KARNATAKA STATE OPEN UNIVERSITY

MUKTHAGANGOTHRI, MYSURU

DEPARTMENT OF STUDIES AND RESEARCH IN

PSYCHOLOGY

M.Sc PSYCHOLOGY

THIRD SEMESTER

COURSE-13 : PSYCHOTHERAPY

Course Design and Editorial Committee

Prof. Vidya Shankar
Vice – Chancellor & Chairperson
Karnataka State Open University
Mukthagangotri, Mysore – 570 006

Prof. Kamble Ashok
Dean (Academic)(IC)
Karnataka State Open University
Mukthagangotri, Mysore – 570 006

Course Co-Ordinator and Editor

Dr. S. Surma
Course Coordinator M.Sc Psychology
Assistant Professor
DOS & R in Psychology
Karnataka State Open University
Mukthagangotri, Mysore – 570 006

Course Writers

1. **Prof. S. Venkateshan** — Block-1 Unit-1, 2, 3, 4; Block-2 Unit-5, 6, 7, 8
   Chairman
   DOS in Psychology
   AIISH, Mysore.
2. **Dr. Manjunatha. P** — Block-3 Unit-9,10,11,12
   Assistant Professor
   DOS&R in Psychology
   Karnataka State Open University
   Mysore.
3. **Dr. Lancy d'Souza** — Block-4 Unit-13,14,15,16
   Associate Professor
   DOS in Psychology
   Maharaja College, UOM,
   Mysore

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COURSE-13 PSYCHOTHERAPY

INTRODUCTION

This course Psychotherapy is about using Psychological methods and techniques to treat the individuals suffering from various Psychological problems and disorders. Psychotherapy is the collaborative treatment between an individual and a psychologist. In this process the psychologist helps the individual to develop healthier and effective habits and behaviours to deal with one's own environment. This is done through the use of verbal and psychological techniques where a professional psychotherapist helps a client to handle his general and specific psychological problems.

The first block deals with introduction to psychotherapy, its nature, its goals, the difference between psychotherapy and counselling, classification of psychotherapy its application in different settings. It explains the ethics to be followed in the psychotherapy, the therapeutic relationship, its meaning, purpose, goals, the components, importance of therapeutic relationship. It discusses about the Indian perspectives vs American perspectives.

The second block deals with types of psychotherapies, the supportive psychotherapies like guidance, tension control and release, milieu therapy, sociotherapy, reassurance, prestige suggestion, persuasion, confession ventilation, etc it also explains the importance of these and how they help an individual relieve his psychological tensions. It provides an understanding about reeducative and reconstructive psychotherapies , its applications, the major types like relationship therapy, attitude therapy, hypnotherapy, psychoanalysis, etc. Other than the major therapies there are certain special therapies like: play, art, music, dance, sports, creative therapies, sensory therapies, which are gaining importance nowadays. These are being discussed here. Therapies are done for a single individual as individual therapy, or sometimes group therapy based upon the requirement. The group therapies, its principles, applications, types are discussed here.

The third block deals with the classical psychoanalysis, its nature, process the role of a psychoanalyst, the techniques used in classical psychoanalysis of Sigmund Frued, that is free association, catharsis, dream interpretation, resistance, transference. The neo-Freudian and modern psychoanalysis of Alfred Adler, Eric From, Karen Horney, Harry Stack Sullivan

are being discussed in detail. The cognitive therapy and behaviour therapy, its techniques like desensitization, extinction, flooding, aversive conditioning, are being dealt .The importance to the client is the priority in client centered therapy given by Carl Rogers, the psychodrama, role playing, and relaxation therapies are discussed.

The fourth block deals with social and group therapies, the individual therapies, group therapies, different techniques adopted in these, the group education, psychosocial therapies, family therapies and specialized therapies are being discussed in detail.

This course has provided you a detailed understanding about the therapies used in treatment of mental disorders. A thorough knowledge of psychotherapy provides a perspective to look at the psychological treatment in a broader aspect.

Wishing you All the Best

Dr. S. Surma
Course Coordinator M.Sc Psychology
Assistant Professor, DOS&R in Psychology
Karnataka State Open University,
Mukthagangothri, Mysore.

BLOCK - I: INTRODUTION TO PSYCHOTHERAPY

UNIT 1: INTRODUCTION OF PSYCHOTHERAPY

STRUCTURE :

1.1 OBJECTIVES

After going through this unit you will be able to explain

- Meaning, definition, goals, nature and procedures involved in psychotherapy;
- Difference between counseling and psychotherapy;
- Characteristics and personal traits you need to develop in order to become an effective psychotherapist; and,
- Applications of psychotherapy in clinical practice.

1.2 INTRODUCTION

There are a variety of helping professions to address the problems of a person's physical, psychological, intellectual, emotional or spiritual wellbeing, such as, medicine, nursing, psychotherapy, psychological counseling, social work, etc. Despite being one among these professions, psychotherapy is different. Usually people confuse counseling, psychoanalysis, psycho-education and many other forms of therapy with psychotherapy. This unit will clarify these basic terms. You will realize that it is one thing to read about psychotherapy and quite another thing to practice it as a profession. There are many behavioral characteristics and personal qualities you must develop to become an effective psychotherapist in clinical practice. These traits will be listed along with their practical applications.

1.3 MEANING & DEFINITIONS OF PSYCHOTHERAPY

Psychotherapy is all about using psychological methods and techniques through interpersonal interactions to help a person seeking to change and overcome distress. The term psychotherapy is derived from ancient Greek word 'Psyche' (meaning spirit or soul). The term is also the source for the word 'psychology'. Whereas 'psychology' is study of 'soul', the term 'psychotherapy' literally stands for 'healing or treatment of soul'. However, this is not valid anymore since modern scientific psychology no longer talks or believes in 'spirits' or 'soul'.

Wolberg defines psychotherapy as 'a treatment, by psychological means, of problems of an emotional nature in which a trained person deliberately establishes a professional relationship with the patient with the objective of removing, modifying or retarding existing symptoms; mediating disturbed patterns of behavior and promoting positive personality growth and development'.

The definition of psychotherapy adopted by American Psychological Association as given by JC Norcross is: 'informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable'.

The Merriam-Webster Dictionary defines psychotherapy as: 'treatment of mental or emotional illness by talking about problems rather than by using medicine or drugs'. Other dictionary meanings view psychotherapy as 'psychological treatment of mental, emotional and nervous disorders'. Another definition mentions psychotherapy as 'treatment of a behavior disorder, mental illness or any other condition by psychological means'. The Royal College of Psychiatrists describes psychotherapy as 'helping people to overcome stress, emotional problems, relationship problems or troublesome habits…they are all treatments based on talking to another person'. Given below are some more definitions.

'the process of working with a licensed therapist to develop positive thinking and coping skills and treat mental health issues such as mental health and trauma': Joseph Rauch

'…a way of changing your perspective on how to handle a situation': Noor Pinna

'…a dynamic process that occurs in a safe and contained relational frame wherein destructive patterns of being are identified and replaced with healthy and positive ones': - Paul Hokemeyer

According to American Association of Psychotherapy, it is a collaborative treatment based on the dialogue and relationship between an individual and a psychologist'. It provides a supportive environment that allows you to talk openly with someone who is objective, neutral and non-judgmental. The individual and psychologist work together to identify and change the thought and behavior patterns that are keeping the individual away from feeling the best.

There are many definitions of psychotherapy depending on the sources from where they emerge. They maybe: client-centered, cognitive-behavioral, dialectal behavioral, existential, family focused, gestalt, interpersonal, and psychodynamic psychotherapy. They could emerge from the field of psychiatry, psychology, health care, life events, in-depth, personal, political, legal, trans-cultural, phenomenological, etc. Nowadays, psychotherapy is turning online. With technological advances, online psychotherapy, telemedicine and virtual reality, are bringing fascinating changes to the field. All this might pose greater challenge to define psychotherapy.

1.4 GOALS OF PSYCHOTHERAPY

The primary goals of psychotherapy are:

- To know yourself better;
- To lessen emotional pain and confusion in the affected individual;
- To assist you in developing a complete understanding of one's psychological issues;
- To establish more effective coping mechanisms; and,
- To foster a more accurate understanding of your past and what you want for your future.

Some authors identify three goals for psychotherapy. They are: personal, theoretical and ultimate goals. Personal goals address the individual by improving insight, reducing dependency, enhancing sense of self control, facilitating formation of one's identity, helping recognize and handle feelings, developing their ego strength and self-esteem. Theoretical goals refer to cognitive change, symptom reduction and self-knowledge. Ultimate goals are broader goals like health, quality of life, well-being and empowerment of the individual.

A distinction is also made between short-term and long-term goals of psychotherapy. The initial goal of treatment is to relieve the distressing symptoms of the patient as quickly as possible to re-establish emotional balance and clear thinking. The intention is to provide symptom relief and restore the patient quickly to the former level of healthy functioning. The stress is to focus on a specific problem and direct intervention to overcome it. This is done by giving immediate coping and solution-focused techniques. In contrast, the long term goals of psychotherapy are more generic. The goal is to help people identify and understand the behavior, emotions and ideas that contribute to their long standing life problems contributing

to their present illness. The aim is to enable them to solve problems and improve the quality of their life.

1.5 NATURE OF PSYCHOTHERAPY

Psychotherapists are professionally trained specialists with formal university or institutional degrees. They undergo in-service clinical internship training for short or long periods of time. Their qualifications equip them with the knowledge, skills and experience to practice in therapeutic settings. In western countries, an accreditation from one of the professional associations is mandatory before entering into clinical practice. To enter this field, you must have an understanding of a complex body of knowledge, clinical skills, self awareness, analytical techniques and problem solving skills. You must show the ability to evaluate evidence, arguments and assumptions before making sound independent judgments.

The theoretical knowledge base of a typical psychotherapist covers basics of psychology and philosophy, human growth and development, ethics and law, psychopathology, and the functioning of groups and organizations. The practical skills typically cover competency for relationship building, communication, psychological assessment and diagnostic formulation, reflective practice, monitoring, evaluation, research and implementing strategic psychotherapeutic interventions.

Psychotherapists offer a range of services to address mental health and wellbeing of the general public in a variety of settings. They practice with respect for human dignity and sense of inclusion that embraces all human beings irrespective of gender, language, caste, religion, race, disability, or ethnicity. Their actions are to be guided by sound ethical principles. They may work in private practice, or as part of government and non-government organizations involved in the cause of serving the humankind. The psychotherapeutic practice may take place as an agreed contract, in a discrete private place, or as time bound sessions. They must also have additional skills to work on their own initiative and in cooperation with others. They must have the ability to work in small groups with some understanding of the dynamics involved in such groups.

1.6 PROCEDURES OF PSYCHOTHERAPY

The psychotherapy practice typically begins with the patient feeling the need for a professional consultation or intervention. Are you always worried? Are you unable to concentrate on anything because of some unrecognized reasons? Are you continually unhappy? Do you lose your tempers easily and too often? Are you troubled by frequent sleeplessness? Do you have wide mood fluctuations? Do you continually dislike being with people? Do you feel upset when your daily routines are changed? Do others constantly get on your nerves? Do you feel fearful without any apparent cause? Are you always on the right and others are always wrong? Do you have numerous aches and pains without any physical cause? If your answer is 'yes' to these questions, it might be that you are not fully a mentally healthy person. It means that you might require a professional consultation.

Signs, symptoms or situations indicating referral for psychotherapy are when you are troubled by a prolonged sense of helplessness or sadness, when your problems do not seem to get better despite best efforts from your own self and/or the help from family and friends, or when you have difficulties in concentrating on work assignments or to carry out other everyday activities, if you worry excessively, expect the worst to happen or you feel constantly on the edge or when you are into drinking too much alcohol, using drugs or being aggressive by harming others.

Having identified the problem/s, the next step is to find a psychologist for psychotherapy. One must ensure that the person is a trained professional with graduate, post graduate diploma or doctoral level qualifications with supervised clinical internship experience. An authentic list of licensed or certified psychologists is available in the official website of Indian Association of Clinical Psychologists and Rehabilitation Council of India.

Professional psychotherapists begin their work by setting goals, terms and conditions, the venue, dates, frequency, timings and number of sessions required for a regime of treatment. It is important to understand that there is general stigma continuing to be attached to consult a psychotherapist for oneself or for a family member in our country. There are confusions between psychotherapist and psychiatrist. People consult a psychotherapist expecting quick cures through mind reading, hypnosis, medicines or shock treatments. Such myths must be dispelled. Psychotherapists start their first few sessions by undertaking a detailed assessment through techniques of case history, clinical interviews, use of paper-

pencil tests, behavior observations and recording. The procedures may roughly involve opening up sessions, therapeutic contract, establishing rapport, conceptualization, diagnostic formulation, questioning, confronting, resistance, stabilization, symptom relief, transformation or behavior change to closure, conclusion, and termination.

1.7 COUNSELING & PSYCHOTHERAPY

The term 'psychotherapy' is often confused with words like counseling, advising, guidance, information giving, mentoring, life coaching, psychoanalysis and psycho-education. To begin with, counseling is different from psychotherapy. The dictionary meaning of counseling is to 'advise, recommend, guide and exchange ideas and opinions'. As we have seen, psychotherapy is all about 'psychological treatment of mental, emotional and nervous disorders'. Clinical psychology and psychiatry understands that psychological problems exist in human beings as if along a continuum. Some of them are *simple, routine, not-so-serious, age or situation related life problems*, while others are more serious. The so called 'serious' psychological problems also vary from time bound 'adjustment' issues to relatively 'more serious' neurosis and 'very serious' psychosis. In short, counseling deals with *simple, routine, not-so-serious, age or situation related life problems*, or at the most, time bund 'adjustment' problems, psychotherapy chooses to focus on the relatively more serious neurotic, psychotic as well as personality problems. A few important differences between counseling and psychotherapy are:

- Counseling views client as healthy individual;
- Psychotherapy views client as mentally sick;
- Counseling is a supportive treatment exercise;
- Psychotherapy is a re-educative, reconstructive, reorganizing and re-interpretative treatment exercise involving the destructive elements of conflict in the individual's personality;
- Counseling facilitates self-understanding and support individuals to view problems from new or different perspectives;
- Psychotherapy deals with deep rooted psychopathology;

Now, let us see how counseling and psychotherapy are different from 'advising'. Advising is usually given or taken voluntarily. It is not binding on the receiver. It is given out of wisdom or experience. For example, an elder advises a young man to quit smoking. The advice might be given unsolicited. The young man may or may not take the advice. The term

'guidance' refers to 'assistance given to individuals to make intelligent decisions and adjustments'. For example, the victim of a crime maybe guided to approach a legal cell for redress of her grievance. Guidance is an act of giving correct and factual information to a recipient who is unaware and in need for it. Mentoring or life coaching is 'a developmental partnership through which one person shares knowledge, skills, information and perspective to foster the personal and professional growth of someone else'.

Psycho-analysis is a set of psychological and psychotherapeutic theories and associated techniques created by Sigmund Freud. This approach believes in the role of unconscious conflicts causing the symptoms in a patient. The treatment techniques like free association, fantasies and interpretation of dreams is used by the psychoanalyst to resolve the conflicts in the individual by providing insight.

Psycho-education refers to the education offered to individuals with a mental health condition and/or their family members. It empowers them to deal with the clinical condition in an optimal way. For example, the patient and caregivers of a person suffering from schizophrenia may require psycho-education covering scientific information on various aspects of their condition including its symptoms, causes, use of medicines, side effects of the medicines, prognosis, home care and rehabilitation. Psycho-education is considered as one of the important components of psychotherapy program.

1.8 CHARACTERISTICS & PERSONAL TRAITS

It is one thing to read about the theoretical details on psychotherapy from a text book. It is quite another thing to become a successful psychotherapist to practice it as a profession. There are many behavioral characteristics and personal qualities one must develop to become an effective practitioner. These traits are listed below along with their practical applications.

It is all about cultivating and possessing a sophisticated set of interpersonal skills. You must have both expressive and receptive language skills. It involves impressive speaking and patient listening. While you are alert at one end to sense what the patients are thinking or feeling, there must be also a show of warmth, acceptance, empathy, and sincerity at the other end. Listening does not mean passive noting. The patient should gather a sense of being attended. The therapist must punctuate the listening with periodic or meaningful pauses, pertinent questions, interesting observations, and sensible paraphrasing. You should not be

doing all the talking. You should also not allow the patient to dominate all the happenings during the psychotherapy session.

Communication skills of the therapist include body language and non-verbal competencies. The manner in which you move your eyes, face, mouth, shoulders, arms, legs or other body parts during a therapeutic interaction is as important as what you speak or express through words. For example, a flushed face may mean anxiety or embarrassment, just a direct eye-to-eye contact means attentiveness. Leaning forward indicates interest, or leaning away implies withdrawal. Rate of speech being fast or slow, pauses and silence are also to be carefully cultivated and used correctly to convey appropriate meanings during the interpersonal communication.

The therapist temperament must combine playful friendliness as well as an appearance of seriousness. The conversations should be moving, appreciative and facilitative. Where needed, assertiveness should be applied by the therapist and also allowed to be exercised by the patient. The therapist must infuse a sense of trust, care and protection in his patient. It means that they must be able to achieve a working relationship or therapeutic alliance. Instead of playing the role of an expert, the therapist must strive to be an authentic person. You must be someone with whom the patient feels comfortable enough to open up and reveal oneself.

An effective therapist cannot and should not have a rigid schedule of treatment. It is important to realize that no one pattern can fit each and every one. Flexibility is to be adopted in all aspects of the therapy. Change is the basic element. People change, times change and circumstances change. So also, explanations for symptoms must change.

The ideal therapist would have to be a person of unusual honesty and integrity. Above all, the therapist should be a self-knowing person, who has realized his or her own positive and negative traits or strengths and weakness. Many times, the conflict ridden patient may end up throwing their inner emotions or thoughts upon the therapist as though they were real objects. The therapist must rise above such experiences and not react to them. You must always have an optimistic outlook and a strong belief in the possibility of personal growth and change.

It is important for you to develop or always maintain an open-minded, non-judgmental, positivistic, unconditionally accepting, and optimistic attitude towards the patient. Avoid making judgmental statements, such as, 'that is right' or 'what you thought was evil'. Some authors use the phrase 'ethical neutrality' to describe this temperament of 'equipoise' or being unbiased or impartial without having to be reactive and over-involved in each and everything that is going on during therapy. In short, check whether you score high on temperamental qualities, such as, emotional stability, open-mindedness, trustworthiness, ability to keep secrets, patience, sensitivity, compassion or genuine concern for others, great listening skills, empathy, self-awareness, discretion, and authenticity in your dealings with people.

1.9 CLASSIFICATION OF PSYCHOTHERAPY

There are many ways of classifying the different types of psychotherapy. One way is based on depth, duration and/or degree of engagement one has with the patient during the process of treatment. Based on the model of a continuum, beginning from the level of a supporting relationship, counseling may be viewed as a little more of professional relationship. This is followed by supportive psychotherapies which attempt a superficial level of treatments in order to maintain, restore or improve the affected individuals ego functioning, self-esteem and adaptive skills. Self-esteem involves the patient's sense of efficiency, confidence, hope and self-regard. Ego functions or psychological functions include relation to reality, thinking, defense formation, regulation of emotions, synthetic function, etc. Adaptive skills are actions associated with effective functioning. For example, following a traumatic personal experience, such as, death and bereavement, a person may require supportive therapies covering techniques like ventilation, catharsis, or talking out the pent-up feelings. The very fact that the person talks about the dying event several times in front of the mourners as it is done for over ten days in the Indian custom relieves ones grief or distress. It also helps them to regain their emotional strength to resume routine activities of daily life thereafter.

More deep than supportive therapy is in-depth interventions involving re-education and re-construction procedure. Re-educative therapy aims at giving insight to the patient, making them aware of their conflicts with deliberate efforts at goal modification and maximum utilization of existing potentialities. Examples of re-educative therapies are: relationship therapy, attitude therapy, psychobiology, reconditioning and re-educative group therapy. Re-constructive therapy aims at giving insight to the patient into his or her

unconscious conflicts by also attempting extensive alteration of their character structure. Examples of re-constructive therapy are: Freudian Psychoanalysis, Adlerian and Jungian Therapy, Object Relations Therapy, Self-Psychology, etc.

Another way of classifying the many different forms of psychotherapy is according to the recipient or target of treatment, such as, individual psychotherapy, group psychotherapy, family psychotherapy, marital therapy, divorce therapy, etc. Psychotherapy may also be classified in terms of the theory espoused by the therapist: Freudian, Jungian, Adlerian, Roger's Client-Centered Therapy, Behavioral, Body-Centered, Cognitive, Existential, Gestalt, Multi-modal, Paradoxical, Transactional, Transpersonal, Yoga, etc.

1.10 APPLICATIONS OF PSYCHOTHERAPY

There are many practical applications of psychotherapy. One way of looking at its uses can be based on particular age groups and/or specific disorders. It has been used for treatment of a variety of minor to major mental disorders, individuals with Alzheimers Disease, AIDS, those who are HIV positive as well as those with terminal illnesses such as cancer. A terminal illness is a disease or sickness that has no known cure and that will result in death. Within the field of psychiatry, it can be used with slight variations in the treatment of neurosis or minor mental disorders, psychoses or major mental disorders, and character or personality disorders.

Patients with different types and at various stages of cancer are known to suffer from symptoms like pain, disturbed or loss of sleep and appetite, tiredness, anxiety, and depression. Psychologically, many such patients begin each day on a negative note focusing on how many few days they are left with. Many of them feel isolated and misunderstood. They may suffer alternating bouts of rage, grief, denial, exhaustion, intense fears, stress and sadness. They tend to feel ill-equipped to deal with many day-to-day situations. Periodic psychotherapeutic sessions can help patients ventilate or share their bottled up thoughts and feelings.

Children with terminal illness may require special attention and help to avoid the long term problems that may follow them into adulthood. Parents of such children may have their own concerns requiring professional psychotherapeutic help. Of course, psychotherapy for the so-called 'dying person' has to be different from the psychotherapy that is generally offered to the other 'typical' persons. Probably, the therapy must be time limited and focused. The goals of such therapy must be modest. It must allow open communication, facilitate their expression, provide a supportive relationship, and bridge them with their

family members. Moreover, it should be well coordinated with other medical, nursing and religious practices of the person.

Group based psychotherapies are available based on age, gender, life roles, and clinical conditions. Psychotherapeutic groups may be support groups, skills training groups, and psycho-education groups. Support groups simply seek to provide help to members usually in non-professional or non-profit manner. For examples parents of children with hearing impairment join together to exchange information and tips of taking care of their special needs. Skills training groups are formed for activities like anger management, relaxation training or social skills training.

1.11 SUMMARY

To conclude, this unit must have helped you to understand the meaning, definitions, goals, nature and procedures involved in psychotherapy. You must have understood the difference between counseling and psychotherapy. You must have realized that it is one thing to read all about psychotherapy and quite another thing to become one or practice it effectively as a profession. The list of ideal qualities one needs to develop in order to become an effective psychotherapist is going to be life-long effort. None can claim to have become the ideal psychotherapist. The last part of this unit covered details on applications of psychotherapy in clinical practice according to different age groups and/or clinical conditions.

1.12 KEY WORDS

Alzheimer Disease
Confidentiality
Counseling
Ethical Neutrality
Family Therapy
Neurosis
Personality Disorders
Psychoanalysis
Psycho-education
Psychoses
Psychotherapy
Re-constructive Psychotherapy
Re-educative Psychotherapy
Supportive Psychotherapy
Therapeutic Alliance

1.13 CHECK YOUR PROGRESS

1. Define psychotherapy.
2. Mention the goals of psychotherapy.

3. Bring out the nature and content of psychotherapy as a field of study.
4. Describe the procedures used in the practice of psychotherapy.
5. Distinguish psychotherapy and counseling.
6. Highlight the personal qualities of an effective psychotherapist.
7. Attempt a classification on the various types of psychotherapy.
8. Write a note on the applications of psychotherapy.

1.14 ANSWERS TO CHECK YOUR PROGRESS

1) 1.3
2) 1.4
3) 1.5
4) 1.6
5) 1.7
6) 1.8
7) 1.9
8) 1.10

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UNIT- 2: ETHICS IN PSYCHOTHERAPY

STRUCTURE:

2.1 OBJECTIVES

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

- Meaning, definition, nature and content of ethics in relation to psychotherapy;
- Major ethical principles applied to psychotherapy;
- Interaction between law and psychotherapy; and,
- Special issues and considerations in the practice of psychotherapy.

2.2 INTRODUCTION

Critical situations and questions continually arise in the context of psychotherapy practice. What should I do next? Should I take the side of the patient or her spouse? Must I bring a closure to the therapy sessions or let it continue since it fetches me money for consultations from this wealthy patient? Can I go out for an evening dinner invite or accept the costly gifts offered by a patient? Shall I inform the secrets revealed in confidence by a patient to his or her family members? Such dilemma brings forth the questions like: Is there a 'right' thing to do? Is it 'good' or 'bad'?

Psychotherapists have coined the term 'ethical intelligence' (somewhat like general and emotional intelligence) as 'an active process of continuous awareness that involves constant questioning and personal responsibility' on the part of a therapist during clinical practice. In the previous unit, we have seen that 'ethical neutrality' and 'non-judgmental attitude' are important therapist qualities. However, these qualities cannot be easily achieved and maintained in practice. With loads of case work, urgency of meeting appointment deadlines, the need for paper work and record keeping, combined with your own exhaustion can all be quite challenging. There is risk that you may ignore the ethical issues in psychotherapy practice.

With the decrease in stigma associated with consulting mental health professionals in our country, more and more people are seeking or approaching specialists for psychotherapy. It has been shown that eighty per cent of those who seek psychotherapeutic help have improved. Evidence indicates that the therapeutic change is not temporary. It is well maintained over a longer duration of one's life. This unit proposes to take you through topics like what is ethics, and how it is different from being moral. You will learn about how to be

an ethical practitioner, what are your duties and obligations while treating patients, which techniques should be or should not be used, how to maintain privacy, confidentiality and the clinical records.

2.3 MEANING & DEFINITIONS OF PSYCHOTHERAPY

Ethics is a branch of philosophy that deals with moral problems and judgments. White (1988) defines ethics as 'the evaluation of human actions'. The word 'ethics' is derived from Greek 'ethos' which means 'habit' or 'custom'. Ethics investigates questions like 'which is the best way for people to live. What actions are right or wrong for given circumstances. We evaluate behavior as 'right' or 'wrong', 'good' or 'bad', 'virtue' or 'vice', 'justice' or 'crime', 'acceptable' or 'unacceptable' based on moral grounds that one uses. In this unit, we will be concerned with ethical issues related only to psychotherapy practice. This is important because therapists target the most internal, private, hidden, and intimate world of an individual. Many sensitive matters like suicide risk, boundary issues in interpersonal and sexual relationships bring out ethical issues during psychotherapeutic practice.

Several centuries ago, in 400 BC, the Greek philosopher Hippocrates offered the first professional code of ethics. It is even now taken as 'oath' by medical practitioners. In 1972, the American Psychological Association has issued a code of ethics to be followed by psychologists. All national and international institutions have their own declared ethical guidelines to be adopted and followed. A code of ethics is not to be confused with scope of practice for any given profession. It is used to define the standards or permitted actions, procedures and processes for the licensed professionals. It covers a range of responsibilities, types of patients or caseload and guidelines that determine the boundaries within which they can practice (Venkatesan, 2011; Rigger & Maki, 2004).

