of the most familiar models include the five stages of grief, the four tasks of mourning.

**Five Stages of Grief**

In 1969, Elisabeth Kubler-Ross Identified five linear stages of grief:

Denial, Anger, Bargaining, Depression, Acceptance.



Kubler-Ross originally developed this model to illustrate the process of bereavement. Yet she eventually adapted the model to account for any type of grief. Kubler-Ross noted that everyone experiences at least two of the five stages of grief. She acknowledged that some people may revisit certain stages over many years or throughout life.

**Four Tasks of Mourning**

Psychologist J. W. Worden also created a stage-based model for coping with the death of a loved one. He divided the bereavement process into four tasks:

* To accept the reality of the loss.
* To work through the pain of grief.
* To adjust to life without the deceased.
* To maintain a connection to the deceased while moving on with life.

Grieving allows us to 'free-up' energy that is bound to the lost person, object, or experience so that we might re-invest that energy elsewhere. Until we grieve effectively we are likely to find reinvesting difficult; a part of us remains tied to the past. Grieving is not forgetting.

**RECOVERING FROM GRIEF**

Everyone grieves in their own way and in their own time. Some people recover from grief and resume normal activities within six months, though they continue to feel moments of sadness. Others may feel better after about a year. Sometimes people grieve for years without seeming to find even temporary relief. Grief can be complicated by other conditions, most notably depression. The person’s level of dependency on the departed can also cause complications.

The grieving process often involves many difficult and complicated emotions. Yet joy, contentment, and humour do not have to be absent during this difficult time. Self-care, recreation, and social support can be vital to the recovery. Feeling occasional happiness does not mean a person is done mourning. Grieving the loss of a loved one be a difficult process, whether the loss is due to death, a breakup, or other circumstance. One of the hardest challenges is adjusting to the new reality of living in the absence of the loved one. Adjusting may require a person to develop a new daily routine or to rethink their plans for the future. While creating a new life, a person may adopt a new sense of identity.

**BEREAVEMENT AND CULTURE**

Certain aspects of grief are virtually universal. Most cultures have rituals of mourning after a death. Crying is common, regardless of a person’s origins. However, the bereavement process can vary dramatically depending on one’s culture. Cultural values may affect a person’s:

**Attitude toward death:** Many Western cultures display death-denying traits. Death is often depicted as something to fight or resist. Eastern cultures, meanwhile, tend to characterize death to be a part of life. Death is often considered more of a transition than an end. Research suggests people in death-denying cultures tend to have more anxiety around death than people in death-accepting cultures.

**Remembrance of the deceased:** Some cultures, such as the Hopi or Achuar peoples, grieve by attempting to forget as much of the deceased as possible. It may be taboo for loved ones to say the person’s name or to touch their belongings. Rituals are done to sever connections with the dead. Other cultures mourn by sharing memories of the deceased. People in the Akan region of Ghana often hold elaborate funerals which may cost a full year’s income. The deceased are typically placed in “fantasy coffins” personalized with symbols of their life.

**Emotional Displays:** Social norms can differ regarding how much emotion is “appropriate” to show. A 1990 study compared bereavement norms in two Muslim societies. Mourners in Egypt may be encouraged to grieve for an extended period of time. A person might display their love for the deceased through displays of unrestrained emotion. Meanwhile, Balinese culture tends to pathologize overt sorrow. People are encouraged to put on a happy face in front of others and to cut ties with the deceased.

When analysing grieving behaviours, context matters as much as the symptoms themselves. Bereavement trends which are typical in one culture may be stigmatized in another. When working with individuals in grief, therapists may need to keep cultural influences in mind.

**Class Tasks**

What mourning rituals are practised in your culture?

**DISENFRANCHISED GRIEF**



Disenfranchised grief occurs when a person’s mourning is restricted in some way. Society may stigmatize a person’s mourning process or refuse to acknowledge their loss. Grief may be disenfranchised for several reasons:

Society devalues the loss. The loss of a pet often garners less sympathy than the loss of a human relative. Others may say “it was just an animal” and accuse the person of being too emotional. Yet research shows the mourning period for a pet is about the same length as for a human family member.

The loss is ambiguous. An adopted child may grieve the loss of their birth parents, even if said adults are alive. If a loved one has late-stage dementia, family members may feel as if the person they knew is gone.

Society stigmatizes the circumstances of the loss. Pregnancy-related loss is often considered taboo. Women who undergo a miscarriage may feel guilt and shame. They may avoid telling others about the loss to avoid being blamed.