Therapeutic interventions on human subjects may sometimes involve children or young people with intellectual/mental disabilities. It could target vulnerable human subjects, such as, persons dependent on medical care professionals or those involved in unequal relationships, orphans or destitute, those with HIV/AIDS, peoples from minority or tribal communities. There are special ethical considerations that emerge when such human beings become part of therapy interventions. Since these participants cannot protect themselves owing to insufficient intelligence, education, resources or strength, the need and justification for ethical considerations for their inclusion becomes an issue of paramount importance. Some examples of instances wherein ethical concerns come to the forefront may be:

- Telling the patient to leave a religious cult and join another established one because you happen to be a member of it;
- Arguing exclusively for a monogamous relationship or specifically telling a patient to get divorced before getting married or going in for same gender relationship;
- Advising for or against abortion without allowing the patient to be the primary decision maker;
- Suggesting a caregiver to go for hysterectomy for or on behalf of an adult with moderate-severe intellectual disability;
- Accepting a significant gift from the patient;
- Accepting unremunerated personal services from the patient, such as, errands to the store;

In all or similar other instances, there can be no absolutely right or wrong action. As a psychotherapist, you cannot even recommend the patient to do or not do such a thing. The eventual decisions have to be their own. The situation is like a table game wherein you display all the cards before the patient before leaving the final choice or decision to them. You cannot and should not decide on their behalf in as much you may feel tempted or pressurized to do so,

2.4 ETHICAL PRINCIPLES

The core ethical principles that should guide behavior of psychotherapists are explained below:

(a) Doing no harm or Non-malfeasance: The psychotherapist is to continually strive for providing maximum benefit to their patients. There should be no damage caused to the client either intentionally or unintentionally. Therapists are expected to take reasonable steps to avoid harm to the patient as a result of the therapy. For example, giving treatments based on electrical shocks in the name of aversion therapy or electro-convulsive therapy raise several ethical issues. Sometimes, squirting of lemon juice into the eyes of a child throwing a problem behavior has been attempted in the guise of behavior therapy. Many times, drugs are prescribed at the slightest indication of sleep disturbance or inattentiveness in classroom. Also called as the principle of maximal safety, this practice ensures safety and risk free participation in the therapeutic process.

(b) Respecting Autonomy: Every individual has right to decide his or her life or on what actions they should take. They are masters of their own decisions. In as much it may be tempting or, sometimes, even asked for, the psychotherapist must stop from deciding for or on behalf of the patient and/or their caregivers. For example, a parent may come up with a question whether their intellectually disabled ward can be married or whether they should go in for surgical removal of their teenage daughter's uterus to safeguard her from unwanted pregnancy. The ethical practice would be to highlight all the pros and cons related to the issue and leave it for their choice or decision making. Inherent in this approach is the principle of voluntarism. This means that the choice of participation or otherwise in an ongoing therapeutic activity must be entirely left to the freewill, choice and self-determination of the patient. None can be forced to undergo a therapy nor can it be undertaken through a ploy or deceit. Sometimes, caregivers may ask whether you can visit their house casually in the guise of a 'friend' or whether they could bring their ward to your place as 'well-wisher' without telling the reasons for such a consultation. Such practices must be discouraged.

(c) Benefiting Others: All the actions undertaken by the psychotherapist must with the intent of benefiting the patient and their family members. It must not only be so, but also, it must appear so. However, in case of mishaps, accidents or injuries, there must be also appropriate forums for placing such grievances and herd by concerned or responsible authorities.

(d) Being Fair and Just: There should be no discrimination by thought or actions of the psychotherapist. You must learn to treat all patients equally irrespective of their caste, creed, gender, socio-economic status, ethnicity, language, race or religion. This is called as the principle of *distributive justice*. This is easily said than done. It is natural for most of us to give preference to someone who belongs to the same caste or language. But, one must become aware of such tendencies and see to it that you are not biased by way of giving preferential treatments to such persons.

(e) Being Faithful: Fidelity, loyalty, truthfulness, trust, promise keeping, and respect are not to be taken as shallow words in psychotherapy practice. You must be

sincere, frank, straightforward, and without an intention to deceive or mislead others. All this is to be practiced both in letter and spirit.

(f) Treating Others: It is important that you treat every person with respect, care and compassion, and yet maintain your personal distance as well as professional boundaries. All sorts of frivolous talk, empty gossip, exchanging messages, and unwanted chatting are to be avoided.

(g) Pursuit of Excellence: The practice of psychotherapy is a continually learning process. Every client is like another new book of experience even for your own personal growth and development. You must constantly become aware of any shortcomings in your own self to improve them the next time. Stating that you were 'unaware', 'uninformed' or 'not knowing' can be no excuse for the faults in ethical practice. Similarly, incompetence is inexcusable. Psychotherapists can be considered as unethical and short of competence if they become exploitative, irresponsible, insensitive, vengeful, or fearful during clinical practice. Competence is possession of required skill, knowledge, qualification and capacity to deliver the therapeutic services. Also called as the principle of *professional competency*, it is based on an understanding that the professional therapist has undergone required internship training, gather clinical experience, and is self aware of own and patient's emotional states while dealing with them. As a therapist, you should know your limits. Where or when do I refer the patients? When has the situation crossed beyond my level of competence? Such questions must be always in your mind during the practice of psychotherapy.

(h) Accountability & Transparency: The therapist is equally accountable and responsible for whatever actions, inactions or transactions that take place between the patient and self during and after sessions. You should not end up blaming the patient or others to escape from your responsibility. The therapy is undertaken only with professional intention and not casually and/or in outside relationships. The therapeutic contract must be realistic and clear. Therapists should not undertake therapy when their own functioning is significantly impaired by personal or emotional difficulties, illness, alcohol, drugs, or any other cause. Remember that everything that happens during therapy is subject to scrutiny or audit when the situation demands it.

(i) Privacy & Confidentiality: Psychotherapy respects personal privacy as well as confidentiality. Privacy is a state in which one is not observed or disturbed by other people. It is a state of being free from unauthorized observations or public attention. Confidentiality is more to do with protection of personal information. It means that the patient's information is kept only between the patient and therapist. It is not revealed to others. It applies to all verbal, written, recorded, computer stored materials pertaining to the therapeutic context. If there is no assurance of confidentiality, people will be reluctant to share about themselves. Then, they would derive less benefit from therapy. Confidential details can be divulged only with prior informed consent from the patient. Exceptions to the rule of confidentiality are when there is danger to the patient or another person at the patient's hands, or when there is a court order, or when the case material is being used for research or training without revealing personal details. Wherein patients are incapable of giving informed consent, the therapist should obtain consent from their legally authorized guardians.

(j) Promotional Activities: It has been debated whether availability of professional psychotherapy services could be advertised in the general public. Although advertisements for psychotherapy workshops frequently appear in professional journals, similar attempts in newspapers or mass media has been dubbed as quackery in popular psychology. Traditionally, psychotherapists have avoided or evaded the issue of marketing their profession. However, in recent times, yellow page entries, glossy brochures, social media, and websites have become the order of the day to promote professional psychotherapy services. Any publicity material in audio, video or written format should reflect accurately the nature of the service offered along with the training qualifications and relevant experience of the therapist.

(k) Recognition of Human Rights: A human rights approach to psychotherapy is strongly recommended. The therapeutic process should serve as an opportunity for patients to speak about their experiences, to describe the real effects of what they went through, and for this to be powerfully acknowledged. When these experiences are thoroughly explored, when the effects of particular actions and practices are richly acknowledged, it indirectly creates space for the person to

become aware of the effects of these practices on others, including the times they may enact them.

(l) Principle of Integration, Inclusion & Mainstreaming: Psychotherapy in the context of persons with special needs raises another important dimension regarding integration, inclusion and mainstreaming. Integration and inclusion is to do with efforts to bring back to mainstream all the diverse populations of children or adults who have been segregated from the main society. For example rather than detaining persons with chronic schizophrenia or moderate-severe intellectual disabilities in closed wards or residential schools, the approach must be to empower them to stay with their families, attend regular schools or jobs. In doing so, barrier free environments are to be promoted. The contemporary view is that persons with special needs have greater problem with the unfriendly and inaccessible barrier than with their own primary disability, disease or disorder. For example, the absence of ramp can be barrier to a wheel-chair bound person as much as the stigma of 'immorality' attached to every patient who has AIDS or is checked as HIV positive.

2.5 LAW & PSYCHOTHERAPY

Psychotherapy can get into conflict with the law of land on several accounts. The term 'law' includes all systems of civil and criminal law, including statute, common and case laws. Therapy and law work on dissimilar premises and in different directions. Whereas therapeutic practice works on the subjective nature of individual experience, law is concerned with objective and verifiable facts. Therapists work by cooperation with the client to co-construct their felt meanings and experiences. Law works on proceedings wherein one side wins and the other loses by proving or disproving statements between parties and witnesses. While therapists attempt to show themselves as neutral and non-judgmental, the law works towards a final judgment.

Whatever might be their position, ultimately, therapists are also bound by law. They need to abide by it. Mishap instances may arise owing to the therapist's negligence, incompetence or acts of omission and commission. It could be on a special invite as expert to witness. It could be because you have been accused of professional misconduct leading to physical or psychological damage. A frequent allegation by patients against therapists is one of sexual harassment or misconduct. In the west, there are guidelines prescribed or not prescribed by certain professional associations, such as, American Psychological Association,

American Mental Health Counselors Association, National Association of Social Workers and others. They prescribe many do's and don'ts regarding psychotherapist-patient relationships.

There are codes of ethics on therapist-patient physical touch, decision making boundaries and boundary crossing, sexual relationships, and unprofessional conduct. Sanctions and strictures leading to denial, suspension, cancellation of license to practice, monetary fines, and even imprisonment is prescribed for those found guilty. All this can happen because the professions of psychotherapist are recognized and regulated in the advanced countries. Clear entry level memberships, periodic in service updates, and licensing practices based on their levels of educational qualifications as well as years of are in place. There are laws and regulations for education and training thereby leaving no scope for quackery. Minimum number of hours by theory and practice is prescribed by law in different countries in order to become a licensed psychotherapist. Persons claiming specialty in certain specific methods of psychotherapy, such as, behavior therapy, psychoanalysis, client-centered psychotherapy, family therapy, cognitive therapy, psychodrama, or others must have proven credentials after the requisite training.

Laws of the countries along with their laid down rules and regulations stipulate clear job charts for practitioners as to who can undertake testing, diagnose, certify, initiate a therapy or be part of a usually multidisciplinary team to handle every patient or groups of patients. A few countries also offer reimbursement or refunding by social security institutions for any fees paid or expenses incurred on account of receiving psychotherapeutic treatments. Psychotherapists must be aware of the law and its implications for their clinical practice. They must know when to report about any infractions of the criminal law to an appropriate agency.

Many times, there are instances wherein it is not the therapist but the client who is in conflict with law. And, this matter may come to the notice of the therapist. For example, it might be the disclosure of a past criminal offence committed by the patient. In such instances, questions arise whether the therapist must maintain client confidentiality or not. Whatever may be the case, the therapist is accountable for the decision both from stand point of ethics as well as law. It is important to understand that many legal concepts are related to the ethical principles already explained. For example, fidelity or being faithful is linked to duty of confidence just as autonomy is to informed consent. Beneficence is to duty of care just as non-malfeasance or avoiding harm is to maintaining a minimum standard of care.

2.6 SPECIAL ISSUES & CONSIDERATIONS

While being in a therapeutic relationship may or may not be beneficial to the client, it is often asked as to what happens to the therapist. Those providing therapy run the risk of themselves becoming patients. In a national survey of psychologists' experiences, problems and beliefs carried out by Pope and Tabachnick, about 61 % reported clinical depression and 29% admitted to suicidal feelings in themselves following their working as psychotherapists. If this is so, there appears to be a grave risk for the helping professionals themselves requiring help. For this reason, providing personal therapy to other therapists was identified as an area of special concern by American Psychological Association. This led to coining of the terms 'psychotherapist patient's' or 'therapists therapist' (Geller, Norcross &Orlinsky, 2005). The common advice psychotherapists were recorded as giving to their fellow psychotherapists were:

- Treat all patients equally and consistently;
- Maintain clear boundaries and avoid dual relationships;
- Avoid over-identifying with patients;
- Remember that therapists are not immune to problems of other humans simply because they are therapists;
- Don't be overwhelmed or intimidated by performance anxiety;
- Listen empathically;
- Anticipate and attend to counter transference reactions;
- Clarify the treatment contact and goals early in the therapy;
- Be respectful;

Although the psychotherapist must be fair and just by making no discrimination between patients based on their diagnosis, age, caste, creed, gender, socio-economic status, ethnicity, language, race or religion, this is quite a challenge during clinical practice. Some of us have a natural flair and feel comfortable working with children. Some feel at ease with teenagers as some others are at home with elders or senior citizens. This is no cause for worry. Do not expect that you should feel comfortable or effective working with all types of people or problems. You can have your pick. If you think or feel that you are not cut out to work with Lesbians, Gays, Bisexuals and Trans-Genders (LGBT), you may choose another area. There are several areas as there are very many special populations to choose from to specialize and sharpen your psychotherapeutic skills. A few examples are: gender issues and domestic violence, HIV/AIDS, disability and impairments, cancer and terminal illnesses,

pediatric or geriatric populations, teenage and adolescent mental health, crime and victim studies, child abuse, chronic ill health, marriage and interpersonal relationships, problem behaviors and delinquency, traumatized patients, chronic mental illnesses, etc. Likewise, some of us feel competent in handling psychotherapy at individualized or one-to-one interpersonal level, while others are adept to handle group based psychotherapies.

Actually, the special considerations for psychotherapeutic treatment vary with each and every different type of population. For example, the geriatric end-of-the-life care patients cannot be expected to be educable. They may not be able to bring about drastic changes in their daily routines or life style. The common themes of concern for geriatric psychotherapy are restoration of a positive self-concept and self-esteem, dealing with loss, ageing, illness, possible dependence, or even death and dying. Likewise, special considerations for employing psychotherapy with children having disabilities include: (a) modifying therapeutic techniques to fit the child's cognitive, language, and communication strengths and preferences; and, (b) considering the child's functioning within the larger social-ecological context that includes the family. Involving the parents, siblings and grandparents may be required for providing optimum benefits to such children.

Psychotherapy with children in general as compared to those addressed upon adults need special considerations. Children, for example, are conceptually more concrete, linguistically less competent, and less introspective than adults. They are less likely to see themselves as having difficulties and may not find any value in talking about their problems. A frustrated parent may forcibly take his or her child to a therapist and say, 'If not with me, at least you can open up and talk to him about your problems!' Nothing much is likely to happen. Children are often taken to treatment due to concern of others rather than as a result of their own level of personal distress. Hence, they are likely to be less motivated to participate in the therapy. And, you are likely to experience greater challenges as a psychotherapist dealing with them.

When it comes to children, emphasis must be placed on non-verbal communication and interactions than in the case of adults. Thus, use of drawings or play activities can be a useful medium for psychotherapy with children. Since the child is dependent on others, it may be considered whether such significant others are also to be roped in as partners during therapy. It is to be further noted that child psychopathology is different from adults. A child may use a disease symptom to communicate conflicts or distress. For example, a child with

academic delay may manifest vomiting or fainting to convey that she is unable to cope with school. You must have the acumen to read children through and beyond their symptoms.

There are unique cultural issues that emerge when the target of psychotherapy is women. There is a lot of gender stereotyping that goes on for or against women all over the world including our country. Oppression, abuse and intimate partner violence is common which often go unreported. There is adverse or idealized portrays of women in media. Gender of the patient, therapist, or their interaction has impact on treatment outcomes. However, when compared with the form of therapy, the success of the therapy differs between men and women.

2.7 SUMMARY

In sum, by reading this unit, you must have understood the meaning, definition, nature and content of ethics in relation to psychotherapy. You must have learnt about the major ethical principles that are applied to psychotherapy. The relationship and interaction between law and psychotherapy was explained before dwelling upon the special issues and considerations in the practice of psychotherapy with specific groups or target populations.

2.8 KEY WORDS

Accountability	Autonomy
Confidentiality	Distributive Justice
Ethics	Inclusion
Integration	Mainstreaming
Malfeasance	Privacy
Professional Competency	Transparency

2.9 CHECK YOUR PROGRESS

(a) Define ethics. Explain its nature and meaning.

(b) Narrate few examples of ethical dilemmas encountered in psychotherapy practice.

(c) Attempt an essay on various ethical principles underlying the practice of psychotherapy.

(d) Bring out the interaction between law and psychotherapy.

(e) Highlight the special issues and their considerations involved in psychotherapy.

2.10 ANSWERS TO CHECK YOUR PROGRESS

(a) 2.3 (b) 2.3 (c) 2.4 (d) 2.5 (e) 2.6

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UNIT - 3: THERAPEUTIC RELATIONSHIP

STRUCTURE:

3.1 OBJECTIVES

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

- Meaning, definition, and importance of therapeutic relationship in psychotherapy;
- Various components of a therapeutic relationship;
- Measurement of therapeutic relationship; and,
- Drawbacks in establishing therapeutic relationship.

3.2 INTRODUCTION

Psychotherapy sessions require the patient to change completely on how they think and rationalize behaviors. It can be a stressful overwhelming emotional experience. A strong therapeutic alliance or the felt positive bond between the therapist-client can help you through it. Research has shown that patients make some improvement between making a telephone call to fix an appointment with the therapist, and the actual first session of therapy itself. They feel better just in anticipation of meeting the therapist. It may be because they feel that they have taken control of things, that they are willing to change, or that there is someone with whom they can at least ventilate. All this can make them feel less anxious or depressed.

3.3 MEANING AND DEFINITIONS OF THERAPEUTIC ALLIANCE

A therapeutic alliance or relationship is a helping coalition. Also called 'working alliance', it is the relationship between a healthcare professional and patient or client. The two persons engage with each other hoping to effect a beneficial change in the client. In the course of this relationship, the client shares intimate thoughts, beliefs, and emotions regarding certain issues in question. In the relationship, the therapist provides a safe, open, trusting, and non-judgmental atmosphere wherein the affected individual can be at ease. It is the mutual trust between the therapist and client that keeps the sessions moving even during all difficult or painful times. The therapeutic alliance is important for many reasons. Only when it is formed, the client feels comfortable to open up with ones concerns or problems. It also helps the therapist to gather the client's perspective or point of view on the given problem. It is only then that the therapist can provide the most appropriate treatment to address the issues.

The concept of therapeutic alliance can be traced back to Sigmund Freud. According to Freud's psychoanalysis, the therapeutic relationship is explained as comprising three parts, viz., working alliance, transference/counter transference and real relationship. Therapeutic alliance or working alliance is not to be confused with therapeutic relationship. While transference and counter-transference reflects a neurotic attachment of childhood impulses in an adult form, therapeutic alliance denotes the attachment between the therapist and patient which is qualitatively different than the one based on childhood experiences.

Greenson (1965) defines working alliance as 'a reality based collaboration between patient and therapist'. Luborsky et al (1983) define therapeutic alliance as 'patient's experience of treatment or relationship with the therapist as helpful in achieving the patient's goals'. Gelso & Hayes (1998) define therapeutic alliance as 'the joining of a client's reasonable side with a therapist's working or analyzing side'. Bordin (1979) viewed working alliance as consisting of three parts: tasks, goals and bond. Tasks refer to what the therapist and patient have mutually agreed to undertake in order to reach their well laid goals. The bond refers to the mutual trust and confidence that the performance of tasks given to the client as they closely reach towards their goal. According to Safran & Muran (2000), therapeutic alliance is 'the mutual human response of patient and therapist to each other, including undistorted perceptions and authentic liking, trust, and respect'.

3.4 PURPOSE AND GOALS OF THERAPEUTIC ALLIANCE

The purpose of therapeutic alliance is to assist the individual in therapy to change his life for the better. The relationship is essential to share intimate thoughts, beliefs and emotions. The therapist must ensure a safe, open and non-judgmental atmosphere wherein the patient can be at ease. On their part, based on the nature of their alliance, the patient develops a sense of trust, respect, and congruence to relate with the therapist. The alliance gives an opportunity for therapists to demonstrate empathy and genuineness. It facilitates the curative process of therapy. It fosters engagement in specific techniques of therapy. Therapeutic alliance is seen as necessary but not a sufficient change factor in psychotherapy. Anesthesia is needed during the start of surgery. Eventually, the surgical procedures themselves become important. Similarly, therapeutic alliance has no value of itself. It allows the therapist to use technical interventions, such as, say identifying automatic thoughts in a patient, searching for their alternative attributions. Not much of therapy can be done before a strong positive relationship is achieved through therapeutic alliance.

Positive therapeutic alliance seeks to promote a directed therapeutic experience. Without it, the therapy may drift into a social exchange without any meaning or content. It may not result in meaningful transactions. In short, you can make no progress in therapy without it. Important issues may be avoided, the pace and direction of change may slow down, and no purposeful end will be achieved. The purpose of therapeutic alliance is to stabilize the relationship and even help in initial symptom reduction. Hope and positive expectations are activated even though problems may not be completely resolved. From time to time, it will also help the patient to advance to the next level.

3.5 COMPONENTS OF THERAPEUTIC ALLIANCE

The nature and content of therapeutic alliance vary depending upon ones approach to psychotherapy. Therapeutic relationship in psychoanalytic and cognitive-behavioral approach, for example, can be different. In psychodynamic approach, the relationship focus on transference, counter transference, resistance and defense mechanisms. The aim of these approaches is to enable the patient to develop insight into their problems through interpretation. In cognitive behavioral approach, the relationship is active-directive and psycho-educational. The aim is to teach patients cognitive and behavioral techniques that they will practice in order to alleviate their problems. Therefore, therapeutic alliance seeks to demonstrate that the therapist is an expert, credible, trustworthy and attractive. Other things include the therapy setting, status of therapist and patient expectations. The important components of therapeutic alliance are:

(a) Genuine Interest:

A good therapist gives the client a clear and full undivided attention. He listens to what all that the client has to say by asking pertinent clarifying questions. The therapist should not be attending phone calls, shifting papers, checking emails, or appear preoccupied with other things when the session is in progress.

(b) Specialization:

The therapists need to have a complete understanding on what the client is going though in order to help him or her. This means that you must have the background about what a given patient is suffering from, as well as details about their personal, socio-economic, language, religious, race, caste, cultural, and ethnic background.

(c) Comfort:

A minimum comfort level must get established between the therapist and his client in order to develop a successful therapeutic alliance. This consonance of feelings

between them across sessions is called rapport. This can be developed by asking great questions, with some good sense of humor, or by showing empathy.

(d) Common Goals

There should be mutually shared goals between the therapist and his client so that both can work together towards the same direction. You must have a common ground for the relationship to blossom and grow.

Therapeutic alliance is not an all or none phenomena. It is not something that simply happens overnight. It means that the therapist and patient need to constantly struggle and work towards it. Sometimes it may 'click' and happen with one therapist. Despite all efforts, it may simply not happen at all happen with another. When a patient is beginning therapy, it is fine to consult several professionals. Sooner or later, one may settle down to seeing one therapist regularly. Of course, never getting to find any therapist at all despite several searches can also mean that it is merely a escape or window shopping tendency.

According to Carl Rogers (1951) the active components of therapeutic alliance are: empathy, congruence and unconditional positive regard. Going by the understanding that therapeutic alliance varies according to stages in a therapy, it has been proposed that there are two types. The first is found in the early phases of therapy and is based on the patient's perception of the therapist as supportive. The second type, more typical of later phases in the therapy, represents the collaborative relationship between the therapist and patient. This is when both share the responsibility of working in union to achieve the goals of therapy. When defining therapeutic alliance in the context of group therapy, it is important to consider elements like group cohesion, and belongingness to the group that brings about a working alliance and which does not arise in the case of therapist-client dyad.

3.6 IMPORTANCE OF THERAPEUTIC ALLIANCE

A strong therapeutic alliance can make a big difference during treatment. It forms the foundation for any therapy. By creating a strong bond between the patient and therapist, it will lay the path for recovery. The following points may be taken as important principles underlying the establishment of therapeutic alliance:

- Select the patient appropriately;
- Facilitate the development of bond aspect of therapeutic alliance by conveying warmth, respect, and genuine interest;
- Outline the therapeutic rationale including tasks and goals at the beginning of treatment;

- Establish realistic goals;
- As therapy proceeds educate or remind patients about the purpose and function of therapeutic tasks that do not make sense to them;
- Establish and maintain a therapeutic focus;
- Maintain a balance between activity and receptivity;
- Detect alliance ruptures and address them before they turn serious or unmanageable;
- Prepare patients for termination before it is too late

While a healthy therapeutic relationship may foster positive benefits to the patient, an unhealthy one can wreck the whole scheme of things. A therapeutic alliance can rupture or breakdown owing to several factors. It may be due to the therapist qualities of conveying an impression as though they were not listening. It could be because they were rigid, overly structured, critical, insensitive, uninvolved or uncertain during therapy sessions. They might have been perhaps using inappropriate self-disclosure. How does one know that a therapeutic alliance is failing? The warning signs of a crumbling working alliance are:

- There are no clear goals of the ongoing therapy;
- Therapist has become judgmental about the client's behavior;
- There is increasing tendency of blaming each other;
- There are no time lines or plan of action about how the therapy should proceed or when it is to be terminated;
- When one or the other between the therapist or client talks too much or too little;
- When the therapist tends to push his or her decisions on the client;
- When the client awaits and expects for a ready-made decision to be made and delivered by the therapist;
- Too frequent 'confrontations' or 'withdrawal' between the therapist-client;
- When the therapist has become inactive;
- When the therapist-patient relationship has turned romantic or sexual;
- When there is show of pity, friendship, humoring the patient or the patient's family;
- Tacit collusion or mutual avoidance of areas that need to be explored;
- Receiving or giving gratifications that do not serve any therapeutic purpose;

In beginning stages of the breakdown or rupture in therapeutic alliance, efforts can be made to repair the situation by using techniques like acknowledgement of client feelings, negotiation, attempting explorations of parallel situations outside therapy, arriving at

consensus or shared understanding of the client's dissatisfaction and attempting re-negotiation on how to work together. Sometimes, new styles of relating or attempting alternative ways of managing the blocks may be discussed. However, when a therapeutic alliance breaks down entirely, it would be best to terminate the therapy, and/or recommend for another therapist.

3.7 ESTABLISHING THERAPEUTIC ALLIANCE

The relationship between the therapist and client needs to be consciously developed. It will not happen on its own. It must be meticulously planned and fostered. The first meetings are crucial. Initial impressions are formed on either side. Mutual goals and roles are to be delineated. Action plans need to be worked out. The professional boundaries may have been clearly drawn. The scope and limits of confidentiality must be enunciated and respected. The expectations of the patient must be drawn and understood. Realistic and self-articulated goals keep things clear. There must be mechanisms in place to periodically check or monitor progress. Are we progressing as per the plan?

According to Sommers- Flanagen, the three important ingredients that will foster therapeutic alliance are: (a) Goal consensus between the therapist-client; (b) Collaboration on therapeutic tasks; and, (c) Emotional bonding. You must know what the client wants. Goal consensus or agreement involves listening carefully and closely to the patient's distress and hopes before being able to articulate them back to the patient. Collaboration on therapeutic tasks can cover history taking, home assignments, self-recording, diary keeping, practicing muscle relaxation techniques, etc. Emotional bonding comes from compassionate and empathic listening or humor or by giving positive and supportive feedbacks. The power of relationship between the therapist-client is shown to be more important than even the type of kind of psychotherapy techniques that are used for the treatments.

It is also important to give enough room for the patient's to express, and release their thoughts or emotions. They must feel that they are being heard, accepted, and understood. If the therapist dominates the proceedings session after session, the alliance is likely to suffer. It requires a lot of ingenuity, creativity and patience particularly to enable a silent, passive-dependent or introverted patient. Such patients may initially speak little, appear anxious, make poor eye-contact, or appear lost in their own world. With involvement in a mutual activity, for example, the ice can be broken and mutual communication could be restored. Another example is the hostile and aggressive client who refuses to share anything or

everything with the therapist. In such instances, the therapist must be careful not to show themselves as some kind of authority figure or pretend as being the representative for or on behalf of their parent. Another technique would be to allow them to give feedbacks on the ongoing therapeutic process.

Despite best efforts, a therapist-client relationship can hit roadblocks. There might be occasions when the patient puts up resistance. Their resistance is likely to be more if they have been sent for the therapy by someone and they have not come on their own accord. A student once spoke up aggressively: 'You better give all this therapy to my father than to me. He is the one who has the problem and needs it, not me!'

A positive therapeutic alliance requires giving sufficient emotional supports to the individual and members of the family. It needs successfully managing negative emotions so that they are not hurt. It also requires that the therapist regulates his or her own negative emotional reactions for or against the client or their family members. Given below are a few tips to establish therapeutic alliance:

- Speak directly, simply and honestly.
- Allow two-way communication.
- Ask about the patient's thoughts and feelings about being in therapy.
- Focus on the patient's distress.
- Acknowledge the patient's doubts, or confusions.
- Explore the purpose and goals of treatment.
- Show tolerance and avoid judgmental comments.
- Never pass a condemning or moralizing statement to the patient's failures.
- Appeal to the patient's positive side to build self-esteem.
- Accept that therapy is difficult and challenging.
- Ask open ended questions.
- Be a good listener.
- Ask patient's feedback about every session.
- Maintain a moderate to high level of activity for both therapist and patient.
- If necessary, feel free and make use of adjunctive treatments including medicines.
- Show an involved active attitude.
- Manifest willingness to develop and contribute to a real relationship.
- Make attempts to develop positive transference.

- Show empathy willingness to understand and concern for the patient.
- Support and encourage the patient's healthy adaptive efforts.
- Treat and respect the patient as human being.

3.8 MEASUREMENT OF THERAPEUTIC ALLIANCE

Yes. Several scales have been developed and standardized to assess the nature and strengths of patient-professional relationship in therapy. Examples: Working Alliance Inventory, Barrett-Lennard Relationship Inventory, California Psychotherapy Alliance Scale, Scale to Assess Relationships, Pennsylvania Scales, Toronto Scales, Therapeutic Bond Scales, etc. Typical statements in these instruments requiring clients to rate would be, 'confident that the therapist and I were working well together' (task oriented), 'that we talked about the things that were important to me' (goal oriented), or 'like the therapist understood me/that the therapist was honest and sincere' (bond oriented). Alliance should be measured frequently in the manner of feedback form so as to monitor the ongoing therapy.

Apart from the use of scales to therapeutic relationship, Patient Satisfaction Surveys, Rate Your Relationship Survey, and Interaction Analysis have also been attempted. Others have tried narrative analysis and critical consultation analysis by seeking to identify and expose hidden tensions within a therapeutic relationship. There are many problems in the use of these techniques. The elderly, the poor, and those limited by education or social exclusion will less likely report dissatisfaction. Factors like knowledge of the therapist, trust, loyalty, and positive regard may bias the responses of the client in favor of the therapist.

3.9 DRAWBACKS IN ESTABLISHING THERAPEUTIC ALLIANCE

In as much it may be the ideal of every psychotherapist to establish optimum therapeutic alliance with every client it may not be always possible. There are certain psychiatric conditions, wherein the attempts may be formidable. Special issues and problems arise in the formation of therapeutic alliance in patients with narcissistic, borderline, and paranoid personality disorders. Such patients have troubled interpersonal attitudes and behaviors that will complicate their engagements with the therapist. In dealing with personality disorders, such as, schizotypal, schizoid and paranoid, wherein there is profound impairment of interpersonal relationships, the therapist must use appropriate strategies. For personality disorders like antisocial, borderline, histrionic and narcissistic types, therapists need to exercise care not to push the limits beyond during their attempts to establish

therapeutic relationships with them. For patients who are anxious, fearful, avoidant, dependant, and obsessive-compulsive, they are generally emotionally inhibited and averse to interpersonal conflict.

There are special challenges to establishing therapeutic relationships with vulnerable populations like children, adolescents, and elderly. A few more challenging instances are victims of physical or sexual abuse, those with risk for suicide, or those with multiple disadvantages. Children and adolescents are placed in therapy owing to directions from their teachers, parents or caregivers. They do not come to therapy on their own. Therefore, alliance with them will be more difficult, complex and challenging. Factors like respect for adult, openness, freedom, trust, and role characteristics are important especially while establishing therapeutic alliance with adolescents. When engaging in therapeutic relationship with children and adolescents, it must be noted that there is third dimension of continually engaging their parents or family too. Ice breaking activities through art, painting, games or play is frequently recommended depending upon their age and developmental levels before engaging young clients in psychotherapy. Children should be informed about their problems in an appropriate manner.

3.10 SUMMARY

In sum, a therapeutic relation is said to exist when one person offers help, support or caring to another person in need. At an informal level, relationship exists when a mother washes and puts a plaster on her child's bruised knee or when someone offers a shoulder massage to a stressed friend. Of course, the helper may not be qualified or paid to do so. The relationship may be reciprocal or familial and not based on contract. A professional therapeutic relationship as we have seen, exists when one of the two people has skills and expertise which the other person wants to alleviate suffering. This relationship happens in a particular setting and ends when the services are no longer required. There are critical issues which manifest uniquely to a therapeutic relationship, such as, the length of such a relationship, intimacy of information shared, use of physical touch and working with vulnerable groups that needs to be understood in psychotherapy practice. This unit has covered the various aspects of meaning, definition, and importance of therapeutic relationship in psychotherapy, its components, measurement and drawbacks that may emerge while establishing therapeutic relationship.

3.11 KEY WORDS

Therapeutic Alliance — Working Relationship

Emotional Bonding — Vulnerable Groups

3.12 CHECK YOUR PROGRESS

1) What is therapeutic alliance?
2) Highlight the purpose of therapeutic alliance
3) Explain the nature and meaning of therapeutic relationship.
4) Expand the components of therapeutic alliance.
5) Enumerate the importance of therapeutic alliance.
6) Suggest tips and techniques to establish therapeutic relationship during psychotherapy.
7) Explain how therapeutic relationship can be measured.
8) Give the drawbacks or difficulties in establishing therapeutic alliance with special populations any vulnerable groups.

3.13 ANSWERS TO CHECK YOUR PROGRESS

1) 3.2
2) 3.3
3) 3.4
4) 3.5
5) 3.6
6) 3.7
7) 3.8
8) 3.9

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UNIT- 4 : INDIAN PERSPECTIVES

STRUCTURE:

4.1 OBJECTIVES

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

- Meaning, classification and characteristics of Indian vs. Euro-American perspectives to psychotherapy;
- Concept of holistic mental health;
- Salient features of psychotherapy as propounded in ancient Indian thought, Buddhism and Bhagvadgita;

4.2 INTRODUCTION

While we have seen the western approaches to psychotherapy so far, the uniquely Indian perspective on this subject was not discussed. The Indian approach is largely based on faith orientation. Other unique feature of psychotherapy in India is that it is not meant only for the sick. It is also meant for the healthy. The patient and therapist are not viewed as equals. The therapist is always viewed as being on a higher pedestal-almost equal to teacher or god. The patient has to accept whatever the therapist says. In the Indian view, everyone is not considered as fit for psychotherapeutic relationship.

With increasing liberalization, privatization and globalization, things are changing even in our country. The divide between the rural-urban is no more as wide as it was a few decades ago. While long term case intensive and deeper forms of individualized psychotherapy may be a luxury or even unaffordable to many people in the country, short term supportive psychotherapies may be preferred. India has a hoary past covering Vedas, Puranas, Upanishads, and the great epics in Ramayana and Mahabharata. All these are alive to most typical citizens. The concepts of Moksha, Reincarnation, Karma and Dharma are widely held by most people with great conviction. Given this background, formal training in psychotherapy is almost non-existent in the country. There is also stigma attached to psychiatry, psychology and mental diseases. Lay persons dread or avoid consulting mental health professionals. Evidenced based research on the subject is also sparse. Professional bodies for training and certification based on Indian approaches are scattered.

4.3 INDO-EUROAMERICAN PERSPECTIVES

JS Neki classified psychotherapy in India under the following headings:

A. Mystical-Metaphysical Traditions
B. Medical Traditions
C. Recent Trends

4.3.1 MYSTICAL-METAPHYSICAL TRADITIONS

These traditions are further sub divided into Buddhist, Yogic and Bhakti or Devotional traditions. The Medical traditions cover Ayurveda, Unani and British Medicine. In recent times, closer to 19th century, psychoanalytic psychotherapies and contemporary university based academic psychology seem to be in vogue. They will be discussed at the end of this unit.

One of the oldest sources of knowledge available in the country are the Vedas. The term is derived from 'vid' which means 'to know'. The Vedas are written in the form of hymns or mantras composed around 1500 BC. The Vedas has undergone several revisions given that they were transferred only by the word of mouth. There are four forms of Vedas: the Rig, Yajur, Sama and Atharva. Each Veda has four parts. They are:

- Samhitas: Consisting of prayers in metrical hymns called mantras;
- Brahmanas: Written in prose and explain the hymns;
- Aranyakas: Treatises for hermits and saints who concentrate on meditation, asceticism, retired into the forests;
- Upanishads: Philosophical treatises with information on mystical aspects of Vedas.

Apart from four Vedas, there are four subsidiaries called 'Upa-Vedas', which cover:

- Ayurveda: Holistic system of treatment and maintenance of good health. Use techniques like oil massage, mud bath, herbs etc.
- Dhanurveda: Science of archery, use of weapons.
- Gandharvaveda: Treatise on dance, music and theatre. Origins to Sage Narada
- Arthashastra: Treatise on polity and public administration.

All the Vedas are deemed canonical i.e., they are ought to do or be prescriptions for daily practice. Health or Swasthya is understood to be based on equilibrium of the three principles of Air (Vatha), Bile (Pittha) and Phlegm (Kapha). Daily routines of early rising, bathing, oil baths, gargling and regulated sleep is advised. A value based principled life is recommended. Righteous conduct and ethical living is stressed. Purity, truth, self-faith and fearlessness are considered four virtues for happy and healthy living.

4.3.2 MEDICAL TRADITIONS

The Indian traditions have evolved indigenous medical systems of treatment, such as, Naturopathy, Ayurveda, Yoga Psychology, etc.

(a) **Naturopathy**

Naturopathy covers both therapeutic and prophylactic aspects or curative and preventive aspects of health or disease. This system views nature as healer. The five elements, viz., earth, air, water, fire and ether are primordial. Fasting is recommended as best medicine. It is called as Ether Therapy or Akashopasana. Sun bathing is called Fire Therapy or Tejopasana. Water therapy is Jalopasana. Air Therapy is Vayupasana. Eating pure fruits and vegetables is Earth Therapy or Prithvipasana. Individuals who abide by the natural ways of life are Yogis. Those who indulge in the senses are called Bhogis. Excess indulgence leads to ill health or Rogi and Drohi.

(b) Ayurveda:

Ayurveda literally means life and knowing. In other words, it is simply the science of life. Ayurveda believes in the power of five elements or PanchaMahabootas. They are: Akasha (Ether), Vayu (Air), Agni (Fire), Aapa (Water) and Earth (Prithvi). The sixth component is Atma (Life spirit). The human body is understood to be made of Doshas (bio humors) Dhatus (Body matrix) and Malas (Excretion products). The three bio-humors or Tridoshas are: Vata-Pitta-Kapha. The Dhatus are Rasa (Plasma), Rakta (Blood) and Mamsa (Muscles). There is also mention of Meda (Fatty tissues), Asthi (Bone), Majja (Bone Marrow) and Shukra (Hormones). Health is a state of equilibrium between all the elements. Ill Health or Disease is result of faulty life styles.

Excesses of Rajas-Tamas can result in illness. Seasonal changes are another cause of disease. Food habits and healthy eating patterns is the cornerstone of maintaining good life. Ayurveda covers extensively on women health and hygiene. Mental disorders like anxiety, passion, anger, grief, inferiority complex, epilepsy, psychoses, and alcoholic psychosis is recognized. A scheme for Mental Status Examination is given by covering details, such as, sheela (habits and temperament), chesta (psychomotor activity) and achara (conduct). A course on therapy occurs as: Daivavayapashraya (Divine therapy), Yuktivyapashraya (Drug therapy) and Satwajaya (Psychotherapy). Other recommended forms of therapy are:

- Daivavyapashraya: This involves wearing sacred herbs, precious gems, propitiatory rites, etc
- Yuktiyapashraya: This covers physical methods of drug administration
- Satwajaya: This refers to treatment without drugs like psychotherapy as well as preventive aspects of mental health.
-

(c) Yoga Psychology:

Yoga Psychology dates back to more than 5000 years ago. Acharya Patanjali is attributed as its founder. Yoga literally means 'yuj' is union with god to attain mukti. It is the science of consciousness. It provides mastery over all stages of consciousness. There are different schools of yoga:

- Bhavana Yoga: This indicates devotion through Jnana, Bhakti and Karma
- Patanjali or Ashtanga Yoga: This involves eight steps, viz., Yama, Niyama, Asana, Pranayama, Pratihara, Dharana, Dhyana and Samadhi.
- Kundalini or Shakti Yoga: This involves energy as power to stimulate the chakras.

According to yoga philosophy, reality is viewed as unchanging and unmoving. The world as we perceive it, with its perpetual change, is illusion or Maya. Originally there was only one self in the form of undifferentiated energy. It was infinite, unchanging and formless. Later, the differentiation occurred. The split between subject and object or the individual self and universal self continues to remain. Yoga attempts to see though the illusion and perceive the true reality. Truth or reality are viewed as, both, unchanging and unmoving. The attempt to re-establish the original union between the individual and universal self is yoga. This can be achieved in a state of enlightenment. Enlightenment will then bring liberation from all pain and sufferings and then lead to lasting happiness.

Yoga philosophy explains four paths: Karma or Deeds, Bhakti or Devotion, Jnana or Knowledge and Rajas or Valor. Yoga has eight limbs: Yama, Niyama, Asana, Pranayama, Pratihara, Dharana, Dhyana and Samadhi.

- Yama is ethical conduct toward others;
- Niyama is ethical conduct towards self;
- Asanana is practice of yoga postures;
- Pranayama involved breathing exercises to control mind;
- Prathyahara is to withdraw ones attention from body and its senses;
- Dharana is concentration of the mind;
- Dhyana is meditation; and
- Samadhi is uninterrupted contemplation of reality.

Yoga believes in three bodies: Physical (seeking food and health), Astral (involved in sensation, perception, thinking, feeling and decision making) and Causal Body (feeling the ultimate blissful health). The yoga system recognizes SEVEN chakras and 72000 Nadis. The three main Nadis are Ida, Pingala and Sushuma.

Asana or Postures have therapeutic value. A typical yoga session includes:

- Pranayama or breathing;
- Dhyana or Meditation;
- Kapalbhati or purification or breath cleansing;
- Mantra chanting or guided practice;

The various examples of mantras are chanting of AUM or OM NAMAH SHIVAYA. The term YANTRA denotes the sequence that is followed in the performance of Asanas. There are many asanas. Some popular and regularly practiced asanas are: Surya Namaskar, Bhujangasana or Cobra pose, Paschimottsasana or Sitting Forward Bend pose, Shavasan or Corpse pose, Vrikshasan or Tree pose, Thadasan or Mountain pose, Matsyasan or Fish pose, Halasan or Plough pose, Chakrasana or wheel pose, etc.

Many people confuse between performance of yoga asanas and general fitness exercises like aerobics, calisthenics, or fast walking. Physical exercises involve rapid forceful movements, increased muscle tension, involving fatigue and high risk for injuries. Yoga asanas are slow dynamic and static movements. There is no or low risk of muscle injuries or ligament tearing. The effort on the part of practitioner is minimal and relaxed. Rather than consuming energy, it is an energizing activity. It is an activity which balances the opposing muscle groups. No yoga posture is to be performed till the point of feeling pain. Thus, the regular practice of yoga is shown to provide physical and mental benefits. Among the physical benefits, yoga is shown to improve body flexibility and balance, cardiovascular endurance, digestion, abdominal strength or enhanced overall muscular strength. It has been used to achieve relaxation of muscular strains, as means to gain weight control, increase energy levels, and enhance the immune system. Among the psychological benefits, yoga has been shown to relieve stress, tackle blood pressure, headaches, respiratory problems, nerve or joints related problems, sleep or stress related disorders as well as give intellectual enhancement.

(d) NadiPariksha and Chikitsa or Examination and Treatment of Pulse:

An offshoot of Ayurveda and Siddha, this form of traditional treatment involves diagnosis of disorders by reading the pulse. According to all systems of medicine, the artery is the main channel to supply blood to all parts of the body. The examination of pulse involves placing

ones index, middle and ring fingers on the patient's forearm, a little below the writ, on the radial artery. There are various levels of pressure that has to be applied to read the pulse. While reading the pulse, the practitioner comes to conclusions as to why the patient is experiencing the current state. The focus is on the cause of disease rather than its symptom. After diagnosis, a treatment chart is prepared wherein the patient is prescribed a combination of appropriate diet, herbal remedies, yoga, psychological, spiritual and past life remedies. Catharsis or allowing patients to pour out stored emotions in the sub-conscious and counseling is given importance in this form of treatment. During examination, the patient is advised to be on empty stomach with permission to only drink plain water at room temperature. Hence, it is carried out early in the morning before the patient starts indulging in daily activities. This treatment is not applicable for children below three years.

Agasthya, the great Dravidian guru, is attributed as the founder of Siddha System of Medicine. This approach understands health and wellness at sub-atomic level. The term Siddha comes from the word Chitta which refers to atomic particles that are the building blocks of the universe as well as human consciousness. They believe in ten principle Nadis or nerves. Its herbal treatments do not cause any side effects. This system of treatment has been used for a variety of conditions like infertility, bladder stone, psoriases, piles, asthma, hypertension, diabetes, migraine, sinusitis, and neurological disorders. The system classifies diseases into three stages depending upon their current status and prognosis: saadhyam, klishtasaadhyam and asaadhyam. The system believes that every patient is unique. Therefore, its practitioners always try to treat the patient rather than the disease.

Despite the advantage of their low cost, reduced side effects, effectiveness with chronic conditions, and widespread availability, these types of treatments are inappropriate many conditions, such as, an acute appendicitis, a broken leg, or a heart attack.

These approaches are not based on an objective prescription of medicines or dosage. There is poison risk associated with few wild herbs, or when they interact with allopathic medicines. There is no market regulation on the manufacture, or distribution of drugs used in these types of treatments.

4.3.3 RECENT TRENDS

The scientific discipline of modern Indian psychology owes itself to its western counterparts since the turn of 19th century. While ancient Indian psychology is rooted in religion, spirituality, art, mythology, morals, metaphysics, mysticism and philosophy, its

modern trends are born out of interaction and influences from the west. The origins, genesis and development of Euro-American influences upon contemporary Indian psychology had its beginnings in pre-independent India. The chronology of only important events is highlighted below:

1905 Dr. BrajendraNath Seal (1864-1938), King George V Professor of Mental and Moral Philosophy, drafts the first syllabus for experimental psychology and sets up a laboratory in the Department of Philosophy, University of Calcutta.

1916 Dr. Narendra Nath Sen Gupta (1889-1944) upgraded it into Department of Experimental Psychology, University of Calcutta to undertake studies on attention, sensation and perception.

1918 Central Institute of Psychiatry established in Kanke, Ranchi. It was called European Lunatic Asylum till 1922 before it was renamed as European Mental Hospital. In 1952, it was called Hospital for Mental Diseases. The Department of Clinical Psychology starts teaching program titled Diploma in Medical Psychology in 1962.

1922 Dr. Girindrasekhar Bose (1887-1953) elected first president of Indian Psychoanalytic Society. Dr. Bose was first to receive a Ph.D. in Psychology from University of Calcutta for the topic titled 'Concept of Repression'.

1923 Psychology was included as separate section in 12th session of Indian Science Congress held at Varanasi, Uttar Pradesh, following instructions from Government of India though university programs were offered as 'Arts'.

1924 Dr. MV Gopalaswamy was among the founding fathers of the second oldest Department of Psychology at University of Mysore. Other famous pioneers associated with the department are Dr. B Kuppuswamy, a renowned social psychologist, and Prof. B. Krishnan, known for his work in the field of Indian psychology.

1925 Formation of Indian Psychological Association owing to the efforts of SN Gupta. The Indian Journal of Psychology started in 1926 with NN Sen Gupta as first editor.

1934 Dr. JaduNath Sinha wrote a book on Indian theories of perception. This was followed by books on 'Cognition' (1958) and later on 'Emotions and Will' (1981).

1943 Department of Psychology instituted in University of Madras in 1943 by Gunamudian David Boaz (1908-1965). The Madras Psychology Society was formed in 1944.

1946 Department of Psychology started in University of Patna, Bihar, with Dr. HP Maiti as Professor and Head.

1949 Psychology Research Wing established by Ministry of Defence, Government of India, for selection and recruitment of army personnel.

1950 Department of Experimental Psychology established at University of Pune, wherein Prof. VK Kothurkar trained in Cambridge was appointed as Professor and Head.

1954 Department of Psychology and Human Relations started in NIMHANS, Bangalore. The first training program titled as Diploma in Medical Psychology was started in 1955 and the first batch for Ph. D. in Clinical Psychology was commenced in 1967.

1956 UGC provides funds for establishment of 32 psychology departments in universities all over India by the end of 1960. Examples: Rural and Social Psychology (Allahabad), Test Construction (Mysore), Industrial Psychology (Osmania), and Measurement and Guidance (Patna).

1961 The National Council of Educational Research and Training, New Delhi, reviewed all the psychological tests that had been prepared in the country till that date.

1966 Department of Clinical Psychology established in All India Institute of Speech and Hearing, Mysore.

1968 The Indian Association of Clinical Psychologists started.

1975 By this year, 51 of the 101 recognized Indian universities were offering programs in psychology.

1984 Department of Clinical Psychology established in National Institute for Mentally Handicapped, Secunderabad.

1995 By this year, 70 of the 219 recognized Indian universities were offering programs in psychology.

2005 The Asian Applied Psychology International Regional Conference was held in Bangkok, Thailand.

2008 The Gujarat Forensic Science University is established by Government of Gujarat which covers an Institute of Forensic Science, Institute of Behavioral Science, and Institute of Research and Development.

4.4 CHALLENGES FOR PSYCHOTHERAPY IN INDIA

An outstanding feature in the field of Indian psychology in recent times is the Psychoanalytic Movement initiated by GS Bose through the establishment of the Indian Psychoanalytic Society in 1922. Contrasting classical Freudian approaches, which emphasized on sexuality, the Indian psychoanalysts viewed repression as due to opposition of infantile wishes. Further, they postulated a theoretical ego against practical ego. They stressed the importance of local language, situational variables and customs rather than the classical intra-psychic explanations. It was felt that Indian culture fosters dependency and cooperation as opposed to individualism and competitiveness in the west.

Moreover, mythology and influence of Hindu epics were more deep and intense on an average Indian psyche as compared to west. For example, symbols of Lord Hanuman as bachelor hero or goddess Lakshmi as personification of wealth is typical across Indian minds. The Guru-Chela (Techer-Disciple) relationship tends to pervade even into the psychotherapist-patient alliance in our country. Under these circumstances, it is argued that the western models of psychotherapy may not be practical when applied upon the Indian patients.

Further, it is acknowledged that there are practical difficulties in attracting or training professional students into the discipline of modern psychotherapy. If young students in their twenties or thirties are recruited, they fail to make impact and gather acceptance across populations who foresee helping professionals to be typically aged, experienced and worldly wise. In the west, a young psychotherapist with professional degrees will be readily accepted and appreciated. The same cannot be true in our country. Available training programs in psychotherapy within the country are heavily loaded on western models. Adherence to specific schools of psychotherapeutic practice, such as, Gestalt, Cognitive-Behavioral, Psychoanalytic, Existential, Humanistic, Directive-Non Directive, or others may not meet success in clinical practice. Instead, an eclectic approach tailor made to the needs of given patients or problems may be more appropriate in our conditions.

Currently named as Psychoanalytic Therapy and Research Center, since 1974, a group of psychoanalysts in Mumbai founded a public charity trust. It aims to promote growth and development of psychoanalytical work with children and adults within the country. Meanwhile, the Indian Psychoanalytic Society at Calcutta continues to offer training combined with extensive personal analysis and later under supervision. Eventually, they are automatically taken as member of International Psychoanalytical Association.

It has been argued that psychotherapy as practiced in west might be suitable only for the educated elite in urban India. There is greater dissociation between thinking and feeling within a typical Indian psyche as compared to west. One may have knowledge on a given topic but may still harbor disconnect between their thoughts and action. The terms privacy and confidentiality highly cherished in western practice. It is not viewed as important in the daily clinical practice by Indian clinicians. We have multitude of languages and dialects in the country. Unless one is conversant with as many of them, success as practicing psychotherapist is difficult to achieve in our country. A family oriented approach to psychotherapy may be more pragmatic than dyadic therapies prized in the west.

4.5 CONCEPT OF HOLISTIC MENTAL HEALTH

Health is defined as 'a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity' (WHO, 1976). The focus of this definition is on the positive side of health rather than ill health, disease or infirmity. The components that need to be integrated within health are: Individual, Society, Mind, Body and Spirit. Mental health is viewed as 'ability to respond to the many varied experiences of life with flexibility and a sense of purpose'. It is also defined as 'a state of balance between the individual and surrounding world, a state harmony between oneself and others, a co-existence between realities of the self, other people and that of the environment'. A mentally healthy person is expected to be:

- Self & other adjusted: Is free from internal conflicts-not at war with oneself; Gets along well with others, accepts criticism, & not easily upset;
- Self-actualizing: knows himself, his needs, problems & goals
- Has positive relationships
- Seeks & Knows meaning of Life: Searches for identity; Shows goal oriented behaviors; has life directed philosophy;
- Is reality oriented & shows reality testing with self, others & situations; Orientation to place, person & time;

- Has strong sense of self-esteem;
- Shows autonomy &self-determinism: Has stable self-control to balance oneself emotionally & rationally;
- Faces problems and solves them intelligently by coping with stress and anxiety;
- Accepts responsibility;
- Seeks to maximize subjective well-being& happiness;
- Maintains a physical, mental and spiritual health

The official indicators of mental health are:

- Quality of community life
- Psycho-social stress
- Subjective well being
- Confidence in coping
- Social support availability

Against this background, holistic approach to mental health refers to treating the whole person. A holistic view infers that disease does not merely inhabit the body. It can infiltrate the mind and spirit too. Therefore, holistic medicine uses both conventional and alternative medicine to treat disease. It is not intended to serve as 'band-aid' or 'quick-fix'. It follows really a lifestyle approach by striving to live better, healthier and completely. Examples of holistic therapies and treatments are: massage, meditation, yoga, aroma therapy, exercise, herbal remedies, counseling or talk therapies, dietary practices, vitamin supplements, oxygen therapies, acupressure, hydrotherapy, naturopathy, homeopathy, acupuncture, prayer, Chinese medicine, body work, etc.

The 'whole person' approach to recovery is central to a decent quality of life. The history of this approach dates back to the teachings of Hippocrates during ancient Greek civilization. The body, mind and spirit are not independent of one another. They are intertwined. What affects one affects the others. This approach believes that focus only on one aspect is an incomplete approach. It is sometimes referred as complimentary health alternative health or natural health practices. Nonetheless, all holistic treatments are individualized to the unique needs of each person. The patient and practitioner make decisions together as partners to develop health care plans. This approach encourages the individual to engage in self-care and educate themselves about their health. It urges them to be active participants in their health care rather than giving all the power to the health care provider. There are several published scientific studies that dispute the efficacy of holistic medicine. They are dubbed as 'placebo' effect.

4.6 PSYCHOTHERAPY IN ANCIENT INDIAN THOUGHT:

4.6.1 ANCIENT INDIAN THOUGHT

Ancient Indian thought derives its impacts from a variety of sources including the Vedas, Smritis, Shastras, Upanishads, Puranas, Yoga, Buddhism, folklore, mythology, and the twin epics of Ramayana-Mahabharata. Mental wellness is viewed as a positive attitude. It includes emotional well-being, capacity to lead full and creative life. Body postures, breathing exercises, diets, fasting, religious rituals and practice are routinely prescribed as antidotes to daily life stress and strains. Attending spiritual discourses, pravachans, satsangs, holy places, undertaking pilgrimages or having holy dips in rivers, observing daily rituals, making donations, are all treated as means to periodically cleanse the body and soul.