Society doesn’t recognize the person’s relationship to the deceased. A co-worker or friend may mourn a person, but they will likely receive less support than a family member. The same is true for ex-spouses, even though they used to be family. In societies with systemic homophobia, same-sex partners may also have disenfranchised grief.

Others do not consider the person capable of grief. When young children experience loss, adults may misinterpret signs of bereavement. They may believe the child is not capable of understanding the loss or have prolonged feelings about it. People who have cognitive impairments or intellectual disabilities may also have disenfranchised grief.

Disenfranchised grief can interfere with the bereavement process. If society does not recognize a loss, the person may have trouble accepting it themselves. They may try to repress or deny their emotions. Shame and secrecy can make the symptoms of grief more severe.

Social support is often vital to recovery. A community can provide emotional and financial aid when people are vulnerable. Mourning rituals can offer closure. If a person is forced to grieve alone, they may have a delayed recovery.

If you have lost someone or something precious, you may wish to find a therapist. Therapy can help with any sort of loss, whether society validates the grief or not. Therapy is an opportunity to explore your feelings and memories without judgment. No loss is too big or too small to warrant support. You do not have to endure your grief alone.

**What not to say to a person in grief**

* 1. At least she lived a long life, many people die young
* 2. He is in a better place
* 3. She brought this on herself
* 4. There is a reason for everything
* 5. Aren’t you over him yet, he has been dead for a while now
* 6. You can have another child still
* 7. She was such a good person God wanted her to be with him
* 8. I know how you feel
* 9. She did what she came here to do and it was her time to go
* 10. Be strong

**What to say to someone in grief**

* 1. I am so sorry for your loss.
* 2. I wish I had the right words, just know I care.
* 3. I don’t know how you feel, but I am here to help in any way I can.
* 4. You and your loved one will be in my thoughts and prayers.
* 5. My favorite memory of your loved one is…
* 6. I am always just a phone call away.
* 7. Give a hug instead of saying something.
* 8. We all need help at times like this, I am here for you.
* 9. I am usually up early or late, if you need anything.
* 10. Saying nothing, just be with the person.

**Conclusion**

Grief counselling becomes necessary when a person is so disabled by their grief; and, so overwhelmed by their loss that their normal coping processes are disabled or shut down. Grief counselling facilitates expression of [emotion](https://en.wikipedia.org/wiki/Emotion) and thought about the loss, including their feeling sad, anxious, angry, lonely, guilty, relieved, isolated, confused, or numb.

It includes thinking creatively about the challenges that follow loss and coping with concurrent changes in their lives. Often people feel disorganized, tired, have trouble concentrating, sleep poorly and have vivid dreams, and they may experience the change in appetite. These too are addressed in counselling.

Grief counselling facilitates the process of resolution in the natural reactions to loss. It is appropriate for reaction to losses that have overwhelmed a person's coping ability. There are considerable resources online covering grief or loss counselling.

**Post Test/Discussion**

Should it be mandatory that organizations should give their staff equal or longer periods to mourn their loss as given for child delivery?

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**DPC 119**

**INTRODUCTION TO RESEARCH**

**RESEARCH METHODOLOGY IN COUNSELLING**

**1.0** **LEARNING OBJECTIVES**

This training will help the student:

1. To understand the scientific method of research

2. To describe what research can do

3. Understand the importance of research for counsellors

4. To articulate the principles of research for counselling

5. To develop effective written communication skills as these applies to professional practice in Counselling.

**1.1 Reflection**

* What do you understand by research?
* What do you hope to gain from this module about research?

**2.0 Introduction**

For any profession to survive and develop, on-going research is necessary, challenging old concepts and introducing and developing new ideas. In order for this to take place a reliable procedure needs to be followed.

**2.1 What is Research?**

Research refers to systematic ways of conducting a study regarding a topic which needs to be explored or a topic that needs to be replicated in terms of its reliability to past and/or present findings.

**2.2 What can Research Do?**

There are many reasons for conducting research; with the primary driver being the desire to know on the part of the researcher. In addition,

* Research can be seen as an attempt to establish “evidence-based” credentials of therapy often called outcomes studies.
* Given the appropriate method, research can contribute to the knowledge and insight into almost any question that can be framed.

**2.3 Why Should Counsellors Do Research?**

* From a research perspective, they are driven purely and simply by the need to know…curiosity.
* Doing research helps you advance your profession
* Doing research is that it will in some way improve the lot of clients: evidence-based practice of knowledge and skills to help clients.