Close to Buddhism, although different from it, Jainism is a characteristic soul-psychology. Jainism is also interested in clairvoyance, telepathy, extra sensor perception and omniscience. Meditation cuts cross many forms of Indian thought as solution to relieve oneself from stress or distress. Upanishads distinguish between the self as an ultimate entity and self as empirical ego. Whereas the ego engages itself in worldly affairs and experiences pleasure as well as pain, the 'atman' or ultimate entity is devoid of pain or pleasure. It is an onlooker devoid of senses, surpassing time, space, and causality. It is perceived or known by our mind as it is different from phenomenal reality. It can only be realized through meditation. In order to terminate suffering, one must awaken the higher self and let it conquer the lower one.

4.6.2 BUDDHISM

Buddhist psychotherapy is a novel approach to the clinical practice of mental health. It combines conventional psychotherapy with Buddhist psychological theory and practice. There are as many schools of Buddhist thought and practice as there are different approaches in psychotherapy. The dysfunctional mental tendencies of unconsciousness, inaccurate perception, unrealistic cognitions, disturbing emotions, and reactive actions are all rooted in a single, deeply ingrained lack of knowledge (avidya). All this leads to suffering which is created by the vicious cycle of ignorance and resulting habit patterns. The Buddhist method attempts to break the chains of this causal cycle, counteracting each stage. An ethical lifestyle counters reactive actions, the development of positive attitudes such as love and compassion

counter grasping and aversion, and the wisdom of relativity counters the root misperception of separate autonomy.

Cognitive-Behavior therapies have also recognized their own classifications of mental aberrations owing to maximization-minimization, over generalization, distorted thinking, and catastrophizing which inhibit appropriate action. Classical psychoanalysis mentions similar notions in their descriptions on defense mechanisms, such as, denial, splitting, and projection. They also talk about the resulting disturbances to psychic equilibrium and the impediments to genuine expression of the self.

Buddhist psychotherapy attempts to make the individual mindful of one's distortions so as to eventually achieve a psychological state of happiness. The mind that eliminates the root cause eventually achieves freedom (nirvana) from negative emotions (klesha) and compulsive actions (karma), and arrives at a state of awakening (Buddha). The awakened mind completely reverses the causal cycle of suffering and therefore perceives the relative nature of self and reality clearly, feels completely contented, loving and interconnected with all of life, and consciously acts skillfully for the welfare of all.

Similar to the methodology of cognitive therapies, in Buddhist approach, the therapist and patient work together to identify dysfunctional mental patterns of thinking, feeling, and behaving that stem from a patient's identification with their traumatic narrative. Once these specific issues are recognized, patients are prepared to use the healing relationship as an emotional corrective and employ meditation techniques to counter their particular cognitive-affective-behavioral habits. In this sense, it is insight oriented psychotherapy.

Again, similar to that of psychoanalytic therapies, the Buddhist method harnesses the dynamics of human interaction within the context of the therapeutic relationship. Particularly relevant is the process of mentor-bonding in which the therapist symbolically represents the role model of a healthy parent figure that accepts the patient. Buddhist psychotherapy offers a comprehensive contemplative education that includes a number of meditation techniques designed to enhance introspection, develop awareness, cultivate positive emotions, and evoke insight. These methods are not faith-based; rather, to be effective as they require a person to learn them by effort. In sum, Buddhist psychotherapy combines three major elements into its practice: 1) interpersonal dialog aimed at recognizing core issues and blind spots specific to a patient's identification with their traumatic narratives; 2) role-modeling aimed at providing a corrective emotional experience within the long-term process of re-parenting; and, 3)

individual meditation training yoked with wisdom and ethics, which empowers a patient in their own process of conscious self-correction.

4.6.3 BHAGVADGITA

In modern mental-health, psychotherapy is defined as the treatment by psychological means of problems of an emotional nature in which a trained person deliberately establishes a professional relationship with the patient with the object of: (1) removing and modifying or retarding existing symptoms; (2) of mediating disturbed pattern of behavior; and (3) of promoting positive personality growth and development. This is perhaps the most widely accepted definition given by Wolberg in 1967.

The essence of psychotherapy has been present in all traditional practices in our country. It has existed in a submerged form, interwoven with social structures, norms, religious practices, customs, myths and rituals. Mahabharata is a great textbook of psychopathology. Gita is a great treatise in psychotherapy. Bhagavad Gita describes various aspects of psychotherapeutic techniques through 18 chapters of self-knowledge.

Gita frees a person from guilt in its own frame work, resolves repression, supplies energy and morale by making a person dig deeper still in his own self and develop insight into its working. The guru-chela model of psychotherapy which will widely be accepted by Indian patients is ingrained in it. The word guru in Indian tradition means a teacher and a spiritual preceptor. The guru acts as a physician of mind and soul with objectivity and competence. The guru takes his disciple through an experiential journey of self-exploration with an aim to liberate the disciple from all sufferings. It is tenable where self-discipline, rather than self-expression is to be inculcated in patients and where creative harmony is sought between patient and society. More activity and direct guidance or advice by therapist is adopted as a form of psychotherapy. The Guru-Chela relationship is polyvalent, poly-vibrant and multidimensional. It is much wider than the transference relationship of western psychotherapy.

4.7 SUMMARY

After reading this unit, you must have got a bird’s eye view on Indo-Euro perspectives on psychotherapy. There are many unique features to the Indian approach as seen in traditional practices like naturopathy, Ayurveda, yoga psychology and treatment

modalities undertaken by means of reading the pulse. This unit gives a timeline of major events that as happened in the importing of western psychology to contemporary times within the country. However, such a transplant is not without its own challenges and limitations. The modern trend of holistic mental health is explained before elucidating the notions of psychotherapy in ancient Indian thought, Buddhism and Bhagvad Gita.

4.8 KEY WORDS

Ayurveda	Bhagvad Gita
Buddhism	Mental Health
NadiPariksha/Chikitsa	Naturopathy
Puranas	Shastras
Smritis	Upanishads
Vedas	Yoga

4.9 CHECK YOUR PROGRESS

1) Give an account on Indo-Euro perspectives on psychotherapy
2) Explain Naturopathy, Ayurveda, Yoga Psychology and NadiPariksha /Chikitsa
3) Attempt a chronology on the events connected to the origin and development of western psychology in modern India
4) Delineate the challenges for psychotherapy in contemporary India
5) Enunciate the concept of holistic mental health
6) Elucidate the notions of psychotherapy in ancient Indian thought, Buddhism and Bhagvad Gita

4.10 ANSWERS TO CHECK YOUR PROGRESS

1) 4.3
2) 4.3.2
3) 4.3.3
4) 4.4
5) 4.5
6) 4.6

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BLOCK 2: TYPES OF PSYCHOTHERAPIES

UNIT 5: SUPPORTIVE PSYCHOTHERAPIES

STRUCTURE:

5.1 OBJECTIVES

After going through this unit you will be able to explain

- Meaning, definition, goals, nature and procedures of supportive psychotherapy;
- Several illustrative types of supportive psychotherapy, such as, milieu therapy, socio-therapy, reassurance, prestige suggestion, persuasion, ventilation and others; and,
- Characteristics and applications of various forms of supportive psychotherapy are given.

5.2 INTRODUCTION

You have already seen that the various types of psychotherapy are classified based on the depth, duration and/or the degree of engagement the therapist has with the patient during treatment. Based on this continuum, it was mentioned that even a non-professional supporting relationship can be beneficial although to a limited extent. Many people overcome their crisis and conflicts merely by talking it over with their friends, relatives, or kith and kin. However, this may not be sufficient for some others or for few other psychological problems. A professional counseling or even deeper, supportive psychotherapies may be warranted.

5.3 MEANING & DEFINITIONS OF SUPPORTIVE PSYCHOTHERAPIES

The following are some of the important views given by different authors on the theme.

- Knight (1954) describes it as 'superficial psychotherapy' which utilizes inspiration, reassurance, suggestion, persuasion, and other techniques for patients who are psychologically fragile, inflexible, or defensive for exploratory devices.
- Bloch (1979) stresses sustenance and maintenance rather than suppression and repression as focus of supportive psychotherapies. He deems it a form of treatment for patients with chronic psychiatric conditions for whom basic change is not seen as a realistic goal'.
- Werman (1984) sees supportive psychotherapies as substitute form of treatment that supplies the patient with those psychological functions that s/he either lacks entirely or possesses insufficiently.

Wallerstein (1988) defines supportive psychotherapy as one that strengthens defenses and represses selected symptoms in favor exploring others, using means other than interpretation or insight to achieve these goals. To Wellerstein, it is an ego strengthening

therapy which uses means other than interpretation or insight to help patients suppress mental conflicts and its attendant symptoms.

- Pinsker and Rosenthal (1992) describe supportive psychotherapy as 'a dyadic treatment characterized by use of direct measures to ameliorate symptoms and to maintain, restore, or improve self-esteem, adaptive skills, and psychological function'.
- Novalis, Rojcewicz and Peele (1993) define supportive psychotherapy as involving the use of techniques that have been observed to work, (1) to achieve therapist-patient relationship; (2) to enhance the patient's strengths, coping skills, and capacity to use environmental supports; (3) to reduce the patient's subjective distress and behavioral dysfunctions; (4) to achieve for the patient the greatest practical degree of independence from his or her psychiatric illness; and, (5) to foster the greatest degree of autonomy in treatment decisions for the patient.

To begin with, supportive psychotherapies differ from other types of therapies in that it is not dependent upon any specific over riding concept or theory of mind. It simply utilizes the rich work done by many therapists in understanding how people change.

Supportive psychotherapy has a long and varied history dating back to ancient Greeks. They used humane methods of treating the mentally ill through emotional catharsis, massage, music, rest, and appropriate physical work, temple healing procedures, verbal methods or education. Such approaches were revived by PhilipePinel (1745-1826) known for unchaining the patients with mental illness in the mental asylum in Paris and later by Benjamin Rush, who is considered as founder of American psychiatry. In 1938, Paul Schilder wrote that supportive psychotherapy consisted of techniques like discussion, advice, persuasion, reassurance, daily routines, hobbies, authoritative firmness, confession, ventilation, and appeal to will power, hypnosis, suggestion, relaxation and concentration. The first two books exclusively devoted to supportive psychotherapy were written by DS Werman (1948) and LH Rockland (1989).

The principal concerns of supportive psychotherapy are self-esteem, ego functions, and adaptive skills. Supportive psychotherapy is best understood by differentiating it from exploratory or expressive treatments. The style is conversational. The patient-therapist relationship is a real relationship and it is not usually analyzed. Defenses are generally supported unless they are maladaptive. Acquisition of insight is not a significant objective. Every effort is made to minimize frustration and anxiety in the therapy, although it is not always possible to avoid all discomfort. Supportive psychotherapy uses direct measures to

ameliorate symptoms and to maintain, restore or improve self-esteem, ego function and adaptive skills.

5.4 GOALS OF SUPPORTIVE PSYCHOTHERAPY

The goals of supportive psychotherapy are limited to:

- Reducing behavior dysfunction;
- Reduce subjective mental distress;
- Support and enhance the patient's strengths and coping skills;
- Increase the patient's capacity to use environmental supports;
- Maximize the patient's sense of independence and autonomy;
- Provide insight and understanding;
- Explore interpersonal experiences;
- Discover inner experiences;

5.5 APPLICATIONS

Supportive psychotherapy is applicable for short term gains in resolving acute crises situations, such as, bereavement, trauma, accident, suicide attempt, sudden hospitalization, medical illness, natural or manmade disasters, etc. It is also applicable for caregivers of patients with mental illness in order to enable or empower them to comply with treatment regimen, to handle inappropriate behavior in home situations, to decrease negative though processes and content in the patients, for improving their coping skills and social skills, to resolve external conflicts, to prevent relapse, deterioration or re-hospitalization, to enhance self-esteem, to improve reality testing of the patient and others, to strengthen healthy defenses, for weakening maladaptive defenses, for maximizing family and social supports.

Hellerstein et al (1994) argued that supportive psychotherapy should be viewed as the treatment model of choice or default therapy. Sometimes, it is used as initial format before switching on to long term or deep re-educative and reconstructive forms of the treatment in target individuals or clinical conditions. In recent times, internet based supportive psychotherapy is gaining popularity through emails and telephone. Irrespective of the target population or the precise type of supportive psychotherapy that is scheduled to be used, the basic strategies that are to be implemented are as follows:

i. Formulate the case. This means that the case must be conceptualized. It is something like the therapist's theory or understanding of the case. It is the

why, what, where, when and how of the case. The therapist need not necessarily share the case formulation with the patient.

ii. Be a good parent. The therapist-patient relationship is somewhat like a parent-child relationship. Such a viewpoint will allow the therapist to developmentally see the patient's strengths and weaknesses.

iii. Foster and protect the therapeutic alliance. The value and importance of therapeutic alliance needs no reiteration.

iv. Manage the transference. Patients invariably have feelings about their therapists. They may, for example, look upon the therapist as the 'father figure' of their childhood. All transference is not negative. There is no need to rush to explain or correct the patient's misperception. Rather, it is to be accepted, interpreted and used constructively in therapy.

v. Hold and contain the patient. This refers to the use of empathy, understanding and verbal comfort. At what point should the therapist start intervening involves a critical decision.

vi. Lend psychic structure. This means that the patient ends up using the therapist as an alternate or auxiliary ego or superego.

vii. Maximize adaptive coping mechanisms. Enable the patient to make use of positive defense mechanisms like humor, sublimation, altruism, intellectualization, and rationalization in contrast to use of negative ones like denial, projection, and acting out. Skill training and self-management techniques can be useful in this context.

viii. Provide a role model for identification. In this regard, therapeutic self-disclosure can play an important role. It should be judiciously employed with the best interests of the patient in mind. The therapist need not and should not reveal every personal detail. The use of fables, short stories, mythological events, and/or biographical anecdotes have been successfully used in this stage.

ix. Verbalize feelings, emotions and sentiments. Often, one ends up stating that there are no words to express ones feelings. In that pretext, the feelings are locked up and left unexpressed. 'I may not say it in words. But, cannot my spouse see it in my eyes or in my actions?' This is a common refrain that must be turned explicit for success of the therapy.

x. Make connections. Many problems are the result of disconnect between ones thoughts, feelings and actions. A person with stammering, for example, may have an automatic thought to avoid picking up a telephone call or attempting to make an enquiry for fear of failure. Such connections must be identified and highlighted for benefit of the patient.

xi. Raise self-esteem to decrease sense of hopelessness. It is important to foster independence and sense of competency in the patient. Self-talk correction of cognitive distortions, activity scheduling, record keeping, unraveling subjective sense of guilt, interpersonal and social skill training are some techniques to foster self-esteem in patents.

xii. Focus on here-now rather than there-then. Supportive psychotherapy need not and does not waste time or energy on unraveling early childhood experiences.

xiii. Encourage patient activity. There must be lot of 'things to do' in supportive psychotherapy rather than simply things to say, discuss or talk about. Set goals that are concrete and achievable. Use diary or record keeping, and self-monitoring techniques.

xiv. Educate the patient's family. The involvement of the patient's support systems must be undertaken at all stages of supportive psychotherapy. Issues like symptom observations, drug compliance, use of free time, possible side effects of medicines, and on-the-job performance can be best modulated only by involving the patient's family.

xv. Manipulate the environment. Many behaviors could be the offshoot of undetected or unrealized environmental triggers. If they are correctly recognized and handled, it could bring positive behavior changes in the patient.

5.6 LIMITATIONS OF SUPPORTIVE PSYCHOTHERAPY

Supportive psychotherapy is to be basically viewed as one step over and above professional counseling but below all forms of re-educative and re-constructive psychotherapies. In being so, it is to be deemed only as ego-building or self-esteem enhancing therapy. On an alternative track, it has been also used for 'psychologically healthy' patients in crises, such as, medical illness, disaster and bereavement as well as 'unhealthy' patients in crises, such as, someone who attempts suicide. Patient selection is crucial for supportive psychotherapy. It cannot address to very severe conditions like chronic

schizophrenia, dementia and intellectual disabilities. This means that it leaves out those who are cognitively impaired, have low capacity for introspection, exhibit poor object relations and have poor impulse control.

Supportive psychotherapies have been criticized as being overtly directive. It is willful or unwitting imposition of values on the patient. For example, when a patient is told to take up a hobby, rear a pet or sublimate his impulses into creative activities, it is viewed as imposed by the therapist. Advice usually results in mistrust, resistance, and suspicion. It is also dangerous to the therapeutic alliance. Advice fosters dependency and submissiveness in the patient. It deprives the patient of the opportunity of working out his or her own intra-psychic conflicts. All this will actually weaken, not strengthen the patient's defenses. Advice is viewed as intrusion and interference into the patient's autonomy. Further, advice based on incomplete information can even create risks for the patient.

One might go to a dietician to improve one's nutrition. This will not raise a moral question. You may believe and accept the dietician's advice on trust. Hence, the relationship involves an element of faith. The same cannot apply to psychotherapy. It is morally not all right to be directed on your personality by a therapist.

5.7 TYPES OF SUPPORTIVE PSYCHOTHERAPY

5.7.1 GUIDANCE

In an earlier unit, 'guidance' was explained as the act of 'assistance to individuals to make intelligent decisions and adjustments'. For example, the victim of a crime maybe guided to approach the legal cell for redress of her grievance. Guidance is an act of 'giving correct and factual information to a recipient who is unaware and in need for it'. It is especially given by someone in authority. Guidance may be visual, verbal, manual, and/or mechanical. When a coach shows the learner a correct way of holding the cricket bat by demonstration, it may be understood as an example of visual guidance. If it is associated with a running commentary on the task, it is taken as verbal guidance. Sometimes, the learner may require physical holding and manipulation as in manual guidance. Guidance can be of three types: (a) educational guidance; (b) vocational guidance; and, (c) personal guidance.

Guidance of a student based on educational needs to sort out issues like correcting reading habits, study schedules, or discipline practices is usually made available in schools. It maybe also to do with choosing subjects for study, obtaining scholarships, appearing for

examinations, continuing higher education in colleges and universities. According to A. Jones, educational guidance is 'concerned with assistance given to pupils in their choices and adjustments with relation to school, curriculum, courses and social life'.

Vocational guidance provides information and advice with regard to choosing an occupation, preparing for it, entering it, and progressing in it. It helps the individual to become aware of his strengths and weaknesses in the world of occupations. According to Frank Parson, it is defined as 'a process designed to aid the young person to choosing an occupation, in preparing for it, in finding an opening in it, and in building up an efficient and successful career'.

Personal guidance, which is closer to supportive psychotherapy, is directed towards total development of an individual personality. It fosters individual growth, helps them overcome adjustment problems, improves their interpersonal relationships, and to develop the right perspective towards life.

5.7.2 TENSION CONTROL & RELEASE

We are all now living in an age of anxiety and tension. The ability to relax under stress is an essential part of personal safety. All tension isn't bad. It actually puts us in a state of alert. It prepares us emotionally and physically to respond in the face of danger, threat or risk. It is a sort of alarm signal. Although the feelings of tension are apparently unpleasant, they are useful. The symptoms of tension are increased heartbeat, tight muscles, headache, sweating, and nausea.

There are many ways to overcome tension. One way would be to sit in a chair or lie down on a bed before clenching or tightening each part of your body and slowly relaxing it. Cover from the fists, elbow, eyes, lips, teeth, jaw, neck, shoulders, stomach, down to the legs one at a time. Another technique is to practice slow, systematic, and rhythmic breathing in and out while fully concentrating to the changes within your body. Remember that regular practice is important to fight tension and gain relaxation. It is also important to correctly identify whether the source of your tension is internal or external. However, in most cases, it must be your inner thoughts or attitudes which may be the real cause of your tension. In such a case, with a change of attitude, stress and tension would disappear, irrespective of the external conditions. Given below are few tips to relieve stress and tension.

- Pay attention to your body in the state of tension. Do you find it to be stiff and contracted? Release and relax them repeatedly.

- When stressed, stand up and take few deep breaths to relax.
- Drink a cup of water, wash your hands and face
- Observe within yourself to see what are the thoughts or images that are making you feel tense. It might be that you are exaggerating. Think of other positive alternatives.
- If the stress is due to other people, open up and talk to them
- Talking out your tensions can itself become a great relief
- Find a cause to laugh. Don't keep up a straight and serious face.
- Watch a comedy serial on television or read something funny
- Leave everything of what you are doing and take a walk outside
- Go for a swim or the gym.
- Take it easy. Don't pile up work. If you plan too many things to be done in short time, you are likely to be stressed
- Detach yourself from what is troubling you. Look at the whole situation as an outsider, as though it does not belong to you.

5.7.3 ENVIRONMENTAL MANIPULATION

Human behavior is understood to be controlled by events or happenings occurring either before or after it. For example, a child sees the mother and starts throwing a tantrum, or the same child sees the father and stops that behavior. Seeing the mother is the antecedent. The mother may offer a candy to the crying child which can be termed as consequence. Antecedent based environment manipulations involve carefully controlled arrangements in the aspects of a person's environment that is believed to influence his or her behavior. A girl who has the habit of looking out of the window when the lessons are on in the classroom may be instructed to sit in the front bench right before the teacher. A common notion in many parents is that a child with behavior problems would turn alright if put into a hostel or residential school. Antecedents may be particular settings, situations, places, specific time lines, persons, task difficulty levels, sudden change of routines, methods of instruction used by a teacher, etc. It is well recognized that children reared in impoverished environments are generally dull, inactive and unenergetic. Such behaviors have been found to alter once they are put into a changed enriched environment.

5.7.4 MILIEU THERAPY

This is a form of psychotherapy which involves the use of therapeutic communities. Patients join together to form small groups of 20-30 members for a period ranging from 9-18 months. During the stay together, they are encouraged to take responsibility for themselves and others with the group. They make and follow their own rules of community living. Infringements have their own sanctions and punishments.

The word 'milieu' is derived from French which means 'middle'. In English, 'milieu' means 'surroundings or environment'. Milieu therapy attempts to make substantial changes in the patient's immediate circumstances and environment in such a way that it will facilitate effective interpersonal relationships, adaptive coping and positive behaviors. The history of psychiatry has shown how PhilipePinel in France during late 1700s, succeeded in improving many chronically ill and hospital confined long stay patients simply by altering their environments. In 1946, Main coined the term 'therapeutic community' and in 1948, Bettleheim coined the term 'milieu therapy'.

Milieu therapy assumes that every individual has potential to grow despite their inherent strengths and weaknesses. Every interaction that takes place during milieu therapy is an opportunity to grow. Peer pressure is an important, useful and powerful tool which helps in this growth. Inappropriate behaviors get discarded and socially productive useful behaviors are retained. At the end of such a therapy, the patient is likely to achieve a sense of autonomy which can be generalized to other aspects of life. Milieu therapy promotes mutual respect between participants, provides opportunities for interpersonal communication, attempts to enhance their self-esteem, promotes socialization, uses team approach and peer pressure to respect or follow rules and regulations. Group discussion and temporary seclusion is a preferred to acting out behaviors.

Milieu therapy stresses the use of techniques like distribution of power, open communication, work related activities, community and family involvement. It uses the word containment to refer to the process of providing food, safety and security to its participants. They feel protected from their illness as well as the social stigma. No formal uniforms are insisted. The term validation is used to refer to the affirmation of the patient's rights and individuality. An advantage with milieu therapy is that it does not view the patient as a sick person. The environment is deliberately contrived and designed to be like a home.

Independence rather than dependence is fostered. A therapeutic milieu is deemed to be a safe place, which is non-punitive, nurtures the self, and encourages interpersonal relationships.

5.7.5 SOCIO-THERAPY

Drawn from the field of sociology and social work, socio-therapy is basically a life enrichment program. Clinical socio-therapy typically targets groups of children and adolescents, employees of a given organization, a group within a treatment facility, and others. The Society for Furtherance of Socio-therapy defines socio-therapy as 'the methodical management of the living environment of a group of clients, directed towards reaching the treatment targets of this group—and conceived as a means of achieving the treatment targets of the individual client—within a functional unit, usually in a clinical treatment setting'.

According to the Free Dictionary, socio-therapy is defined as any form of treatment which emphasizes socio-environmental and interpersonal relationships rather than intra-psychic factors. Interaction is promoted by close living, inward looking community that is somewhat cut off from the rest of the world. Socio-therapy is provided by a team of workers who, working together in a system of changing eight-hour shifts, guide the clients to give form to their daily life. The daily and continually open method of exchanging information (communication and interaction) is the principal concern. The daily life interactions with each other provide information about the potential and limitations of the clients and the socio-therapist adjusts his interventions according to this information.

Socio-therapy is based on the theoretical foundations of socialization. To live and interact with both yourself and others is socialization. It happens through contact, communication and interaction. Socio-therapy stresses upon building awareness, relationships and the integration of life with one's environment. It fosters healthy living through building interpersonal relationships. Hence, it is also called relationship therapy. In actual practice, for example, the socio-therapist may use the technique of support companionship wherein an introverted patient may be lured into activities to reduce the risk of social isolation. Interactions with other residents or the community may be encouraged by the socio-therapist.

Community based socio-therapy goes a step further and attempts to bring groups that are isolated, marginalized or vulnerable into the mainstream. It is a way to help people to come together to cure their problems. In group format, the members are given an opportunity to help their companions to overcome problems as well as to solve their own. The group is

used as a therapeutic medium to establish trust and confidence in another. It opens environments for group discussion and peer support. Practitioners of socio-therapy stress on safety, sense of mutual trust, care, respect and adherence to rules as the main principles for its effective practice. In practice, rules are made and followed, activities are allocated to everyone, certain duties have to be performed, reports have to be made and a busy timetable of group meetings is to be executed. Socio-therapy has been found to benefit victims of group violence, people traumatized in natural or manmade disasters. It has helped those who are deficient in social skills. It has been also tried on persons with personality disorders.

5.7.6 EXTERNALIZATION OF INTERESTS

Sigmund Freud recognized that externalization is one of the unconscious defense mechanisms used by the threatened ego in the human psyche. It involves the projection of one's own internal characteristics onto the outside world. It may also involve use of another type of mature defense mechanism called sublimation, wherein socially unacceptable or unfulfilled impulses are unconsciously transformed into socially acceptable actions or behavior. Sport is an example of putting our emotions or aggression into something constructive.

Externalization of interests is simply another way of displacement of one's emotions into a constructive rather than destructive activity. It is the transformation of unwanted impulses into something less harmful or rather more constructive. Many great artists and musicians have had unhappy personal lives. They have used their art as medium of expression for themselves. Everyday examples of this phenomenon may be that an angry man goes out to chop wood and ends up with a useful pile of firewood. Her poor relationship with her own parents may convert a woman to turn into a better cook for her own children. Giving a creative expression to your self is all about externalization of interests. You need not be an accomplished musician, painter or sportsperson. Just a few minutes or hours of regular indulgence in your favorite hobbies, interests or leisure time activities will be sufficient. Knitting, embroidery, painting, drawing, cooking, teaching children, sports, collage making, story writing, trying with clay or crayons, social service, volunteering, or just about anything you love to do will do.

5.7.7 REASSURANCE

Reassurance is simply the action of removing someone's doubts or fears. In psychotherapy, it is one of the important techniques used to alleviate distress in patients. It is

an attempt to reduce another person's anxiety or fears by the use of words. It encourages people to express their ideas and feelings and to consider the most positive views presented by the therapist. According to Carl Rogers, reassurance is a response that attempts to soothe or pacify feelings. It is viewed as a supportive technique and can have positive therapeutic outcomes. It can be used naturally when some information is provided to the patient. This technique is indicated wherein patients come with vague complaints about particular symptoms or behavior, when they over react with concern or anxiety, or because they have misinformation about their condition.

There are six recognized steps needed for effective reassurance in patient care. These include: (1) Question and examine the patient; (2) Assure the patient that serious illness is not present; (3) Suggest the symptom will resolve; (4) Tell the patient to return to normal activity; (5) Consider non-specific treatments; and, (6) Follow-up the patient regularly. Thus, eliciting the detailed description of the symptoms of the patient is one of the first steps in the use of reassurance technique. Following this, it is important to elicit the affective meaning of the symptoms to the patient. For example, a patient may think his headache as a symptom of ongoing stress at office while another may interpret it as his suspicion that there is a slow growing tumor in his head. The next step is, therefore, to thoroughly examine the patient in order to end up making a correct diagnosis. This is to be followed by explaining the symptom and reassuring the patient. The omission of any one of these steps results in ineffective reassurance. Just as praise must be expressed in term that is meaningful to the patient, so must be reassurance. False reassurance can be dangerous. When used correctly, reassurance can be powerful. When it fails, the credibility of the therapist will be lost permanently. The best reassurance draws on what the patient has already shown that he can do.

5.7.8 PRESTIGE SUGGESTION

A persuasive message delivered by or attributed to a highly respectable or admired source to maximize its credibility is called prestige suggestion. A product endorsement by a sportsperson or film star followed in advertising is an example of prestige suggestion. In the context of psychotherapy, patients tend to view at least initially that their therapists are 'all knowing' and therefore, tend to take in anything and everything at least temporarily owing to the phenomenon of prestige suggestion. Prestige suggestion involves the acceptance of a proposition in the absence of any logical grounds for its acceptance. It works in situations where the patient is emotionally excited or heightened, tired, anxious, fearful, under hypnosis, or lacks in knowledge on a given issue. It also depends on the impressive character

of the source from which the suggested proposition is communicated. People in authority, high social positions, those with superior physical strength, and eminent intellectual gifts are accepted easily.

5.7.9 PRESSURE & COERCION

Coercion involves two parties: a coercer and the coerced. A coercer gets another agent/s to do or not to do something. The coerced is targeted, whose freedom and responsibility is diminished. Coercion is the use of psychological force to cause the learning and adoption of an ideology, designated set of behaviors or beliefs, ideas or attitudes. Coercion usually occurs in small invisible steps. Each step is sufficiently small that the subject does not notice or identify the coercive nature of the process until much later. Psychological coercion typically attempt overcome an individual's critical thinking. The tactics usually involve arousing fear or anxiety. According to Mc Cord (1998), coercion refers to the practice of compelling another party through action or inaction. Coercion is *pro tanto*wrong and violation of basic rights (Pennock and Chapman, 2009). Very few believe that it is always unjustified since no society or family could function without some authorized users of coercion. The actual expressions of coercion may be disciplinary threat, torture, intimidation, infliction of physical pain, injury, psychological persuasion, blackmail or harm intended to enhance the value of threats, demands on cooperation, obedience or compliance.

Coercion is different from related concepts like 'psychological control', 'intimate partner violence'. The Merriam-Webster's dictionary defines coercion as 'the use of express or implied threats of violence or reprisal or other intimidating behavior that puts a person in immediate fear of the consequences in order to compel that person to act against his or her will'. It signifies in general the imposition of external regulation and control upon persons, by threat or use of force and power. It is different from IVP which is 'an act or pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim' (Spitzberg and Cupach, 2009). Therefore, coercion does not primarily represent a problem of safety as in IVP but a problem of human rights and the subjective experience of strain.

Coercion can be physical, psychological and social. Examples of physical coercion may be through restrain (handcuff, tie with rope, drug or sedate, or lock in cellar), excess (stand in hot sun, carry heavy weights, hold ice in hand), harm and violence (give electric shocks, pour hot water or oil, physically shake up, seat in height), or compulsion (insist on

smelling excreta or write an imposition). Psychological coercion may be to antagonize (bully, show a flame, intimidate, emotionally blackmail, or play mind games), verbal (humiliate, frighten, lecture or sermon, make false accusation, ridicule or spread rumors). Social coercion may involve seclusion (confinement in a room, boycott, isolation or segregation), disfigurement (smear charcoal on face, or tonsure head), defilement (undress in public, put a dunce cap or name calling), undoing (insist on saying sorry or take an oath), and surveillance (monitor time and activities or set spies to snoop). Coercion is particularly useful in situations of imminent danger. Seeing a child rush towards the middle of a road, a parent may become physical to block him immediately. The parent cannot be cajoling, requesting or advising at that time. However, use of coercion can generally end up into a backlash. People do not like to be forced to do things against their will. They want to 'get even' at the first available opportunity.

5.7.10 PERSUASION

This is a form of directive psychotherapy wherein the client is encouraged to follow the advice of the therapist. It is an extension of the common sense practice of reasoning or advising people to overcome their difficulties. Some names associated with persuasion therapy are Paul Dubois and Johann Heinroth. They believed in the technique of appealing to the patient's reason and intellect in order to eliminate negative and self-destructive habits. Persuasion may be needed to be applied in a variety of situations. From persuading kids to take bath, to influencing shy friends avoiding an outing, persuasion requires to be at times used even upon ourselves. Persuasion is to convince people to buy a certain line of thought or argument or to bring them to agree to a certain point of view. Some subtle techniques to persuade are by using short proverbs or catchy statements. Repetition not bordering to monotony is another way to bring the patients to around your corner. Use of emotional appeal helps during persuasion.

There are many subtle but powerful ways in which you can advance friendly persuasion with your patients. Try talking about universal examples of the responses you want from them. Tell positive stories of how people in everyday life have overcome difficulties. Steer the conversation towards their positive achievements and the people they care about. This reinforces their strengths and lifts their mood. Mix your talk with positive words like hope, resolve, commitment or strength rather than negative words like sad, despair, lonely, etc.

5.7.11 CONFESSION

A confession is any written or oral statement in which a person admits to have committed some transgression, often indicating acknowledgement of guilt for a crime. Confession helps people to ease their sense of wrong doing or guilt. Sometimes the confession may lead to damaging consequences for the confessor, such as, loss of freedom, money or even life itself. Confession in most religions is used to cleanse the individual's soul and to serve as deterrent for wrong doing in society. Confession in psychotherapy is viewed as form of release for bottled up feelings and emotions. Freud observed how many of his patients felt much better after purging their minds of materials buried deeply in their unconscious. Hence psychoanalysis came to be recognized as 'talking cure'. Recent research confirms the healing power of opening up to someone else about ones problems, or other unpleasant truths. Although the actual process of making the confessional statement may be stressful, 'letting it out' or 'getting off the chest' has been found to have therapeutic effects on one's mental health.

5.7.12 VENTILATION

Ventilation is the process of venting out inner feelings, or thoughts. Also called catharsis, it is simply the release of bottled up elements. It is believed that closed thoughts and feelings build up pressure just like air inside a balloon until it bursts at one time. Releasing the emotions from time to time will not end up in such situations. Ventilation of feelings has been shown to provide only temporary respite. It is not a permanent solution to the problem. Ventilation has been recognized as a healing, cleansing and transforming experience. The technique covers two aspects: emotional and cognitive. It involves release of emotions and insight or new realization following the release. All this is believed to result in positive change. The American Psychological Association (2007) defines ventilation as 'the discharge of affects connected to traumatic events that had previously been repressed by bringing these events back into consciousness and re-experiencing them' (p. 153). The use of ventilation as the basis of therapy has been used in Psychodrama (Moreno), Primal Therapy (Janov) and Emotion Focused Therapy (Greenberg).

5.8 SUMMARY

On reading this lesson you must have understood the meaning, definition, goals, nature and procedures of supportive psychotherapy along with few of its illustrative types, such as, milieu therapy, socio-therapy, reassurance, prestige suggestion, persuasion,

ventilation and others. The characteristics and applications of various forms of supportive psychotherapy were given.

5.9 KEY WORDS

Case Formulation	Coercion
Confession	Environmental Manipulation
Externalization of Interests	Guidance
Milieu Therapy	Persuasion
Prestige Suggestion	Primal Therapy
Psychodrama	Reassurance
Socio-Therapy	Transference
Ventilation	

5.10 CHECK YOUR PROGRESS

(a) What is supportive psychotherapy? Give its meaning and definitions.

(b) List the goals of supportive psychotherapy.

(c) Enunciate the applications of supportive psychotherapy.

(d) State the limitations of supportive psychotherapy.

(e) Write short notes on tension control and release.

(f) Describe environmental manipulation.

(g) What is milieu therapy.

(h) Highlight the features of socio-therapy.

(i) Attempt a brief note on externalization of interests.

(j) Write a short essay on pressure and coercion as means of behavior change.

5.11 ANSWERS TO CHECK YOUR PROGRESS

(a)	5.3	(b)	5.4	(c)	5.5	(d)	5.6	(e)	5.7.2
(f)	5.7.3	(g)	5.7.4	(h)	5.7.5	(i)	5.7.6	(j)	5.7.9

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UNIT6 : RE-EDUCATIVE AND RE-CONSTRUCTIVE THERAPIES

STRUCTURE:

6.1 OBJECTIVES

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

- Meaning, definition, goals, nature, procedures, formats, applications and limitations of re-educative as well as reconstructive forms of psychotherapy;
- Features of relationship therapy, attitude therapy, psychobiology, hypnotherapy ad psycho-analysis as some illustrative types of re-educative as well as reconstructive forms of psychotherapy;
- Constraints and cultural significance of re-educative and reconstructive forms of psychotherapy;
- Meaning of adjunctive aids in re-educative and reconstructive forms of psychotherapy in clinical practice.

6.2 INTRODUCTION

LR Wolberg (1954) distinguished three types of psychotherapy: supportive, re-educative and reconstructive. In doing so, we have already seen how supportive psychotherapy promotes the development of maximal, optimal use of patient assets. Its objective is to strengthen existing defenses, elaborate better mechanisms of maintaining control and restoring the patient to a state of adaptive equilibrium. Along a continuum, re-educative therapy aims at giving insight into the more conscious conflicts. It makes deliberate efforts at goal modification and maximal utilization of existing potentialities. Examples of re-educative therapies are relationship therapy, attitude therapy, psychobiology and re-educative group therapy. Much deeper are reconstructive therapies which aim at giving the patient insight into their unconscious conflicts. In doing so, they seek extensive alterations of the patient's character structure. Examples of reconstructive therapies are psychoanalysis (Freudian, Adlerian, and Jungian types) and cultural-interpersonal therapies by Sullivan and Horney.

6.3 MEANING OF RE-EDUCATIVE AND RE-CONSTRUCTIVE THERAPY

Over and above supportive levels of psychotherapy, re-educative psychotherapy involves new ways of perceiving and behaving. Unlike supportive psychotherapy, it requires more time for the patient to explore alternatives in a planned systematic manner. Whereas supportive psychotherapy simply allows the patient to express feelings, explore alternatives, and take decisions in a safe caring relationship, re-educative therapy requires the patient to try alternatives. The therapy may be short-term, brief, solution oriented, reality supported,

cognitive restructuring and/or behavior modification. A majority of therapy fall in this category.

Reconstructive therapy is deeper level of intervention which requires greater understanding of self and others. It may require two-five years of therapy and goes deep into all aspects of the patient's life. Emotional and cognitive restructuring of the self takes place. Positive outcome of reconstructive therapy is likely to be greater emotional freedom, development of potential abilities, and heightened capacity for love and work. This therapy assumes that the past unfavorable experiences have hampered the growth of the individual and making the emotions come into conflict with reality. This form of therapy also necessitates adequate training and expertise on the part of the therapist depending upon which specific type of therapy is proposed to be used on a given patient.

Reconstructive therapy is distinguished from supportive and re-educative therapy by the degree and quality of insight mobilized. In supportive therapy, efforts at insight are minimal. In re-educative therapy, they are more extensive but are at a conscious level. In reconstructive therapy, the objective is to bring the individual to an awareness of crucial unconscious conflicts and their derivatives.

Re-educative and re-constructive therapies try to release what has been called the self-actualizing tendency in the individual. Instead of removing the anxiety producing sources in the life of the individual, they attempt to bolster behavior that permits and enables the individual to cope with anxiety. They try to reduce, and if possible, remove anxiety by altering the individual's perceptions. Re-educative therapy is directed toward producing more harmonious self-structure. Rogers' Client Centered Therapy is an outstanding example of insight therapy with re-educative goals. The reconstructive therapy attempts to gain insight into an individual's unconscious conflicts, thereby bringing about an extensive alteration in the individual's character structure. It releases energies for the development of new adaptive capacities. However, they may not benefit psychotic conditions with active or florid symptoms, vegetative conditions, non-cooperative patients unwilling to undergo therapies

6.4 APPLICATIONS & LIMITATIONS OF RE-EDUCATIVE AND RE-CONSTRUCTIVE THERAPY

Re-educative psychotherapies are the most commonly used formats in routine clinical practice for treatment of neurotic conditions, such as, adjustment problems, anxiety disorders, obsessive-compulsive disorders, phobias, and depression. It is warranted for problems

wherein the patient has partial insight into his condition, left with ego strength not recognized or acknowledged and wherein there is time or inclination on their part to undergo behavioral change. It is useful to tackle escape and avoidance behaviors, problems that have an unacknowledged functional utilitarian value for the patient. It helps persons who lack self awareness or insight, have misunderstanding of human differences and have errors in their thinking. It is relevant for youngsters with potential but having issues related to resolution of their identity problems.

It is preferred treatment for minor mental disorders wherein the symptoms distress the individual. They are recognized as distressful by the patient when they are troubled by it and they want to come out of it. They must be reactive to the events and happenings in their environment. In all this, their reality testing must still be intact. There should be no deep rooted enduring personality patterns of behavior resistant to change. Otherwise, these forms of therapy will not work.

Re-constructive therapies are indicated in the treatment of long lasting and deep rooted personality problems. Although time consuming and effortful, this form of therapy requires long term commitments to behavior change. Cases with even slight distortions in reality testing, disorganized behaviors, and causing distress may be amenable to this form of treatment. Conditions like drug dependence syndromes, borderline personality conditions, passive dependent personalities and others may benefit from these treatments.

6.5 MAJOR TYPES:

6.5.1 RELATIONSHIP THERAPY

There are individuals and conditions wherein inter-personal relationships are affected. Relationships do not happen or sustain on their own. They need to be continually worked upon to keep them alive or sustain them. Conditions such as chronic illness, financial difficulties, routine conflict, substance abuse, emotional distance, intimacy issues, lack of trust, or barriers to communications, for example can impair relationships. Relationship problems can also affect ones health and self-esteem. Such problems can emanate between employees and employers in a workplace, between couples or within a family across several members. Wherein relationship problems are left unidentified or untreated, there is high risk of their turning into various forms of emotional or physical abuse. Healthy boundaries are lost in abusive relationships.

Relationship therapy, proposed by John Levy (1938), focus on all the parties involved in the interpersonal relationships. An effort is made to recognize specific areas or issues in

order to manage, or reconcile the troublesome differences. Relationship based treatments assume that each individual is a unique personality with one's own set of values, perceptions, belief systems and life history. It is also accepted that most relationships can get strained at some time or the other resulting in failure to function optimally. It is then that they start producing maladaptive patterns of self-reinforcing behaviors that get into a kind of self-defeating vicious cycle.

Relationship therapy seeks to change views on a given relationship. If a 'blame game' is going on, attempts are made to stop it. Next, it seeks to identify and modify dysfunctional behaviors. This means that the therapist will ensure that their patients do not engage in physical, psychological or economic harm. This is followed by decreasing emotional avoidance which is typical of damaged relationships. All efforts are directed towards improving communication. Parties are coached to avoid abusive or ridiculing forms of communication. Available strengths in the relationship are recognized and promoted. Certain things to do will be recommended, such as, catching the partner doing something right, or surprising the partner with good things or recreating a together time activity. Listening, anger control and negotiation techniques may have be taught. Sometimes, the therapist will model a more constructive way of managing the environmental provocations that beset the patient. In this form of intervention, the therapist adopts the stance of a non-punitive, helpful authority figure guiding the patient towards more productive ways of life.

A viable solution to the problem might then be to set these relationships on the right track by reorienting the individuals. Issues can be explored collaboratively and discussed openly. It implies that each person attempts to makes his or her own small contribution to change so as to resolve the relationship issues in order to maintain it. In extreme cases, relationship therapy may also attempt to work towards a smooth and healthy breakup.

6.5.2 ATTITUDE THERAPY

Attitudes are settled ways of thinking, feeing and action in a given individual. It may be an expression of favor or disfavor toward a person, place, thing or event. Attitudes can be formed, measured and changed. Behaviors usually, but not always, reflect established beliefs and attitudes. Ideally, positive attitudes manifest well adjusted behaviors. Sometimes, healthy attitudes may also result in harmful behaviors. For example, someone with negative attitude towards divorce may end up perpetuating domestic violence.

Persuasion is a common technique used for changing attitudes. Attitude therapy stresses the evaluation of current attitudes in term of its origins, the purpose they serve and

their possible distortions. Originally, the term ‘attitude therapy’ was used by David Levy (1937), to refer to a process of treatment used on children having disturbed attitudes of their parents. Nowadays, it is used to map negative attitudes before helping the individual to develop healthy substitutes. Distortions in attitudes are examined, their origins discussed, and their present purpose appraised. Following this, attitudes that make for harmonious relationships are introduced as topics for discussion. The patient is helped to incorporate these substitutes in place of their earlier morbid attitudes. Since the patient may not easily give up the old attitudes, repeated emphasis on the new points of view is essential to achieve the desired results.

6.5.3 PSYCHOBIOLOGY

Psychobiology of psychotherapy is understood as exploration of mind-body experience, communication and healing. This approach was introduced in United States by the Swiss psychiatrist Adolf Meyer (1910-1941) in the turn of the century. Although forgotten now, this approach looks into the mind body divide and seeks to find out how one influences the other. Many psychosomatic disorders show apparently physical or body symptoms in an individual in the absence of any organic or biological basis. For example, a woman may present with complaints of voice loss when an ENT examination shows no damage to the larynx.

A range of studies have contributed to understanding the psychobiology of emotional regulation. Functional imaging studies have shown that cortico-limbic circuitry plays an important role in mediating processes such as reappraisal and suppression. Prefrontal cortex may be important in conscious reframing, and emotion evaluation. Hence, following neurobiology, it is hypothesized that during interventions such as psychotherapy there are improvements in emotional regulation, together with the normalization of related psychobiological mechanisms.

Meyer proposed a rather loosely structured and flexible approach to the treatment of mental disorders in the context of psycho-biology. He used the term ‘ergasiology’ to describe a psychobiology that combines the biological, social and psychological factors and symptoms pertaining to a patient. He supported occupational therapy as the mainstay treatment for persons with mental illness. The steps involved in this form of psychotherapy included analyzing the psychological, sociological, and biological factors relevant to the patient's illness before working with the patient on a conscious level, staying close to the original complaint, and utilizing a combination of treatment methods satisfactory to both

psychiatrist and patient. Attempts are made to modify unhealthy adjustments through guidance, suggestion and re-education. Mayer called this as 'habit training'. Psychobiology of psychotherapy encourages a comprehensive and eclectic approach to psychological disorder based on an observation of the objective facts in patient's life, including his psychosocial context. Meyer introduced a special kind of chart called as psychobiogram which enabled connections between significant events in the patient's life to be made. This approach is critical of labeling and making blanket diagnosis of cases.

6.5.4 RE-EDUCATIVE GROUP THERAPY

On many occasions, working in groups can have its own advantages. Educative therapies carried out in exclusive or inclusive homogeneous or heterogeneous groups help creating an atmosphere of mutual supports. If the group turns out to be a close knit community of members, a nonjudgmental setting and unconditional supports can have therapeutic value. A common misconception about group therapy is that members wait for taking turns to receive therapy. Actually, members are encouraged to turn towards one another for support, feedback, and connection. The therapist serves only as a facilitator for the whole group. It will make the individual patient realize that he or she is not alone. The thought that one might be the only person with a given problem can be frightening and unacceptable. While it is true that each one of us unique in ones set of problems or circumstances, none of us is alone in our struggles. A group situation gives insights that one has strikingly similar problem as others in one's group.

Educative group therapies help the individual patient to find a 'voice'. What they had all along wanted to share or express would find an opportunity or medium in the group. Group therapies help relate with others in healthier ways. Sharing can be healing. By revealing your innermost thoughts, feelings and struggles with other group members, you are likely to feel relieved. There are certain insights that you would gather in a group which might not occur in one-to-one settings. Other members in the group may also serve as models to pick up positive behaviors. Group therapy provides a safety net. Diversity is another important benefit of group therapy. People have different personalities and backgrounds, and they look at situations in different ways. By seeing how other people tackle problems and make positive changes, you can discover a whole range of strategies for facing your own concerns.

Of course, confidentiality and anonymity is to be respected in groups. The participants should feel comfortable sharing themselves in the warm and supportive environment.

Educative group therapies can help build social skills. By easing their sense of isolation in the world, it can give opportunity to practice engaging with others. By default, social skills are gained by individual members. In short, group therapies have the major goal of helping individuals transcend their mental health struggles through experiencing their common humanness with others fighting the same battles. Group therapies are also cost effective compared to individual therapies.

However, group therapies are not indicated when the patient is in a fragile emotional state. If clashes are exhibited by certain other group members, such patients may be harmed than being benefitted by the therapy. Group therapy may strike fear in some patients. They may feel overwhelmed by the presence of a crowd. The idea of speaking to a room full of people may turn some patients anxious. A few patients may hesitate to open up in a group for fear of losing confidentiality. Group therapies are not helpful when dealing with crises situations.

6.5.5 INTERPERSONAL RECONSTRUCTIVE PSYCHOTHERAPY

Originally proposed and developed by Lorna Smith Benjamin, IRT has been shown to be helpful in the treatment of personality disorders especially wherein they have not benefitted by other therapies or medication. This therapy is based on the understanding how early attachment patterns affect the patient's later behavior. A good enough early infant care fosters a sense of trust in oneself and others. This may then lead to positive attachment with parent figures. If these early experiences are less than optimal, it can lead to maladaptive behaviors in later life.

Early childhood experiences can leave three types of indelible marks. One, the child acts as the caregiver did. Two, the child acts as the caregiver is still in control. Three, the child treat himself as the caregiver did. For example, if a child was experienced as being ignored during early childhood, then s/he would learn to ignore his own self, spouse and/or children. The original caregiver may have gone. But, the internalized images of the caregiver continue to manifest through the individual. IRT seeks to identify and engage in the maladaptive behaviors of the individual. There are five stages in the course of therapy. The first is collaboration between the patient and therapist. The next is learning about old patterns of behavior and analysis or where or how they came from. The third is to block these old patterns of behavior. The fourth stage is to enable the will to change. The last stage involves learning new patterns of behavior. The whole treatment regime usually takes more than a year.

This is primarily a psychosocial approach to psychotherapy although not averse to use of medications for specific situations. It does not offer any new treatment such as a medicine or a new way of relating to patients. Rather, it offers a new way of thinking about patients that help therapists to choose interventions more effectively from the already available array of methods. Treatment resistant patients, especially those with personality disorders, have been reported to respond positively to IRT. The assumption is that after old expectations and hopes in relation to internalizations are given up, the usual and customary treatments including medications, client centered, cognitive behavioral and psychodynamic therapy have a better chance to work. The IRT treatment manual gives specific instructions for development of case formulations and using it in choosing therapy interventions to address the presenting symptoms.

IRT has been extensively used in the treatment of major and minor depression. Four types of problems have been frequently associated with depression. Such patients are noted to have unusual or severe responses to the death of a loved one. They have many interpersonal role disputes. They have difficulty in adjusting to role transitions like divorce, career change and/or retirement. They have manifold deficits in interpersonal skills. All these aspects are taken care of in the IRT.

6.5.6 HYPNOTHERAPY

Hypnotherapy is a form of psychotherapy used to create subconscious change in a patient in the form of new responses, thoughts, attitudes, behaviors or feelings. In the actual use of this procedure, the hypnotist induces a state of trance in the subject to increase motivation and alter behavior patterns. The therapist and patient need to work in mutual agreement to undertake this type of therapy. It is to be understood that no person can be hypnotized against ones will. There are standard tests which can help determine the degree of hypnotic suggestibility in a given subject. It is also erroneous to believe that one can be hypnotized to undertake tasks against his or her will.

A few important names in the field of traditional hypnotherapy are James Braid and Hippolyte Bernheim. They used direct suggestion and relaxation techniques in therapy. MH Erickson used informal conversational approaches to treat patients with hypnotherapy. Modern hypnotherapy is widely used in the treatment of anxiety, depression, habit disorders, fears, and sleeplessness. Hypnosis is a procedure that opens people to the power of suggestion. A hypnotist puts a subject in an altered state by encouraging relaxation and

sleepiness. It is associated with describing all sorts of physical sensations a subject should be feeling. Once a subject is in the altered state, he or she may act, perceive, think, or feel according to the hypnotist's suggestions. Hypnosis can cause people to relax, have a narrowed focus of attention and be highly engaged in fantasies. It can produce anesthesia, cause hallucinations and distortions of sensory perception. It can reduce inhibitions. However, it cannot work effectively in everyone. It cannot force people to do things against their will. It cannot make people act beyond their levels of physical or mental abilities. It can allow people to re-experience past experiences.

6.5.7 PSYCHOANALYSIS (FREUDIAN, ADLERIAN, AND JUNGIAN TYPES)

Psychoanalysis or psychodynamic therapies owe its origins to the works of Sigmund Freud. It is based on the theory that human behavior is determined by powerful inner forces which are mostly buried in the unconscious mind. They believe that from early childhood, people repress or force out several elements out of conscious awareness especially desires or needs that are unacceptable to themselves or to their society. The repressed feelings can cause personality disturbances, self-destructive behavior or even physical symptoms. Freud developed several techniques to bring repressed feelings to the level of conscious awareness. In a method called free association, the patient relaxes and talks about anything that comes to mind while the therapist listens for clues to the person's inner feelings. The analyst pieces together the free flowing associations, explains their meanings, and helps the patient to gain insight into the thoughts and behavior that is troubling them. Psychoanalysts also try to interpret dreams, which they regard as a reflection of unconscious drives and conflicts. The goal is to help the patient understand and accept repressed feelings and find ways to deal with them.

Sigmund Freud (1856-1939) proposed the notion of psychic determinism (how mind can influence to create physical symptoms), gave an anatomy of human psyche (by theoretically differentiating between an id, ego and superego along with its layers of consciousness). He also proposed the psychodynamics of human personality, stages in psychosexual development, and the theory of defense mechanisms. Classical psychoanalysis requires that the therapist himself undergoes an analysis and training before taking up patients for therapy.

Psychoanalysis recognizes phenomenon like transference, counter transference, resistance, free association and use of interpretation of dreams during therapy. Transference

involves spontaneous shifting of a frustrated need into an object or person that is somewhat similar to the originally needed object or person. It is characterized by an unconscious redirection of feelings from one person to another. For example, the patient may begin to see the therapist as an alternative father figure. Counter transference is the redirection of the therapist's feelings toward a patient. It is the therapist's emotional entanglement with a patient. Any sign of counter transference would suggest that the therapist must undergo further training analysis to overcome these tendencies. Resistance is the patient's tendency to directly or indirectly oppose changing their behavior or refusing to discuss, remember, or think about clinically relevant experiences. It indicates that the patient wants to somehow continue clinging to the illness. It may also mean that they are securing some gain by doing so. When it happens, the therapist chooses to work with resistance rather than against it. Working against it can turn counterproductive for the therapist. Free association is a technique used in psychoanalytic therapy to help patients learn about what they are thinking and feeling. It enables patients to speak about themselves in a non-judgmental atmosphere. Dream interpretation is the process of assigning meaning to the dreams. Dreams are believed to have a manifest or overt content and another latent or hidden meaning content. As a result of distortion and disguise, the real meaning and significance of the dream gets concealed. However, during therapy, wherein an honestly recorded dream is attempted to be interpreted several unconscious dimensions within an individual can be unraveled and understood. Slips of the tongue or pen called as parapraxis are also used to uncover the unconscious in an individual during therapy.