**2.4 Research Methodology**

* Research methodology is a way to systematically solve the research problem.
* It may be understood as a science of studying how research is done scientifically.
* In it we study the various steps that are generally adopted by a researcher in studying his research problem along with the logic behind them

**2.5** **Research Methods**

Research method is the action of the research. It involves the design; sample/sampling methods, data collection and data analysis.

**2.6 The Research Process**

* Identification of general problem/question
* Literature review
* Specify questions/hypotheses
* Determination of research design/methodology
* Data collection
* Data analysis/presentation
* Interpretation of findings
* Discussion of findings

**2.7 Types of Research Designs**

**a) Exploratory Research:** An exploratory design is a research conducted for a problem that has not been studied more clearly or have few or no earlier study to refer to. The focus is on gaining insight for further investigation. It does not offer final and conclusive solution to the existing problems.

**b) Descriptive Research:** Descriptive research design enable researcher to collect data to describe systematically the characteristic features of a given population. It does not explain how, when or why the characteristics occurred.

**c) Causal-Comparative Research:** This design is interested in establishing cause - effect relationships. However, it is different from experimental study in that the researcher has no control over some variables of interest and cannot manipulate them.

**2.8** **Variables**

A variable is a property of proposition being studied.

* **Independent variables (IV):** are those variables the researcher will manipulate in order to determine their relationships with the observed state of affairs. (What you or nature manipulates in some ways).
* **Dependent Variables (DV):** these are variables being predicted when the research studies are done. (What you presume to be influenced by the independent variables.)
* **Intervening variables:** are those variables that cannot be controlled or measured directly even though they have significant effect upon the outcome of the investigation being made. **E.g.** in studying parenting style and marital success, some variables like (personal values, motivation, etc) may intervene.
* **Extraneous variables:** these are variables that make it impossible for one to attribute all changes in DV to IV. **E.g.** in productivity versus remuneration kind of study, the researcher cannot control factors like age, natural ability, previous experience, personality, etc.

**2.9 PROPOSAL GUIDE**

**2.9.1 Research Proposal in Counselling**

Research is important for clients, for practitioners and politically to continue to demonstrate that counselling changes lives. Research provides evidence for the range of issues where therapy can be effective and the positive outcomes for clients. Research methodology is important to counselling because of its relative significance in, and contribution to, counsellor development.

This template follows the 3 parts of the proposal outline which is used in writing a research proposal.

* **Proposed Dissertation Title** (Maximum 7 – 15 words and title must include the name scope of study):
* **Student Name:**
* **E-mail address:**
* **Proposal submission date:**
* **Proposal outline should not be more than 3000 words excluding references.**

**PART 1: INTRODUCTION & LITERATURE REVIEW**

* Briefly describe the history and current trends in the domain of study with statistics. Provide background information on your target variable and audience (e.g. counselling competence among undergraduates), as well as its role within organization, locally and globally.
* Include any specific terms and concepts relative to your industry and / or organization
* Provide a detailed explanation of the problem
* Convert the detailed explanation described above into a single sentence statement of the core problem that you intend addressing in your dissertation
* Note: The Problem Statement is not a lengthy discussion, nor is the Problem Statement a question. The objective of the Problem Statement is that you demonstrate your ability to synthesize the information contained in the explanation of the problem, are able to crystallize your thinking and convert this information into a single sentence statement of the core problem that will be addressed in your dissertation.
* You need to present an overview of the literature that you have reviewed in support of your dissertation proposal.

**Part 2: RESEARCH DESIGN & METHODOLOGY**

* Specify your intended research questions
* Clarify the overall objectives of the research
* Present your proposed research design and your motivation for selecting this research design.
* Provide details of your intended research methodology together with your motivation for your intended research methodology.
* Provide details of your any research instruments that you intend using (example: a questionnaire) and how you intend administering your research instrument (online, face-to-face, etc).
* Provide details and motivation of your intended sample and sample size
* Indicate how you intend selecting your sample (random sampling, etc)
* Describe how you will capture and analyze your data

**PART 3: LIMITATIONS & EXPECTATIONS**

* Delineate the boundaries of your research – what will your research include or exclude
* Briefly describe the significance of your research from organizational, societal and your own individual learning perspective
* What are the expected outcomes from your research and what do you wish to achieve, e.g.:
  + - A new strategy or solution or policy
    - A new conceptual counselling model
    - A new operational process
* Present your detailed plan for researching and writing your dissertation
* You need to include a reference **(In APA style)** of all resources consulted while preparing your dissertation proposal.

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1. [↑](#footnote-ref-1)
2. [↑](#footnote-ref-2)
3. [↑](#footnote-ref-3)
4. [↑](#footnote-ref-4)