Alfred Adler (1870-1937) proposed a theory of individual psychology. The word individual literally means undivided. Instead of talking about a personality in traditional sense of internal traits, structures, dynamics, or conflicts, Adler preferred to talk about life style. It is the way you live, handle problems, and interpersonal relations. Adler postulates a single drive or motivating force behind all human behavior and experience. He called this motivating force as striving for perfection. It is similar to the popular notion of self actualization. While Freud used the term sex drive, Adler preferred to use the word aggression drive or assertiveness drive. The striving to overcome is called compensation. Adler also introduced the phrase masculine protest. If a baby boy fusses or demands to have his own way (masculine protest!), they say he is a natural boy. If a little girl is quiet and shy, she is praised for her femininity. On the other hand, if the boy is quiet and shy, they worry that he might grow up to be a sissy. Or if a girl is assertive and gets her way, they call her a "tomboy" and will try to reassure you that she'll grow out of it! Adler did not see any innate

superiority in men. He saw it as reflection of the encouragement boys received to be assertive and discouragement received by girls for the same. Adler also used another term called striving for superiority. It refers to a desire to be better-better than others rather than better in our own right. This is an unhealthy or neurotic striving.

Another popular concept originating from Adler's writings is inferiority complex. If you are moving along, doing well, feeling competent, you can afford to think of others. Otherwise, you become increasingly focused on yourself. Each one of us has both a weaker and stronger side of our personality. In attempting to compensate and overcome inferiority complex, one may develop a superiority complex. It involves covering up inferiority by pretending to be superior. If you feel small the one way to feel big is to make others feel small. The various psychological types according to Adler are ruling type, leaning type, avoiding type, and socially useful type. The ruling type shows tendency to be aggressive and dominant on others. The leaning type is sensitive people who have developed a shell around to protect themselves. They rely on others to carry them through life's difficulties. The avoiding type survives by avoiding life or other people by retreating into their own worlds. The socially useful type is a healthy person with active social interest and energy. Incidentally, Adler's types closely resemble the types given by ancient Greeks on the basis of body humors: choleric, phlegmatic, melancholy and sanguine respectively.

Adler also believed that birth order, especially if a person has experienced devaluation at an early stage, is important factor in development of personality. The only child is more likely than others to be pampered. The first child begins as only child but soon finds that she or he is dethroned after the arrival of second child. The youngest child is likely to be the most pampered and there is no threat of being dethroned.

Adler's Individual Psychology and its therapy characteristically emphasizes that persons cannot be understood as a collection of parts but rather as a unified whole. In that sense, his therapy is integrative, constructivist, humanistic, and systems oriented. The emphasis is on the patient's subjective experience. People are neither inherently 'good' or 'bad'. They are what were made out of them by their life experiences. His therapy is a growth and wellness model. It is an optimistic perspective that views people as unique, creative, capable and responsible. Therapy is not about offering 'cure'. It is all about encouragement. People seek therapy because they are discouraged and lack in confidence or courage to engage successfully in tasks or problems of living. Encouragement is not a technique but an attitude and a way of being with patients.

Adler's therapy recognizes four stages. In the first stage of engagement, a trusting therapeutic relationship is built between the patient and the therapist. This is when they agree to work together to effectively addresses the problem. In the second stage of assessment, the therapist invites the patient to speak about their personal history, family details, early childhood recollections, beliefs, feelings and motives. This would give a clear picture about the patient's life style. The third stage is insight when the patient is helped to develop new ways of thinking about his or her situations. The last stage is called reorientation when the therapist encourages the patient to engage in satisfying and effective actions that reinforce this new insight. At the end of therapy, the patient gains better insight into their own behaviors and responses to circumstances happening in their lives.

A major criticism of Adler's therapy has been the large amount of family and lifestyle information that needs to be collected, difficulty in interpreting the received data.

Carl Jung (1875-1961) psychoanalytic views are called analytical psychology. Jung expanded Freud's views on unconscious by describing a personal and another collective unconscious. The personal unconscious includes personal memories like Freud's understanding of unconscious. The collective unconscious is shared mythology and symbols of the entire human kind. It is some kind of a psychic inheritance and reservoir of our experiences as species. He explained the experience of love at first sight, déjà vu (feeling that you have been already in new place) or immediate recognition of certain symbols and meaning of certain myths evidence presence of collective unconscious. Another evidence of collective unconscious comes from reports of near death experience by different people which are strikingly similar.

The contents of collective unconscious are called archetypes. Archetypes are representational images and figures that have universal symbolic meaning. Archetypal figures exist for father, mother, child and hero. The archetype has no form of its own. The anima is female aspect present in collective unconscious of men and animus is male aspect present in collective unconscious of women.

Jung developed two types of personality organization-extroversion and introversion. Introverts are people who prefer their internal world of thoughts, feelings, fantasies, dreams and so on, while extroverts prefer the external world of things and people or activities. He recognizes four functions, viz., sensing, thinking, intuiting and feeling. We all have these

functions. We just have them in different proportions. Most of us develop only one or two functions even though our goal must be to develop all the four.

Jung uses Free Association Test for explorations during therapy. It consists of recording the average response time to certain stimulus words. The patient is asked to answer to the stimulus words given by the analyst with any word that comes to his mind. The response time is indicator of the activated unconscious complexes. Jung also uses dream analysis. Unlike Freud, the dream symbols in Jung are decrypted in term of collective unconscious and archetypes. Jung also invited his patients to tell all the things that flow in their mind. The inner fantasies reveal about their unconscious. This technique is called as active imagination which is one form of self-expression.

Jung used the term individuation to refer to a process by which an individual develops into who they are truly intended to be. Individuals with emotional difficulties often feel that they are living fragmented or disjointed lives. Individuation helps them through therapy to develop a holistic and integrated view of self and life.

6.5.8 CULTURAL-INTERPERSONAL THERAPY (SULLIVAN AND HORNEY)

Harry Stack Sullivan (1892-1949) an American neo-Freudian psychoanalyst believed that details of interpersonal interactions of patients can provide insight into the causes and cures for mental disorders. He mentions three modes of experiencing and thinking about the world: prototaxic, parataxic and syntaxic mode.

Sullivan saw anxiety as a result of social interactions. Individuals make use of various techniques (much like Freud's defense mechanisms) to reduce social anxiety. Selective inattention is one of these techniques leading to personification of ourselves and others. There are three basic ways in which we see ourselves: bad-me, good-me and not-me. The bad-me represents those aspects of self that are considered negative and are therefore hidden from others and possibly even the self. The anxiety we feel is often a result of recognition of this part of self. The good-me is everything we like about ourselves. It represents the part that we share with others and that we often choose to focus on. It produces no anxiety. The not-me represents all those things that are so anxiety provoking that we cannot even consider them a part of us. The not me is kept out of awareness by pushing it deep into the unconscious.

Sullivan also proposed a developmental theory of personality. He attached great importance to experiences of individual during adolescence as basis for all turmoil or

otherwise during later adulthood. Sullivan would rather say: 'We exist as relationships not as individuals'. A healthy personality is the result of healthy relationships. Sullivan believed that personality develops according to people's perception of how others view them. People carry distorted views and unrealistic expectations of others into their relationships. The role of therapy is to correct these dysfunctional interpersonal patterns.

His psychotherapy procedures involved genuine efforts to improve the patient's relationship skills in dealing with others. Interpersonal relationships constitute the core of psychotherapeutic treatment. The role of therapist is that of a 'participant observer'. He is necessarily only a part of an interpersonal, face-to-face relationship with the patient. Being an 'observer', the therapist is exempted from being involved with the patient. The therapist is an expert in relationships, not just a friend, chum, or colleague to the patient. He intends to help the patient improve foresight, discover difficulties in interpersonal relations, and restore the ability to participate in consensually validated experiences.

Karen Horney proposed a theory of neurosis called holistic psychology. She views personality attributes as a result of interaction between the person and the environment. She did not believe that there was anything to do with infantile libidinal strivings or adult personality. She challenged the concept of penis envy and Oedipus complex. In her clinical experience, Horney discerned ten patterns of neurotic needs. The first need is for affection and approval. This need is unrealistic, unreasonable and indiscriminate. We all need affection. But we do not expect it from everyone we meet or at all times and under all circumstances. There are times in our lives when we have to be self-sufficient. The neurotic's needs are more intense. The patient experiences great anxiety if the need is not met. The neurotic needs are:

1. Indiscriminate need for affection and approval from everyone under all situations and all circumstances.
2. Need for a partner or someone who will take over one's life. This includes the idea that love will solve all of one's problems. Again, we all would like a partner to share life with, but the neurotic goes a step or two too far.
3. Need to restrict one's life to narrow borders, to be undemanding, satisfied with little, to be inconspicuous.
4. Need for power, for control over others, for a facade of omnipotence. We all seek strength, but the neurotic may be desperate for it. This is dominance for its own sake,

often accompanied by contempt for the weak and a strong belief in one's own rational powers.

5. Need to exploit others and get the better of them. In the ordinary person, this might be the need to have an effect, to have impact, to be heard. In the neurotic, it can become manipulation and the belief that people are there to be used. It may also involve a fear of being used, of looking stupid.
6. Need for social recognition or prestige. We are social creatures, and sexual ones, and like to be appreciated. But these people are overwhelmingly concerned with appearances and popularity. They fear being ignored, be thought plain, "uncool," or "out of it."
7. The neurotic need for personal admiration. We need to be admired for inner qualities as well as outer ones. We need to feel important and valued. But some people are more desperate, and need to remind everyone of their importance -- "Nobody recognizes genius," "I'm the real power behind the scenes, you know," and so on. Their fear is of being thought nobodies, unimportant and meaningless.
8. Need for personal achievement. Again, there is nothing intrinsically wrong with achievement -far from it! But some people are obsessed with it. They have to be number one at everything they do. Since this is, of course, quite a difficult task, you will find these people devaluing anything they cannot be number one in! If they are good runners, then the discus and the hammer are "side shows." If academic abilities are their strength, physical abilities are of no importance, and so on.
9. Need for self-sufficiency and independence. We should all cultivate some autonomy, but some people feel that they shouldn't ever need anybody. They tend to refuse help and are often reluctant to commit to a relationship.
10. Need for perfection and unassailability. To become better and better at life and our special interests is hardly neurotic, but some people are driven to be perfect and scared of being flawed. They can't be caught making a mistake and need to be in control at all times.

Her focus was on the present rather than the past, structure rather than genesis. She theorized that people combat anxiety by adopting one of the three fundamental styles of relating to others: moving towards people-moving against people or moving away from people. Most normal people use any one of these three approaches. Neurotics are compelled to rigidly rely on only one. This generates intra-psychic conflicts in them that may then take the form of either an idealized self-image or self-hatred. The neurotic self-image is expressed

as neurotic search for glory, neurotic claims, or neurotic pride. Self-hatred is expressed as either self-contempt or alienation from self.

She saw the therapist-patient relationship as mutual, cooperative and democratic. The analysis benefits both. She rejected the then prevailing authoritarian model of psychotherapy. Therapy attempts to help patients relinquish their defenses, accept themselves as they are and strive for self-realization.

6.6 CONSTRAINTS OF PSYCHOTHERAPY

The application of psychotherapy in clinical practice has to face several constraints. Beginning from recruitment of the patient, to choice of therapy, setting up of the goals, preparing the therapy setting, schedule, techniques and closure, the challenges are continual for both the patient and therapist. There can be constraints on frequency of sessions, time and length of treatment.

Choosing achievable goals for therapy is one of the formidable challenges. In a sense, the therapist and the patient need to agree on this score. There can be short term and long term goals envisaged if the situation needs it. One of the major reasons for failure of a therapy is the failure of goal setting. Rules and regulations governing the therapist-patient contract must be clearly enunciated and scrupulously followed. Clauses pertaining to confidentiality, privacy and other ethical codes of conduct apply to both the parties. Some therapists provide tea or coffee at the therapy place to decrease the patient's initial sense of anxiety. Others find this unnecessary.

A call needs to be taken on exchange of gifts, or any transgression of the terms of contract. Answering emails or phone calls during or between sessions is another tricky issue. Home visits and social get together can pose issues related to a professional therapist-patient relationship. An ideal recommended duration of a psychotherapy session I around 45-60 minutes. This includes time for warm up, working through and closure. However, not all patients are similar. Some may imbibe matters quickly. Others take a longer time to assimilate what is going on through the therapy sessions. Likewise, the once in a week schedule is most common in outpatient practice. Another question is: How long should the psychotherapy sessions last? Should it continue till the presenting problem is no longer diagnosable? Not really. Some therapists recommend around 20-25 sessions or a period of one to two years especially for issues related to chronic personality disorders.

On certain occasions, there might be requirement for use of a co-therapist. Co-therapists are meant to supplement and complement each other. In sharing between them and examining issues together, each therapist's observational range and therapeutic power is likely to be broadened for the benefit of the patient. A male-female co-therapist combination may help handle certain issues. Psychotherapists must also learn to appreciate and accept the supplementary role of medicines especially for patients who have been prescribed to be on them. The therapist must be aware of the medicines, their side effects and use with the patients.

6.7 CULTURAL ASPECTS

All human beings are part of a culture. Culture refers to the unique ways of life of groups of people. It is the sum total of customs, arts, science, political and religious behaviors taken as an integrated whole that distinguishes one society from another. The understanding about a person is incomplete unless we try to understand his culture. There is no universal definition of what is considered 'normal' or 'abnormal'. Culture and social factors are intertwined in the very conception of mental illness as well as how they deal with it. Culture is defined as the meanings, values, and behavioral norms that are learned and transmitted in the dominant society and within its social groups. Culture influences our cognitions, feelings and our self-concept including the decisions we take for treatment of mental illness. In that sense, the definition of psychotherapy as a culture bound activity is appropriate. Jerome Frank said: 'Psychotherapy is a planned emotionally charged interaction between a trained socially sanctioned healer and a sufferer'.

In the same way, culture can influence the therapy process in a number of ways. The nature or extent of therapeutic relationship, help seeking behaviors, how the therapy is viewed and continued are all determined by cultural factors. In a country like India, the stigma associated with mental illness, consulting a psychiatrist or psychologist continues to prevent many affected patients from seeking professional help. According to cultural competence models, psychotherapists must cultivate an awareness of the cultural identities and beliefs to better understand their patients. The doctor-patient relationship in our country continues to be viewed as god-devotee or even as teacher-pupil (guru-shishya) relationship.

6.8 ADJUNCTIVE AIDS

Adjunct refers to something that is added and is not part of the main course in the practice of psychotherapy. It is an added treatment usually given over and above the primary

treatment. The use of such aids concentrates on improving general mental and physical well being without trying to resolve the basic emotional problems. Music therapy, occupational therapy, physical and recreational therapies are useful adjuncts in psychotherapy. Breathing exercises, cultivating hobbies, developing habit of diary recording, fostering healthy food habits, taking up gardening or socially useful and productive works are generally recommended as adjunctive aids during psychotherapy. A few more activities like indulging in humor clubs, developing habits of entertaining oneself periodically, joining in painting, drawing, knitting, embroidery or cooker classes, undergoing physical training, participation in exercises, sports or drill activities may appeal to some depending upon ones personal taste and inclination. Still other appealing adjunctive aids are muscle relaxation techniques, joining prayer or church services, trying meditation or yoga, aerobics, and workouts can be all useful adjuncts during therapy. Lewis R Wolberg lists the following adjunctive aids in psychotherapy: Relaxation exercises and meditation, biofeedback, somatic therapies, use of medicines (neuroleptics, anti-depressants, Anxiolytics, sedatives, hypnotics and psycho-stimulants), mega vitamin therapy, hypnosis, play therapy, biblio-therapy, art therapy and sex therapy.

6.9 RECENT TRENDS

Psychotherapy offer more helpful techniques than ever. This is emphasized both at the individual as well as social levels.

Neuroscience is about brain functions. It is about how specific parts of the brain are implicated in common human problems. The discipline has facilitated the development of brain based sensorimotor psychotherapy which pays attention to the ways that emotions are expressed through the body. Simple techniques to calm the nervous system and reduce anxiety are recommended. EMDR (Eye Movement Desensitization and Reprocessing) is an example of therapy procedure evolved from neuroscience which is being used in the treatment of Post Traumatic Stress Disorders.

Mindfulness has to do with *awareness*, something we often lack in the midst of our problems. How many times have we said that we don't know *what* we're feeling or *why* we feel so strongly about something? Mindfulness helps. Being completely in touch with and aware of the present moment; and, taking a non-evaluative and non-judgmental approach to your inner experience. In the midst of confusing pain and fear mindfulness helps us to come home to ourselves and become more grounded in our bodies, managing our fear and pain better and becoming more able to find solutions. Fortunately, mindfulness involves skills that

can be learned. Using mindfulness to observe your thoughts and feelings, breathing fully and rhythmically to improve mind-body connections.

Another contemporary trend in modern psychotherapy is the increased emphasis being given to family systems. The child, for example, is being increasingly viewed as a symptomatic reflection of a malaise in the family. The disease is a manner of communication which hints that there might be some issue in the family which needs correction. Therefore, the focus is increasingly on the family as a whole with the individual being viewed as a representative of that system.

The ongoing trend in psychotherapy is to combine multiple approaches for the optimum benefit of the patient. A cognitive-behavioral approach may be combined even with use of medicines along with psychodynamic therapy. Such 'eclectic' approaches are followed in the best interests of the individual client. Another recent trend is to incorporate an evolutionary perspective in the practice of psychotherapy.

6.10 SUMMARY

Based on LR Wolberg's distinction between supportive, re-educative and reconstructive, this unit has elaborated on the last two types of psychotherapy. The unit has covered on the meaning, definition, goals, nature, procedures, formats, applications and limitations of re-educative as well as reconstructive forms of psychotherapy. The features of relationship therapy, attitude therapy, psychobiology, hypnotherapy ad psycho-analysis are elaborated as illustrative type of re-educative and reconstructive forms of psychotherapy. A section of the unit has covered details on their constraints and cultural significance along with the meaning of adjunctive aids in re-educative and reconstructive forms of psychotherapy in clinical practice.

6.11 KEY WORDS

Adjunctive Aid	Archetypes
Attitude Therapy	Birth Order
Circumplex	Collective Unconscious
Complementarity	Cultural Relativism
Dream Interpretation	Ergasiology
Extraversion	Habit Training
Hypnotherapy	Inferiority Complex
Introversion	Masculine Protest

Mindfulness	Neurotic Needs
Oedipus Complex	Parapraxis
Parataxic	Penis Envy
Prototaxic	Psychic Determinism
Psychobiology	Psychobiogram
Relationship Therapy	Resistance
Stereotypes	Syntaxic

6.12 CHECK YOUR PROGRESS

(a) Outline the salient differences between re-educative and re-constructive psychotherapies.

(b) Mention the applications and limitations of re-educative and re-constructive psychotherapies.

(c) Describe relationship therapy.

(d) What is attitude therapy?

(e) Attempt short notes on psychobiology.

(f) Elaborate on the main features of Psycho-educative Group therapy.

(g) Highlight the major characteristics of Interpersonal Reconstructive Psychotherapy.

(h) Write about hypnotherapy.

(i) Explain Freudian, Adlerian, and Jungian types of psychoanalysis.

(j) Expand upon the cultural-interpersonal approaches to psychotherapy as enunciated by HS Sullivan and K Horney.

(k) Mention the various constraints that may surface in the routine practice of psychotherapy.

(l) Discuss the role of culture in psychotherapy.

(m) What are adjunctive aids in psychotherapy?

(n) Outline the recent trends in psychotherapy.

6.12 ANSWERS TO CHECK YOUR PROGRESS

(a)	6.3	(b)	6.4	(c)	6.5.1	(d)	6.5.2	(e)	6.5.3
(f)	6.5.4	(g)	6.5.5	(h)	6.5.6	(i)	6.5.7	(j)	6.5.8
(k)	6.6	(l)	6.7	(m)	6.8	(n)	6.9		

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UNIT- 7: SPECIAL THERAPIES

STRUCTURE:

7.1 OBJECTIVES

After going through this unit you will be able to explain

- Meaning, definition, goals, nature and procedures involved in few special forms of therapy; and,
- Application and limitations of each of the described list of special therapies;

7.2 INTRODUCTION

There are a variety of approaches that may not fully qualify to be called as psychotherapy. But they do fulfill certain requirements of a therapy. These forms of special therapies supplement with the main psychotheraphy by providing an option to the individual to find satisfaction and outlet for certain emotions. They also provide a means of relaxation, enjoyment, they help in the healing process for the disturbed mind of the patient. Hence an understanding of these therapies is important. The major one's are being discussed in this unit.

7.3 MEANING & DEFINITIONS

Special therapies fall in the broad heading of helping professions in order to address the problems of a person's physical, psychological, intellectual, emotional or spiritual wellbeing. Many of them are popular although very few of them may be scientifically validated by means of double blind randomized case controlled intervention studies. Some of them may be self-prescribed and administered, while others may be fostered as small group activities. Many of its practitioners may use a combination of one or more of these approaches. Some of them may have a professional body with their own distinct code of ethics, training and certification, refresher training programs and so on. Others have none of these features. Not all these forms of therapy may be suitable for every type of patient. Further, some of them may be recommended or used in addition to some main course psychotherapy.

7.4 TYPES OF SPECIAL THERAPIES

7.4.1 PLAY THERAPY:

Mostly directed towards children, play therapy encourages them to explore life events that may have effects on their current circumstances through the medium of play. It helps them to communicate, explore repressed thoughts and emotions. It helps them in their growth and development. The importance of play therapy has been emphasized by many psychologists including Melaine Klein, David Levy, Carl Rogers, and Anna Freud.

Play has been used to unravel or understand the child's unconscious, as medium to release their pent up emotions, to access their inner thoughts and feelings, to generate or build a positive therapeutic relationship. During therapy, the child receives a safe and comfortable environment free from restrictions or limitations. The playroom wherein the therapy takes place is typically equipped with age appropriate toys. The child's choice or interaction with these toys often speaks louder than words about their thoughts and words. This is especially true for children who cannot express themselves verbally. Toy materials used may be sand pit, art materials, stuffed animals, puppets, construction toys, kitchen sets, dolls, indoor sports equipments, and games. Allied techniques like clay modeling, storytelling, music, dance, drama or creative visualization may be also used.

Free play is encouraged along with structured play. It may allow them to express their traumatic events. It will foster waiting skills, turn taking and social skills. Play happens in many forms depending on the developmental age or stage of a given child. A few types of play seen in children are solitary play, parallel play, toy play, pet play, enactive play, pretend play, shadow play, symbolic play, spectator play and so on. Play therapy can be also used for treatment of teenagers and adults. It stimulates their cognitive and motor skills. Play therapy has been used in adults with dementia, those suffering from bereavement, grief and loss, post traumatic stress, obsessions and compulsions, anxiety, depression, developmental issues and arrested emotional development. Although play therapy helps children to overcome resistance, increases their communication and socialization, gives the child a feeling of competency and mastery over fears, it requires a long term commitment. Among other things, it enhances relationships strengthens quality attachments, but it can prove expensive, and may be time consuming. Also, some children do not respond well to play therapy.

7.4.2 ART THERAPY

Art therapy or creative art therapy or expressive art therapy encourages a person to express and understand emotions through artistic expression and creative process. It allows both, verbal or non-verbal outlets either by form, content or meaning. It helps in reconciling emotional conflicts and in promoting self-awareness, explores emotions, address unresolved emotional conflicts, improve social skills, raise self-esteem, and attain personal growth. It helps individuals experiencing emotional and psychological challenges achieve personal well-being and improved levels of function. The term art therapy was coined by British artist Adrian Hill who discovered the health benefits of painting and drawing while recovering from tuberculosis. Art therapy has been found to benefit people of all ages. It can improve

communication and concentration, reduce feelings of isolation, and increase self-esteem, confidence and elf awareness.

Positive results by use of art therapy have been reported in conditions like anxiety, depression, substance dependence, cancer, relationship issues, phobias, stress, ageing and geriatric issues. Introverts who find difficulty in verbally expressing themselves find art therapy to be a convenient non-threatening option. The specific techniques used in art therapy includes paining, finger painting, doodling, scribbling, sculpting, drawing, clay modeling, making cards, textile printing, vegetable carving, rangoli, collage making, origami, pottery, etc. Art therapy has become an integral part of many rehabilitation centers, mental health facilities, crises centers, and institutions that strive to promote health, wellness and growth.

7.4.3 MUSIC THERAPY

Music therapy is defined as use of the unique properties and potential of music in a therapeutic situation for the purpose of changing human behavior so that the individual will be able to function in a more worthwhile manner. Another form of expressive art therapy, music therapy uses music to improve and maintain physical, psychological and social well-being of an individual. It involves a broad range of activities such as listening to music, singing, or playing on a musical instrument. Music has been used as a form of therapy since ages. It has been shown to soothe the brain especially the regions involved in emotion, cognition and sensation or movement. Both active and passive techniques may be employed in music therapy sessions. When the person is singing, playing on an instrument, chanting, composing or improvising music, he is considered to be in the active mode. Receptive techniques involve listening to music. This therapy can take place singly or in groups.

It has been used to treat anxiety, depression and hypertension. Playing on instruments have been shown to improve motor coordination, dexterity, strength and power in physically challenged persons. In children with autism, a group session of music can become an occasion and opportunity to improve their social skills. It can be used as a means to provide relaxation.

Music therapy may be useful as adjuvant to a main course therapy. However, it cannot be recommended as standalone therapy. Further, not all individuals may find music appealing. In an extreme condition called amusia the patient maybe actually unable to bear the sound of music.

7.4.4 DANCE THERAPY

Dance or movement therapy uses body motions to help individuals achieve emotional, cognitive, physical and social integration. It helps in reducing stress, disease prevention, and mood management. In addition, it increases muscular strength, improves eye hand coordination, gait, mobility, balance and power. Dance therapy has been used to improve body image and self-esteem. It has helped in conditions like chronic pain, obesity, cancer, arthritis, hypertension, and neuromuscular disorders. It helps in promoting pro-social behaviors, especially in children on the autism spectrum. Dance therapy is based on the principle that body-mind are inter connected and changes in one impacts on the other. Movement can express aspects of one's personality. Therapeutic relationship can be expressed through non-verbal means during dance therapy. Movements express the unconscious layers of an individual.

7.4.5 SPORTS AS THERAPY

Sports and fitness psychology propagates sports as form of therapy. Regular indulgence in sports helps manage stress and anxiety. It promotes general health of persons undergoing psychotherapy. It fosters positive personality traits like endurance, self-confidence, cooperation, team spirit and leadership qualities. It helps individuals develop their social skills. All this is to be distinguished from sports therapist also works on prevention of injury and the rehabilitation of the patient who is injured to bounce back to optimal levels of functioning. Action sports, for example, have been used to help troubled young people to find some relief from their personal struggles. Conditions like obsessive-compulsive disorders are reported to benefit following their involvement into regular competitive sports. Sports are recommended as an ideal context to explore ones irrational beliefs. It can help eradicate dysfunctional thought process and emotions. Prayer has been used as means to alleviate anxiety in the sports field, to establish a strong bond of attachment between team mates, and for coping under certain stressful situations.

7.4.6 DIET BASED THERAPIES

The word 'diet' is derived from Greek word 'diatia' which means 'manner of living. Ordinary food selection by individuals is based on personal preference, positive and negative associations that one has with certain foods, habit, cultural tradition and one's personal values. It can be also influenced by social pressure, emotional comfort, availability, convenience or economy, body weight or image as well as nutrition or health benefits. Examples of this type of therapy may target alpha protein deficits, diet disturbances, enzyme

dysfunction, food allergies, Gluten Free Casein Free Diets, Leaky Gut syndrome, nutritional deficiency or poor nutrition in general.

This form of treatment involves eating prescribed by a physician to improve health. A number of conditions can be treated by the use of proper diet. It also requires avoiding certain foods that do not go with certain diseases. Some conditions may require temporary therapeutic diets while others may necessitate permanent changes to keep the person healthy. People with gluten intolerance, for example, may be advised gluten free diet to prevent damage to the intestines. The diabetic diet is poplar involving limiting high sugar foods to help control blood sugar levels. Similarly, salt is restricted to control high blood pressure, or saturated oils are abstained to manage cholesterol. In this approach the diets are usually tailor made and regularly monitored by a professional nutritionist.

Therapeutic foods or ready-to-eat therapeutic food are water soluble, energy dense, micro nutrient enriched foods which are becoming increasingly popular. Diet based therapies using specialized dietary regimens to promote wellness are being recommended for cancer and cardio-vascular disorders. Some low-fat vegetarian diets can help reverse arterial blockages that cause coronary artery disease. They have been shown to prevent or slow the progression of prostate and other cancers. Persons who follow a specific type of diet have even reported cancer remission. It usually takes months or years for benefits to be observed. Nonetheless, diet therapies are more likely to be effective if practiced as a preventive measure against disease or if started early after the onset of disease.

Therapeutic diets are indicated to restore, correct or maintain nutritional status. It may be needed to maintain weight control, to avoid certain foods in case of intolerance or allergies. There are several safety issues that must be kept in mind while prescribing or practicing diet based therapies. It should be carried out under expert supervision.

7.4.7 SENSORY THERAPIES

Sensory-based therapies concentrate on correcting or improving the body's abnormal response to external stimuli. We all experience the world through our senses— sight, smell, touch, taste and sound. We interpret and react to our surroundings based on information the brain receives from the sense organs. For the entire time we are awake, these varied sensory organs are continuously sending information to the brain. For those of us without brain filters, it is presumed that this constant flow of incoming sensory messages is overwhelming. Among

the sensory based therapies, sensory integration therapy and auditory integration therapy are popular. Smell based aroma therapy and tactile based touch therapy is also discussed below.

(a) Aroma Therapy

The term aroma therapy was coined by the French perfumer and chemist, Rene Maurice Gattefosse in 1937. This involves the practice of using natural oils extracted from flowers, bark, stems, leaves, roots or other parts of a plant to enhance psychological and physical well-being. The inhaled aroma from these "essential" oils is widely believed to stimulate brain function. It is the therapeutic application or the medicinal use of aromatic substances for holistic healing. Essential oils can also be absorbed through the skin, where they travel through the bloodstream and can promote whole-body healing. A form of alternative medicine, aromatherapy is gaining momentum. It is used for a variety of applications, including pain relief, mood enhancement and increased cognitive function. There are a wide number of essential oils available, each with its own healing properties.

The influence of aroma on the brain, especially the limbic and olfactory system is offered as an explanation for the working of this therapy. However, one must be wary of the safety concerns in the use of certain scents. In some people it can cause allergies and irritate the skin. There are many essential oils which can be toxic and therefore avoided. Some of these oils can produce negative side effects from prolonged direct sun exposure. Risks vary on the age of the individual, the manner in which the oils are used, their personal health history, and personal body chemistry. Some health benefits of aromatherapy include its ability to reduce anxiety, ease depression, boost energy levels, speed up the healing process, eliminate headaches, boost cognitive performance, induce sleep, strengthen the immune system, reduce pain, improve digestion, and increase circulation.

(b) Auditory Integration Therapy

Auditory Integration Training or Therapy is a powerful educational music program aimed at helping children and adults succeed in social interaction. It has been used on children with autism, ADHD, speech language problems, dyslexia or learning disabilities. Hearing anomalies are believed to be the root cause of several of these aforesaid problems. This therapy seeks to use music to benefit these persons.

Pioneered by Dr. Alfred Tomatis (1920-2001) adapted electronically modified music by Mozart was used to treat many auditory processing problems. They believed that

behavioral and cognitive problems often arose when an individual perceived sounds in a "differential" manner. This happens when individuals perceive certain frequencies far more acutely than other frequencies. Sounds thus appear to that person in a "distorted" manner. This often leads to difficulties in comprehension and behavior. The objective of this therapy is to reduce "distorted" hearing and hypersensitivity of specific frequencies, so that after Auditory Integration Training (AIT), ideally all frequencies could be perceived equally well. The individual would then be able to perceive environmental sounds, including speech, in a normal fashion.

Children who put their hands over their ears unable to handle certain sounds, who cry in response to certain loud sounds, who avoid noisy or crowded group situations, who do not pay attention to verbal instruction, who are easily distracted by random noises, with auditory comprehension problems, who frequently give odd or inappropriate responses in conversation and so on are considered to have auditory issues that demand further investigation. Following AIT, children have been reported to have achieved increased attention to auditory input, improved social behavior, increased interest in communication, better eye contact, improved articulation, improved auditory comprehension, overall improvement in academic skills, and reduction of sensitivity to sound impulsivity, aggressive behavior, echolalia, distractibility and temper tantrums.

(c) Sensory Integration Therapy

In 1970s, Jean Ayres observed children with learning disabilities often experienced motor, sensory and perceptual difficulties owing to their inability to process information. By providing sensory experiences, it was believed that there will be sensory integration as well as overall improvement. Children are first evaluated to see whether they are hyper or hypo sensitive to noise, touch, smell, sight, or taste stimuli. Also, proprioceptive and vestibular senses are evaluated. A proprioceptive sense involves a person's awareness of what their muscles and joints are doing. It is about where they are in space and how they are moving. The vestibular sense is related to inner ear and involves a person's awareness of movement, head position, balance and coordination.

Specific activities during therapy include drawing with fingers in smooth sand, swinging on a rope, jumping into ball pit, or crawling through tunnel. Sound is focused by experiencing with talking toys, squeaky toys, music, clapping together, rhymes, repeating phrases, using tongue twisters, and games on computers. The proprioceptive system is stimulated through activities that promote eye movements, balance and coordination. Activities may involve using weighted belts or blankets, bouncing on trampoline or a large

ball, skipping or pushing heavy objects. Vestibular system is stimulated by activities like building blocks, construction toys, spinning, somersaulting, rocking, swings, slides, negotiating mazes or obstacle courses, swimming, and merry-go rounds.

The activity is matched to a given child's needs. It seeks to address the sensory challenges by play. It is not that specific sense organs are addressed. Rather, the focus is on integration of all the senses. Multi-sensory integration or multi-modal integration covers all senses to give meaningful perceptual experiences.

(d) Touch Therapy

Therapeutic touch, healing touch or non-contact therapeutic touch is pseudoscientific treatment protocol whose practitioners claim healing and reduction in pain and anxiety. It is believed that every person has an energy field which needs to be appropriately touched in order to elicit the desired therapeutic results. Practitioners place their hands on or near a patient to detect and manipulate the energy field.

Therapeutic touch is based on the assumption that human being is an open energy system with layers of energy that are in constant interaction with the self, others and environment. Illness is the result of an imbalance in the individual's energy field. Cleaning or balancing the energy field promotes health. All humans are believed to have the natural ability to heal themselves as well as others.

Closely allied to touch therapy is the practice of Reiki. It is an alternative form of medicine developed in Japan by Buddhist Mikao Usui. The practitioners use palm healing or hands on healing by which universal energy is transferred through the palms to the patient to cause healing. Other similar forms of therapy are acupressure, acupuncture, and pressure points therapy. Touch based therapies do not claim to cure diseases. They attempt to stimulate the body's natural healing properties by methods of relaxation or stress and anxiety reduction.

7.4.8 LAUGHTER THERAPY

Gelotology is the study of laughter and its effects on the body from psychological and physiological perspectives. Laughter is an excellent medicine to reduce pain and stress. It provides a complete workout for the muscles, and releases stress busting endorphins. Anything that makes you giggle can have positive impact. Laughter therapy aims to get people laughing in group and individual sessions. It can help reduce stress, make people happier and more committed, as well as improve their interpersonal skills. The actual

technique involves clapping in rhythm to 'ho-ho-ha-ha-ha-ha'. While doing so the body indulges in breathing and stretching. The patient indulges in child like play.

Humor or laughter therapy uses humorous materials, joke books, comedy channels, shows, movies or stories, to encourage spontaneous discussions in small groups of patients that are often facilitated by a clinician. Laughter meditation focuses the person to concentrate on the moment. It involves a three stage process of stretching, intentional laughing and a period of meditative silence.

Apart from being a form of therapy on its own, laughter can be used as icebreaker on occasions during any form of psychotherapy. A bout of laughter strengthens any relationship. Exchange of healthy humor can build rapport or ease communication. It can increase therapist-patient bonding, elevate moods, increases energy and help perform activities that we might otherwise avoid. It can subtly change perspectives, provide relief, and facilitate authentic relationships.

7.4.9 ANIMAL ASSISTED THERAPY

Also called hippo-therapy or equine assisted psychotherapy, this procedure involves the use of animals especially horses as tools for increasing self-awareness and healing. It was developed by Liz Hartel, Florence Nightinghale, Boris Levinson and Sonia Bellack. This therapy makes use of the natural bonding that exists between man and animal. Animals often elicit many emotions in us and many people tend to respond positively to the idea of animal interactions. Animal assisted therapies have been shown to be helpful in decreasing stress levels, reduction of anger and aggression, improved social interactions, decreased heart rate and blood pressure, improved self-esteem, patience and trust.

Animals have been used in a variety of settings including schools, prisons, nursing homes, and mental hospitals. Assistance dogs are used by people with disabilities. Dolphins have been used on children with autism and attention deficit disorders. Birds are useful for withdrawn patients. Reading to dogs program has been tried with children having reading problems. It gives enjoyment to children, improves their self-confidence, and increases homework completion. Even in our country, rearing of domestic animals and birds like cows, goats, fishes, hen, or other species is encouraged in most rural households to boost their domestic economy as well as to provide relief for their emotional stress. Among the advantages, animals give a feeling of closeness and privacy. Although they cannot or do not substitute human relations, they do not mock at humans. Interactions with animals improve the physical, psychological and social well-being of human beings. In the disabled, they

improve fine motor skills, balance and wheel chair skills. They reduce anxiety and loneliness, increase self-esteem and verbal interactions.

7.4.10 ALTERNATIVE SYSTEMS OF MEDICINE

Complementary and alternative medicine covers various systems of health care (such as, traditional Chinese medicine, Native American Medicine and Homeopathy), mind-body therapies (such as, Psychoneuroimmunology, Imagery and Meditation) and manipulative therapies (such as, massage and tai chi). It can also include biological based therapies like aromatherapy and energy therapies like healing touch, therapeutic touch and Reiki discussed earlier. It can include herbal medicine, Naturopathy, Ayurveda, Siddha, and Homeopathy. Manipulative and body based practices may include chiropractic medicine, massage therapy, body work practices like rolfing. Energy field based medicine may cover acupuncture, acupressure, Reiki, therapeutic touch and Qigong.

A distinction is made between complementary medicine which is used together with conventional medicine and alternative medicine which is used in place of conventional medicine. There are many reasons why people go in for alternative systems of medicine. It could be because conventional medicine is too expensive. It could be because someone recommended it. Or it might be due to the thought that conventional medicine might not help. Some people may just want to give it a try. Note that complementary and alternative medicine can be dangerous if it interacts or interferes with conventional treatments. Another approach called integrative medicine combines treatments from conventional medicine as well as complementary and alternative medicine.

7.4.11 MEDITATION

Meditation has been used for stress relief and to reduce anxiety. It provides relaxation, decrease oxygen consumption, slow heart rate, decrease blood pressure, improve function of immune system, reduce pain, and improves health. The use of meditative practices in psychotherapyleads to physiological, behavioral, and cognitive changes that may have potential therapeutic benefits. There are many forms of meditation developed by different religious and spiritual traditions. Many involve some form of withdrawal of attention from outer world and from customary patterns of perceptual, cognitive, emotional, and motor activity, performed in a state of inner and outer stillness. Other forms of meditation use music, movement, visual or auditory contemplation of physical objects or processes (i.e., staring at a candle flame, watching or listening to a stream of water or ocean waves). Goleman divides meditation into two categories: concentration methods and insight

techniques. Concentrative meditation fixes the mind on a single object, such as, the breath or a mantra. It tries to exclude all other thoughts from awareness. This kind of meditation is prescribed in the Yoga Sutras and Buddhism. It has been popularized in the form of 'Transcendental Meditation'. Concentration practices suppress ordinary mental functioning, restrict attention to one point, and induce states of absorption characterized by tranquility and bliss. Buddhism, however, introduced the practice of insight meditation (vipassana).

Meditation is an adjunct to therapy, not a replacement for it. Much of the physiological data on meditation suggest its effectiveness for treating a variety of stress-related, somatically based problems. It has been associated with self-actualization, decreased anxiety and drug use, and improvements in behavior and interpersonal relationships. The relaxation model of meditation has allowed it to become more familiar, acceptable, and accessible to the scientific community and public at large. Meditation, Zen, Yoga, and relaxation techniques-such as autogenic training, hypnosis, progressive relaxation and certain forms of prayer have been grouped under "relaxation techniques" which only requires a quiet environment, a mental device for focusing attention, a passive solitude, and a comfortable position.

7.5 SUMMARY

Upon reading this unit, you must have understood that there are variety of approaches and techniques to help people even though they may not officially fit into the tenens of what one may call as psychotherapy. However, owing to their ease, availability, and popularity these special forms of therapy are widely used. They are also inexpensive. Therefore, each form of special therapy was defined, and explained in relation to their goals or practices. However, you must realize that many of them are not scientifically validated. Many of them lack official recognition. However, their practice is fine if it is not at the expense of the main course therapy.

7.6 KEY WORDS

Aerobics	Animal Assisted Therapy
Aroma Therapy	Art Therapy
Breatherianism	Dance Therapy
Diet Based Therapy	Fruitarianism
Hippo therapy	Hypnotherapy
Laughter Therapy	Meditation
Movement Therapy	Music Therapy

Play Therapy	Proprioceptive Sense
Reiki	Rolfing
Sensory Integration Therapy	Sports Therapy
Touch Therapy	Vestibular Sense
Vipaasana	Yoga
Zumba Dance	Zen

7.7 CHECK YOUR PROGRESS

(a) What are special therapies? Highlight their characteristics.

(b) Write short notes on play therapy.

(c) What is art therapy?

(d) Write about the merits and demerits of music therapy.

(e) What are the applications of dance or movement therapy.

(f) Explain the various forms of sensory based therapies.

(g) Highlight the benefits of laughter therapy.

(h) Mention the benefits of animal assisted therapies.

(i) What is alternative system of medicine?

(j) How is meditation useful for improving psychological health and well-being?

7.8 ANSWERS TO CHECK YOUR PROGRESS

(a)	7.2	(b)	7.3.2	(c)	7.3.3	(d)	7.3.4	(e)	7.3.7
(f)	7.3.7	(g)	7.3.8	(h)	7.3.9	(i)	7.3.10	(j)	7.3.11

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UNIT- 8 : GROUP THERAPIES

STRUCTURE:

8.1 OBJECTIVES

After going through this unit you will be able to explain

- Meaning, definition, goals, nature, principles, practices and procedures in group psychotherapy;
- Applications, merits or advantages as well as demerits, limitations or disadvantages of group based psychotherapy;
- Illustrative types of group psychotherapy, such as, activity groups, directive-didactic groups, client centered groups and conjoint, concurrent, combined or marital therapy;

8.2 INTRODUCTION

Working in groups has its own advantages. Psychotherapies carried out in exclusive or inclusive homogeneous or heterogeneous groups help creating an atmosphere of mutual supports. If the group turns out to be a close knit community of members, a nonjudgmental setting its unconditional supports can have therapeutic value. It allows members to turn towards one another for support, feedback, and connection. The therapist acts only as facilitator for the group. The thought that one might be the only person with a given problem can be frightening and unacceptable. A group situation gives insights that one has strikingly similar problem as others in one's group. Group therapies help the individual patient to find a 'voice'. One can share or express through the opportunity or medium in the group. It helps relate with others in healthy ways. Sharing can be healing. By revealing your innermost thoughts, feelings and struggles with other group members, you feel relieved. There are certain insights that you gather in a group which might not occur in one-to-one settings. Others in the group may serve as models to pick positive behaviors. Group therapy provides a safety net. Diversity is an important benefit. People with different personalities and backgrounds tackle problems and make positive changes. You can discover a whole range of strategies for facing your own concerns.

8.3 MEANING & DEFINITIONS OF GROUP THERAPIES

Group therapy is defined as a meeting of two or more people for a common therapeutic purpose or to achieve a common goal. It creates open and closed ended groups wherein people previously unknown to one another may also become part of the group. Research has shown that most patients benefit from group therapy within brief span of time-typically 2-3 months.

Group psychotherapy is a treatment mode which carefully selects people who are emotionally ill so as to form a group of them to be guided by a trained therapist. It helps one another to create personality change. In other words, it is a treatment of psychological problems in which two or more patients interact with one another at emotional cognitive levels in the presence of a trained therapist who act as facilitator or interpreter. A distinction is made between group therapy, therapeutic groups and adjunctive groups. Members in group therapy gain personal insight, improve their interpersonal relationships, change destructive behavior and make necessary alterations to their behavior. A therapeutic group comprises of patients who meet under the leadership of a therapist to work together to improve mental and emotional health. Examples: Groups of expectant mothers, people who have just lost their spouses, or a group of people with a chronic illness may join together to form a therapeutic group. Adjunctive groups deal with selected needs of a group. For example, a group may be formed for sensory stimulation through music therapy, for self-expression through are therapy, or for expression of feelings and emotion through dance therapy.

Another classification differentiates between growth groups, support groups, task groups and education groups. Growth groups are designed to increase an individual's sensitivity on problem-solving ability. Support groups assist an individual to deal with normal life changes and crisis. Task groups use problem-solving strategies to achieve an outcome. Education groups are designed to improvise information and teach new skills.

8.4 PRINCIPLES, PRACTICE & PROCEDURES OF GROUP THERAPHY

When and how do we select as to which patient may be appropriate candidate for group rather than individual psychotherapy? There are no hard rules. However, patients with minimum levels of interpersonal skills, those with poor motivation for individual based treatments, those with interpersonal problems, those who show susceptibility to group influences or those willing to be of help to others may benefit more from group therapies.

Whatever maybe the model of group psychotherapy that one may follow, whether it is dynamic, interactional or relationally based, it is vital that certain principles and practice guidelines are adopted and followed. According to Yalom, the major principles underlying group psychotherapy are universality, altruism, imparting information, installation of hope, corrective recapitulation of the primary family experience, cohesiveness, modeling, catharsis and self-understanding. Each group has a stage of ego development, ego strength of individual members, the population being treated as a group, their individual and group

resistances. It may require the deployment of a variety of techniques, targeting different client populations and different treatment settings. In practice, it is needed to have:

- Focus on the here-and-now;
- Well set therapeutic goals and time frames;
- Maintain record keeping procedures;
- Outline and follow ethical procedures;
- Opportunities to develop socializing techniques, adaptive and effective communication;
- Develop feelings of trust, belonging and togetherness in the group;
- Give opportunities to ventilate strong feelings about past and present experience;
- Help members to gain insight and self-understanding into their own behaviors;
- Encourage interpersonal learning through interactions with fellow members;
- Get involved and be as open as possible;
- Learn to give feedback to others;
- Share both positive and negative feedback;
- Give the feedback as soon as possible;
- Be direct and honest, and provide concrete examples;
- Avoid giving advice;
- Remember that how people talk is as important as what they say;
- Don't deny the patient's feelings by saying you should not feel this way;
- Don't push the patient to divulge details that s/he is unwilling to;

In actual practice, group psychotherapy must have an optimal size of 8-10 members. A therapeutic group relationship must be started under the guidance and facilitation of a trained therapist. A preselected group of individuals must meet periodically to discuss, influence each other, give and receive help, to overcome their emotional problems. The types of patients who are suitable for group therapy are those with psychosomatic problems, alcohol and drug dependence, neurosis or adjustment disorders, those without hallucination and delusions.

It is not uncommon for participants to enter into group therapy with several myths and misconceptions. They may have apprehensions that they might be forced to tell their deepest thoughts, feelings, and secrets to the group, or that they may be coerced to do something that they do not want to do in the group. It is also a common misconception that group therapy will take longer time and be less effective than individual therapy since time is shared with

others. Some members might have hesitation that they may be confronted or humiliated by the therapist or group members.

Ideal effective group settings are demarcated as therapeutic milieu. It could take place in a hospital, school, half way homes, or in clinics. It could follow group based expressive therapies like drama therapy, psychodrama, art therapy, music therapy or others. The schedule of meetings can range between 1-3 times per week. The duration of meetings could be between 90-120 minutes per session. Preferably, the problems of members and the goals are to be about the same. As a facilitator, the therapist seeks to generally focus on here and now. All efforts are directed towards facilitating the development of insight by all group members into their respective problems. The therapist's duty is to protect every member from verbal abuse or scapegoating. Whenever appropriate, the therapist must provide positive reinforcement, ego supports and encouragement to all individual members. The therapist must tactfully set limits from dominating members overtaking the fragile in a gentle, supportive and non-threatening manner. He must effectively encourage introspection and facilitate insight. Laughter and moderate amount of humor can be used as safety valve to strengthen cohesiveness in the group.

The formation of a group to get into therapy usually takes place through three steps: Selection of group members, developing contact and selection of group leaders. Some techniques used in group therapy are reflecting, asking group members to react to another's statement, pointing to important issues raised, and summarizing various points at the end of the session. Other techniques may include clarifying, linking, suggesting, interpreting, modeling, facilitating, blocking, and terminating. Problematic situations that erupt in group therapy situations may include a dominating member with monopolistic behavior, another unusually silent member, a story telling narrator, or yet another always advising participant. There may be also members who show over dependency, too frequent questioning and/or offer intellectualizations.

Homework is another technique commonly used in group therapy. It maximizes what is learnt in the group situation. Homework assignments are designed by members alone or in collaboration. Ending the group at the closure of psychotherapy is also an important step. It involves tasks dealing with feelings of separation, handling unfinished business, reviewing the group experience, giving or receiving feedback, and carrying learning further.

8.5 APPLICATIONS & LIMITATIONS OF GROUP THERAPHY

There are many advantages of group therapy. It helps reduce denial, process ambivalence, and facilitate acceptance. It increases motivation for behavior changes. It treats the emotional conditions like anxiety, depression, or hostility, increases the capacity to recognize, anticipate, and cope with situations that may precipitate maladaptive behaviors. It increases social acceptance and supports.

Patients focused on their problems may begin to look around others in group settings. It offers opportunities to help others and express their altruistic tendencies. It helps the individual members to learn new social skills through role playing and modeling exercises. Group members can also learn by imitating other members who are successfully dealing with difficult relational issues. Groups provide an opportunity for members to learn about relationships and intimacy. The group itself is a laboratory where group members can, perhaps for the first time, honestly communicate with individuals who will support them and provide them with respectful feedback. This is called interpersonal learning.

Group therapy facilitates cohesiveness or sense of belonging that helps the individual not only to relate with oneself but also others. The experience of belonging is both nurturing and empowering. Sometimes group participants will gain a sudden insight through interaction with others, which can cause a significant internal shift in the way they respond to life.

Some of the listed benefits of group therapy are: (a) Support: Patients receive attention and sympathy from other members. They feel that they are not alone and lonely. (b) Ventilation: It gives the patient a chance to ventilate his feelings and the feeling that there are people who understand. (c) Catharsis: it allows an explosive release of hitherto dammed up emotions thus having therapeutic effects. (d) Insight: The patient discovers connections between earlier and present events and may even see the roots of his conflicts. (e) Learn good or socially acceptable behaviors on how to sit, when to talk, how to co-operate with others and punctuality. (f) Feedback: The patient will get feedback from other members about his behavior or progress.

Of course, confidentiality and anonymity is to be respected in groups. The participants should feel comfortable sharing themselves in the warm and supportive environment. Educative group therapies can help build social skills. By easing their sense of isolation in the world, it can give opportunity to practice engaging with others. By default, social skills aregained by individual members. In short, group therapies have the major goal of helping

individuals transcend their mental health struggles through experiencing their common humanness with others fighting the same battles. Group therapies are also cost effective compared to individual therapies.

Many times, group therapy is loosely used to include support groups in psychiatry settings. However, group therapies are not indicated when the patient is in a fragile emotional state. If clashes are exhibited by certain other group members, such patients may be harmed than being benefitted by the therapy. Group therapy may strike fear in some patients. They may feel overwhelmed by the presence of a crowd. The idea of speaking to a room full of people may turn some patients anxious. A few patients may hesitate to open up in a group for fear of losing confidentiality. Group therapies are not helpful when dealing with crises situations. Group therapy is not indicated for patients with antisocial personality elements, or those with severe depression, social phobia, and suicidal tendencies. It may not be useful for acutely symptomatic patients have delusional psychoses. It is sometimes argued that group therapies are unfocussed and impersonal.

Among the well stated ethical guidelines for group therapies, it is mandated that at all times no harm happens to your patients. It is stressed that one must keep the professional boundaries intact during all relationships with the group. Financial dealings are to be restricted only to payment for the services rendered or received. One is recommended to be open about the limits of your clinical skills and be prepared to make outside referrals once it falls outside the scope of one's ability. Diversity in the group needs to be acknowledged and accepted. Informed consent must be taken from all members in the group.

8.6 TYPES OF GROUP THERAPHY

8.6.1 ACTIVITY GROUPS

Activity group psychotherapy happens when participants are permitted to act out their repressed impulses in the presence of a non-participating therapist. Activities in a group may cover exercises, games, or other initiatives. They could be ice breakers, warm ups, and energizers, or they could be activities to facilitate team building, fun games, self-awareness exercises, or trust building activities. Activity based therapies build togetherness and team spirit. They help participants to pool their skills, exchange information, delegate roles and responsibilities, tackle more complex problems than when they can do it alone. It helps them to share diverse perspectives, receive and give social supports, establish a shared identity and find effective peers to emulate. People have been observed to become more productive and resourceful as they indulge in group activities.

Disadvantages in group activity based therapies lies in unequal participation. Some participants remain over involved while others may become passive and under involved. This may cause jealousy and bitterness among members in the group. In any group activity, disagreements are bound to occur between members in the group. Each person may have their own ideas which could conflict with another person. Some people in a group might find it difficult to accept suggestions or ideas from another person. They would want everyone to accept their ideas or suggestions. This conflict could as well put a stop to the flow of work, until the issue is resolved. Group activities do not encourage individual thinking. Being a group effort, decision making may also take more time. If the group is large one, there is tendency for some members loaf around to avoid work.

8.6.2 DIRECTIVE-DIDACTIC GROUPS

This form of therapy is used in group situations. It is a more intrusive form of therapy involving a dialogue between the patient and therapist. It can result in more emotionally intense experiences. During a session, the therapist presents some type of problem or challenge that members of the group are likely to face. Then, s/he teaches them the most effective, healthy, and rational ways to react to overcome or resolve the problem or challenge. The primary goal of the didactic technique is to fortify patients' positive problem-solving skills so that they'll be able to overcome especially difficult and potentially harmful situations. Being a goal-oriented, short-term therapeutic approach, didactic group therapy has been mostly used in the treatment of substance abuse. This is especially so when they are in the stage of recovery or during relapse prevention. At that time, it involves the patients talking about their past experiences.

8.6.3 CLIENT CENTERED GROUP THERAPY:

Also called person-centered group therapy, this approach was developed by Carl Rogers in the 1940s. One of the radical aspects of this approach is their preference to use the term 'client' or 'person' instead of the term 'patient'. This is because they do not see the clients as sick persons needing cure. Rather, they are people who wanted someone to help them to find their own solutions which are referred as 'self-direction'. Earlier, the term 'non-directive' was used to refer to this form of therapy. Later, it was changed as 'client centered' therapy. It is a form of therapy which is non-directive and humanistic wherein the milieu is deliberately kept warm, accepting and free for clients to be at ease with themselves so as to facilitate their positive growth.

According to this approach, people are viewed as innately good and if allowed to develop naturally, they will grow towards self-realization of their inner potentials. The therapy simply provides support rather than proposing solutions, answering questions or actively directing the course of therapy.

Its goal is to provide patients with an opportunity to develop a sense of self. Dubbed as a humanitarian approach, this therapy affirms individual personal experience as the basis and standard for living and therapeutic effect. The client's perception of the therapist's genuineness, unconditional positive regard and accurate empathy constitute the main features of this therapeutic relationship. Six conditions are listed as necessary and sufficient condition for therapeutic change. They are:

1. **Therapist–client psychological contact**: This involves a relationship between client and therapist in which each person's perception of the other is important.
2. **Client incongruence**: This means that incongruence exists between the client's experience and awareness.
3. **Therapist congruence or genuineness**: This means that the therapist is congruent within the therapeutic relationship. The therapist is deeply involved. He is not 'acting'. Both can draw on their own personal experiences through self-disclosure to facilitate the relationship.
4. **Therapist unconditional positive regard**: This means that the therapist accepts the client unconditionally without judgment, disapproval or approval. This attitude facilitates increased self-regard in the client, improves their sense of self-worth.
5. **Therapist empathic understanding**: This underlines that the therapist experiences an empathic understanding of the client's internal frame of reference. Accurate empathy on the part of therapist help the client believes the therapist's unconditional love for them.
6. **Client perception**: That the client perceives, to at least a minimal degree, the therapist's unconditional positive regard and empathic understanding is critical in the relationship.

The goals of person-centered therapy are different from those of traditional approaches. It aims at a greater degree of independence and integration of the individual. Its focus is on the person, not on the person's presenting problem. Its purpose is to assist clients in their growth process. It simply seeks to provide a climate wherein the person can become a fully functioning individual. They must first get behind the masks they wear. This can be

achieved only by openness to experience, trusting in themselves, by making correct self-evaluations and showing willingness to continue growing. No specific goals are chosen for therapy. They have to define and clarify their own goals. In short, the therapy goals are: an increase in self-awareness, improved ability to use self-direction to make desired changes, increased clarity, improved self-esteem, and greater reliance on self.

The therapist does not make attempts for the client to 'do something'. They serve only as instruments to change. The therapists do not take case history, do not ask leading or probing questions, do not make interpretations of the client's behavior, do not evaluate the client's ideas or plans, and do not decide on their behalf. The therapist simply seeks to be real, congruent, accepting, available, and empathetic. He is just a catalyst for change. On their part, clients first enter therapy in a state of incongruence as discrepancy exists between their self-perception and their experience of reality. They become just aware that a problem exists in the present and that they have to come out of it. The clients seek therapy because of their felt helplessness, powerlessness and inability to take decisions on their own. The therapist client relationship gives them that greater self-understanding.

As therapy proceeds, they are able to explore wider range of beliefs and feelings. They distort less and accept more and more of themselves. Their defenses give away and they feel safe and less vulnerable. They become more realistic of accepting themselves and others. Thus, they become more mature and self-actualized. The client is this primary agent of change. The therapy relationship simply provides the supportive structure.

The reflective style of client centered therapy has found applications in the treatment of a wide range of problems including anxiety disorders, alcoholism, psychosomatic problems, agoraphobia, interpersonal difficulties, depression, cancer, and personality disorders. Sensitive listening, hearing and understanding have been found to be useful in crises counseling. This form of therapy demands a great deal from the therapist. Without their attitude and way of being the whole exercise is bound to fail.

8.6.4 CONJOINT, CONCURRENT, COMBINED, COUPLES AND/OR MARITAL THERAPY

This is a form of therapy, wherein the two parties in a union or the individuals making up a family unit are given treatment at the same time in collaborative meetings by at least one professional in the field, rather than being rendered treatment individually. It is an approach to treatment where two or more clients are seen together in a therapy session. When a patient is in medium or long term individual as well as group based psychotherapy with the same

therapist, it is called combined psychotherapy. When one therapist treats the patient individually and one or two other therapists treat him in group psychotherapy then it is called conjoint therapy.

This method is frequently used to conclude conflicts within marriages, wherein it might be referred to as conjoint marital therapy. During the sessions, the couple or family members can get help to improve their communication and coping skills. The sessions occur in a safe place for clients and their families to bring up issues which may be awkward, uncomfortable, or too "loaded" to discuss outside of the office. Individual therapy for a marital problem does not give the therapist a full picture of the marital interactions. It does not allow opportunity to help both partners to systematically address issues of mutual concern.

Under the direction of the single therapist, clients can reduce blaming and negativity in their relationship. Part of the therapy process involves setting goals for improving the relationship and determining the specific steps required to achieve them. With conjoint therapy, each step in this process is completed with the help of a therapist. The client and his or her family don't have to go it alone or feel that they are getting stuck or bogged down in the process.

This type of treatment has the advantage of being highly flexible and its focus can be adjusted according to the needs and goals of the clients involved. Conjoint therapy can also be used in conjunction with individual therapy sessions in situations where a client wants or needs to do some individual work before feeling ready to bring others into the process. It allows discussions on the main problems affecting a relationship. It helps the partners to get an objective or unbiased observations about the relationship. The awareness will provide a clear picture on the strengths and weaknesses in the relationship. It will provide the means to improve mutual communication and foster conflict resolution skills. It will help foster a change in perspective. It may require time, effort and energy to achieve results in these therapies

8.7 SUMMARY

In sum, this unit has covered details on the meaning, definition, goals, nature, principles, practices and procedures in group psychotherapy. It has explained the applications, merits or advantages as well as demerits, limitations or disadvantages of group based psychotherapies. A few illustrative types of group psychotherapy, such as, activity groups, directive-didactic groups, client-centered groups and conjoint, concurrent, combined or marital therapy were also discussed.

8.8 KEY WORDS

Activity Groups	Catharsis
Client Centered Therapy	Combined Therapy
Concurrent Therapy	Conjoint Therapy
Couples Therapy	Didactic Groups
Directive Therapy	Expressive Therapies
Non-directive Therapy	Person Centered Therapy
Positive Regard	Psychodrama
Therapeutic Milieu	Ventilation

8.9 CHECK YOUR PROGRESS

(a) Define group psychotherapy. Explain its salient characteristics.

(b) Enunciate the principles, practices and procedures underlying group psychotherapy.

(c) Explain the applications, merits or advantages as well as the demerits of group psychotherapy.

(d) Justify activity groups as a useful mode of group psychotherapy.

(e) What do you mean by directive-didactic groups?

(f) Bring out the salient features of client centered group therapy.

(g) Highlight the similarities and differences between conjoint, concurrent, combined and marital therapy.

8.10 ANSWERS TO CHECK YOUR PROGRESS

(a) 8.3 (b) 8.4 (c) 8.5 (d) 8.6.1 (e) 8.6.2

(f) 8.6.3 (g) 8.6.4

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UNIT – 9 : CLASSICAL PSYCHOANALYSIS

STRUCTURE:

9.1 OBJECTIVES

After going through this unit you will be able to explain

- Background of psychoanalysis
- Nature and processes of psychoanalysis
- Role of psychoanalyst
- Techniques in psychoanalysis

9.2 INTRODUCTION

Psychoanalysis is tripartite. A theory of human behavior, research tool and a therapy. Psychoanalysis as a therapy, technique exist as a valid treatment procedure when it is solidly based on conceptual ground.

Psychoanalysis is designed to bring repressed feelings and thoughts to conscious awareness so the person can deal with them more effectively. Psychoanalysis is based on Sigmund Freud's theories. According to Freud psychological problems occur due to the anxiety and hidden conflicts between the unconscious.

According to Freud human personality has three elements the Id, ego and superego. These three elements and the external environment of the man are constantly acting and reacting and it is quite possible for these three elements to come into mutual conflict about something. This conflict results in the gradual manifestation of various characteristics and they are the causes of all mental disorders. The main object of Freud’s psychoanalytic technique was to strengthen the ego, knowledge or consciousness of self in man, this can be achieved by rescuing it from the grip of super ego and making it incumbent upon the Id. To achieve this objective therapist has to bring to the conscious level all motives and desires repressed in the unconscious of a patient. This is no simple task because the unconscious mind creates obstacles in the path of direct recognition. It is the task of the therapist to overcome these obstacles and bring to conscious recognition all elements residing in the dark unconscious. And only psychoanalysis can do this.

9.3 BACKGROUND OF PSYCHO ANALYSIS

Psychoanalysis came as a theory of human behaviour research tool and a therapy. The classical psychoanalysis can be understood based upon its historical notes about the psychoanalytic theory in an order. Rapport (1959) divided psychoanalytic theory into four historical eras. The first phase of the history of psychological ego psychology coincides with

Freud's prepsychoanalytic theory, it ends with 1897 the approximate beginning of psychoanalysis proper. The second phase, which ends in 1923 is the development of psychoanalysis proper. The third phase begins with the publication of the Ego and Id(1923) and encompasses the development of Freud's Psychology, which extends to 1937. The fourth phase begins with the crucial writings of Anna Freud (1936), Hartman (1939), Erickson (1937), Horney(1937), Kardiner (1939), Sullivan (1938, 1940) and extends till 1980s. The general Psychoanalytic psychology of the ego based on the foundations laid by the Freud began to evolve in this phase. The study of the historical background helps to understand how the techniques follows the theory, it also helps to indicate which technique are still pertinent to modern practice.

Psychoanalysis as a treatment modality is most suitable for treatment of choice of neurosis even today. Psychoanalysis as a theory of personality and a method of treatment has emerged from the atmosphere of contempt and anger that greeted Sigmund Freud's first formulations to a dominant position in the training centers for mental health professionals.

Freud in 1882, when he was in twenties, first heard of Joseph Breuer's hypnotic treatment of a young woman presenting a variety of historical symptoms – anesthesia of her right arm and leg, Visual impairment and loss of capacity to speak her native language. Four years later, after a period of study with hypnotist Charcot in France, Freud set up a medical practice in Vienna. There he saw many patients with disturbances that were not associated with any organic condition and would not yield to conventional medical treatment. Freud used hypnosis as a tool in those kinds of situations and found it successful, but as years passed, he became disenchanted with the technique, since it rarely produced lasting cures and it could be applied only with some patients.

By 1896, Freud adopted a technique of placing patients on a couch in a quiet room and directing them to report without reservation any thought that entered their mind. Freud sat out of their line of sight and listened to their stream of consciousness his patients reported. Under these conditions, the patients elaborately used to explain the problems and suggested sometimes in veiled terms, the nature and source of their neurotic conflicts. The important and the lasting principles of psychoanalysis were established in these early experiments.

First, Freud established the fundamental rule that the patient honestly and unreservedly report everything that comes to mind without questioning its meaning relevance importance, or acceptability to the therapist.

Second, Freud believed that for the free association, to be truly free, the patient should be relaxed general reclining position, the analytic chamber should be quiet and neutrally decorated, the analyst should be out of sight. This helps the person to avoid getting distracted by the therapist, and the invisibility and neutrality of the therapist tend to evoke fantasies about him on the part of the patient.

The fantasies about the therapist often reflected powerful feelings generated in childhood which the patient unconsciously felt toward significant figures in his adult life. Such repressed feelings, brought to consciousness, could be reexamined in the light of the strength of the adult ego. Psychoanalysis grew out of Joseph Breuer's case study of Anna O. Through Breuer was the first to describe this "talking cure" it was Sigmund Freud who elaborated it into a system of psychotherapy.

9.4 NATURE OF PSYCHOANALYSIS

Freud found that childhood emotional conflict repressed into the unconscious mind cause the symptoms of psychological disorders including conversion hysteria. Freud's aim was to make the person gain insight into his or her repressed conflicts, thereby inducing catharsis and relieving the underlying conflict. This led Freud to develop the form of therapy known as psycho analysis. Traditional Freudian psychoanalysis takes place with the client reclining on a couch and therapist sitting nearby, just out of sight. Freud claimed that this arrangement relaxes the client, thereby reducing the client's inhibitions about discussing emotional topics. Traditional Freudian psychoanalysts might see clients three to four times a week for years.

9.5 PROCESS OF PSYCHOANALYSIS

In the early stages of psychoanalysis the analyst remains impassive, mostly silent and out of the person's sight. In classical psychoanalysis the client lies on a couch while the neutral analyst sits behind him or her. The analyst's silence is a kind of "black screen" onto which the client eventually projects unconscious thoughts and feelings. The interview follows stages psychoanalysis demonstrates free association. The analyst remains fairly quiet, analysis typically proceeds very slowly after the initial awkwardness wears off many people enjoy having the chance to talk without interpretation and appreciate having someone interested in their problems. The client may test their analyst by talking about desires and fantasies they have never revealed to anyone else. But the analyst maintains neutrality throughout the process, showing little of his or her own feelings and personality. When people discover that

their analyst is not shocked or disgusted by the revelations, they are reassured and project on their feelings they have towards authority figures from their childhood a process known as transference occurs. When the client feels good about the analyst the process is called positive transference.

The clients when continue to expose their innermost feelings, they begin to feel increasingly vulnerable. They want reassurance and affection, but their analysts remain silent. Their anxiety builds. Threatened by their analyst's silence and by their own thoughts, clients may feel cheated and perhaps accuse their analyst. This is called negative transference. Negative transference reveals client's negative feelings toward authority figures and their resistance to uncovering the repressed emotions. As the therapy progresses, the analyst takes a more active role and begins to interpret or suggest alternative meanings for client's feelings, memories and actions. The goal of interpretation is to help clients gain insight to become aware of what was formerly outside of their awareness. As the unconscious becomes more conscious, clients may come to see how their childhood experiences have determined how they feel and act now. Analysts encourage clients to confront childhood events and recall them fully. The clients relive their childhood traumas, they become able to resolve conflicts they could not resolve in the past. Working through old conflicts is thought to provide people with the chance to review and revise the feelings and beliefs that underlies their problems. Freud recognized, that the analysis requires great motivation to change and an ability to deal rationally with whatever the analysis uncovers. The traditional psychoanalysis may take five years or longer, and at least three, sometimes five sessions a week are essential. This process does not give immediate help for immediate problems.

9.6 ROLE OF PSYCHOANALYST

In psycho analysis the analyst's role extends beyond that of sorting out, the medium of transference interpretations, the troubled and poignant experiences emerging from the close family ties, the therapist himself becomes an identification figure perhaps the only person with whom the analys and has had an authentic, deeply emotional encounter.

Psychoanalysts are more concerned with ego processes and reality testing than withaprecise delineation of the id impulses in psychosexual development. In the early history of psychoanalysis little attention was paid to the patient's management of everyday relationship and problems. It was assumed that these mundane matters would take care of themselves if the analysis were successful.

The function of a psychoanalyst is to convert the misery of neurosis into the normal unhappiness of the human condition.

9.7 TECHNIQUES IN PSYCHOANALYSIS

An important goal of psychoanalytic techniques is to make the client's unconscious conflicts conscious. To accomplish this the therapist actively interprets the significance of what the client says. The therapist's interpretations are based on the analysis of free association, resistances, dreams and transference.

9.7.1 FREE ASSOCIATION

Analysis of free association in psychoanalysis is the process by which the therapist interprets the underlying meaning of the client's uncensored reports of anything that comes to mind. Analyzing the free association is a main technique in psychoanalysis, which is very much similar to Anna O's "talking cure". In free association the client is urged to report any thoughts or feelings that come in mind, no matter how trivial or embarrassing they seem. Freud assumed, based on the principle of psychic determinism that free association would unlock meaningful information related to the client's psychological disorders.

In Freudian psychoanalysis the client is instructed to talk about whatever comes to mind, with as little editing as possible and without inhibiting or controlling thoughts and fantasies. This process is called free association. Freud believed that the resulting "stream of consciousness" would provide insight into the person's unconscious mind.

In free association the patient is allowed to tell his story, his view of life, without anything hiding. The patient gives a detailed story about his experiences of life, sexual experiences, ambitions, difficulties, hopes, fears etc. The patient is encouraged to talk anything he wants to talk. The patient reveals many memories, emotions and imaginings that does not come easily in conscious. The patients need to relax, free their minds and give every thoughts and ideas which comes to their minds.

9.7.2 CATHARSIS

In the process of psychoanalysis Freud used to make his patients speak freely about their intimate feelings. The patients used to describe their feelings and speak freely which worked as a "talking cure" or as "Chimney sweeping" as Freud says it. Freud calls this as cathartic effect. The cathartic effect is being able to recall memories and to discharge emotions which

are unable to get in touch with normal waking self. This discharge of memories and intense feelings attached to them were called respectively ‘abreaction’ and ‘catharsis’.

9.7.3 DREAM INTERPRETATION

Dream interpretation is the process by which the therapist interprets the symbolic, manifest content of dreams to reveal their true latent content to the client. Freud believed that analysis of dreams was the “royal road to the unconscious”. Dreams are the dramatic aspect of sleep. Dreams are a story like sequence of visual images that commonly evoke strong emotions. Actions that would be impossible in real life may seem perfectly normal in dreams. Sigmund Freud made the analysis of dreams an important part in psychoanalysis, beginning with the publication of the “Interpretation of Dreams” in 1900. Freud provided the first formal view of dreaming as wish fulfillment. Freud claimed that dreams function as the royal road to the unconscious by serving as safe outlets for unconscious sexual or aggressive impulses that we cannot act on while we are awake because of cultural prohibition against them. Having the client free associate about the content of a series of dreams allows the psychoanalyst to interpret the symbolic, or manifest content of the client's dreams to reveal the true, or latent content and their true meaning.

Dream analysis is a technique of psychoanalysis. The explanation of dreams can help to express many desires, conflicts and thoughts repressed in the unconscious. An individual when dreaming, the individual’s unconscious mind is functioning and during this process there is greater independence and freedom. The unconscious adopts various acceptable forms in order to find satisfaction. Dream analysis consists in understanding, comprehension and analysis of dream. The patient is required to relate to his dream.

9.7.4 RESISTANCE

In the process of psychoanalysis a patient seeks the help of a psychotherapist when he is convinced that he is facing troubles. He may be also convinced that the source of trouble in his life is not due to himself but the people with whom he is associated. His adjustment may be faulty but it may still be the best adjustment he has ever managed, and the prospect of a new approach to life might seem even more painful. The patient may recognize that his solutions to problems of living are faulty, but he may retain a powerful attachment to some of them. The patient who is ambivalent may resist accepting responsibility for his own acts, he may resist to try new solutions, he may resist giving up traits and coping devices he admires. A resistance is seen in the patient to open the gates of the unconscious and let out all the fears.

A number of resistances is seen in the patient during psychoanalysis. They are all the byproducts of the patient's fears of what he would discover in his unconscious if these gates are opened. Hence the patient cannot understand of the therapist really. The patient do want to improve his capabilities to meet problems of living without actually disturbing the source of his incapacities.

Analysis of resistance in psychoanalysis is the process by which the therapist interprets client's behaviour that interfere with therapeutic progress toward uncovering unconscious conflict.

In the analysis of resistances, the psychoanalyst notes the behaviors that interfere with therapeutic progress. Signs of resistance include arriving late, missing sessions, abruptly changing topics and talking about insignificant things. The client holds on dearly to resistances to block awareness of painful memories for conflicts. By interpreting the meaning of the client's resistances, the therapist helps the client and uncover these unconscious memories and conflicts. Suppose a client changes the topic whenever the therapist asks him about this father, the therapist might interpret this as a sign that client has unconscious conflicts regarding his father. But resistances might also indicate that the client simply does not trust the therapist's approach to therapy.

9.7.5 TRANSFERENCE

Transference means the crossing of the repression barrier by repressed wishes or thoughts in some disguise. The term transference mainly refers to the irrational attachments to or beliefs about others. These beliefs or feelings maybe plausible but they are irrational, that is they are not based on evidence or based on flimsy evidence.

In Freud's original formulation, the definition of transference was limited to intense feelings of the analysand toward the analyst feelings that were originally directed to the analysand's parents. Freud was convinced that the patient actually hallucinated the image of the parent in the special atmosphere of the analyst's chamber. According to this, the analyst is not judged by the patient to be like his parent but actually is the parent. The analyst is merely a mirror, or blank screen, on which the analys and projects vividly the emotional turmoil of his developmental history.

In psychoanalysis, through the agency of interpretation, previously unconscious feelings and beliefs are brought under conscious scrutiny and the transference neurosis is ultimately dissolved. The patient will lose symptoms and in other ways appear healthier

because he expects to be rewarded or to avoid punishment. Such favorable changes are called transference improvements or, if dramatic in their extent, transference cures.

The Emotionally charged beliefs generated in early childhood about a mother (and, by extension, women in general), a father (or men in general), or siblings(peers in general) are evoked by contemporary persons, including the therapist (without his having done anything to provoke that responses), this can be thought of as a transference phenomenon. Transference can be best understood when restricted to those intense feelings one person has about another that have no realistic basis.

Transference is used by the analyst to help the patient. The patient relieves his troubled life in the secure relationship with the analyst and sees that the complications in his life is from the distorted beliefs, values and feelings and inappropriate coping devices generated in childhood to contemporary relationships and situations.

Analysis of transference is the process in which the therapist interprets the feelings expressed by the client towards the therapist as being indicator of the feelings typically expressed by the client toward important people in his or her personal life. Transference is the client's tendency to act toward the therapist in the way she or he acts towards important people in everyday life, such as parent, lover or teacher. Transference can be positive or negative. In positive transference, the client expresses feelings of approval and affection towards the therapist. In negative transference, the client expresses feelings of disapproval and rejection towards the therapist, such as criticizing the therapist's skill. By interpreting transference, the therapist helps the client gain insight into the earlier interpersonal origins of his or her current emotional problems.

9.8 SUMMARY

This unit has dealt with the classical psychoanalysis given by Sigmund Freud. Psychoanalysis is the process of treatment which helps to bring out the repressed feelings, thoughts from the unconscious mind to the conscious mind in an individual. The role of a psychoanalyst, the process of psychoanalysis is being discussed. The techniques involved in psychoanalysis like free association, catharsis, dream interpretation, resistance, transference are all being discussed, and the importance of this method in treating a number of psychological problems are being dealt in this unit.

9.9 KEYWORDS

Psychoanalysis	Free Association
Catharsis	Dream Interpretation
Resistance	Transference

9.10 CHECK YOUR PROGRESS

1. Explain the nature of psychoanalysis.

2. Discuss the role of a Psychoanalyst in the process of psychoanalysis.

3. Explain the techniques involved in psychoanalysis.

4. Explain the importance of catharsis.

9.11 ANSWERS TO CHECK YOUR PROGRESS

1. 9.4
2. 9.6
3. 9.7
4. 9.7.2

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UNIT - 10 : NEO-FREUDIAN AND MODERN PSYCHOANALYSIS

STRUCTURE:

10.1 OBJECTIVES

After going through this unit you will be able to explain

- The concepts of psychotherapy given by Adler
- Erich Fromm explanation about psychotherapy
- Harry Stack Sullivan explanation about psychotherapy

10.2 INTRODUCTION

The present unit focuses on the role of Neo Freudians and their contribution to modern psychoanalysis Sigmund Freud's Psychoanalysis focuses on the functioning of Id, Ego, Superego and he emphasizes the importance of unconscious part of the mind & the past experiences in deciding the behavior of an individual Neo-Freudians do not completely agree with this viewpoint of Freud in analyzing the behavior, they give more importance to the social and cultural aspects and their influences on the behavior of an individual. They also emphasize that more than the past experiences and childhood events. It. Is important to focus on the present and the future of an individual. In this unit the concepts given by Alfred Adler, Eric Fromm, Karen Horney, Harry Stack Sullivan are being discussed in detail.

10.3 ALFRED ADLER

Alfred Adler was born in Vienna in 1870. Adler was a prolific writer and an indefatigable lecturer. He published more than hundred books and articles during his lifetime. The practice and theory of individual psychology (1972) is probably the best introduction to Adler's theory of personality.

Adler's personal history provides a clear example of the striving to overcome inferiority, which became the central theme in his theory. As a boy, he was weak, clumsy, unattractive and initially a poor student.

Adler recognized that his own success in compensating for these deficiencies served as model for the theory of personality. This is reflected in his statement. "Those who are familiar with my life work will clearly see the accord existing between the facts of my childhood and the views I expressed".

In sharp contrast to Freud's major assumption that human behaviour is motivated by inborn instincts and Jung's principle axiom that human conduct is governed by inborn archetypes. Adler assumed that humans are motivated primarily by social urges. Humans are

according to Adler, inherently social beings. They relate themselves to other people, engage in cooperative social activities, place social welfare above selfish interest, and acquire a style of life that is predominantly social in orientation. Adler did not say that humans become socialized merely by being exposed to social processes. Social interest is inborn, but the specific types of relationships with people and social institutions that develop are determined by the nature of the society into which a person is born in one senses, then. Adler is just as biological in his viewpoint as are Freud and Jung. All three assume that a person has an inherent nature that shapes his or her personality. Freud emphasized sex. Jung emphasized primordial thought patterns, and Adler stressed social interest. This emphasis upon the social determinants of behaviour that had been overlooked or minimized by Freud and Jung is probably Adler's greatest contribution to psychological theory. It turned the attention of psychologist to the importance of social variables and helped to develop the field of social psychology at a time when social psychology needed encouragement and support especially from the ranks of psychoanalysis

Adler wrote that "the decisive basis difference between psychoanalyst and individual psychology is that Freud starts with the assumption that by nature man only wants to satisfy his drives the pleasure principle and must therefore from the viewpoint of culture be regarded as completely bad in social interests".

Adler's second major contribution to personality theory is his concept of the creative self. Unlike Freud's ego, which consists of a group of psychological processes serving the ends of inborn instincts Adler's self is highly personalized, subjective system and makes meaningful experiences of the organism. Moreover, it searches for experiences that will aid in fulfilling the person's unique style of life. If these experiences or not to be found in the world, the self tries to create them. This concept of a creative self was new to psychoanalytic theory. It helped to compensate for the extreme "objectivism" of classical psychoanalysis, which relied almost entirely upon biological needs and external stimuli to account for the dynamics of personality.

A third feature of Adler's psychology that sets it apart from classical psychoanalysis is its emphasis upon the uniqueness of personality. Adler considered each person to be a unique configuration of motives, traits, interest and values, every act performed by the person bears the stamp of his or her own distinctive style of life. In this respect, Adler belongs to the tradition of William James and William Stern.

Adler added other significant voices. Humans are primarily social and not sexual creatures. They are motivated by social and not by sexual interest. Their inferiorities are not limited to the sexual domain but may extend to all facets of being, both physical and psychological. They strive to develop a unique style of life in which the sexual drive plays a minor role. In fact, the way in which one satisfies sexual needs is determined by one's style of life and not vice Adler's dethroning of sex was for many people a welcome relief from the monotonous pansexualism of Freud.

Finally, Adler considered consciousness to be the centre of personality. This alone makes him a pioneer in the development of an ego oriented psychology. Humans are conscious beings they are ordinarily aware of the reasons for their behaviour. They are conscious of their inferiorities and capable of planning and guiding, their actions with full awareness of their meaning for their own self-realization. This is the completed antithesis of Freud's theory which had virtually reduced consciousness to the status of a nonentity froth flotation on the great sea of the unconscious.

Adler's theory of personality is an extremely economical one in the sense that a few basic concepts sustain the whole theoretical structure. For that reason Adler's viewpoint can be rather quickly sketched under a few rubrics. These are Adler's

1 Fictional finalism
2 Striving for superiority
3 Inferiority feelings and compensation
4 Social interest
5 Style of life
6 The creative self

Where does the striving for superiority of perfection come from? Adler said that it is innate. Not only it is it a part of life in fact it is life itself. From birth to death, the striving for superiority carries the person from one stage of development to the next highest stage. It is a proponent dynamic principle. There are no separate drives, for each drive receives its power from the striving for completion. Adler acknowledge that the straining for superiority may manifest itself in a thousand different ways and that each person has his or her own concrete mode of achieving perfection. The neurotic person for example strives for self esteem, power and self- aggrandizement - in other words, for egoistic or selfish goals whereas the normal person strives for goals that are primarily social in character.

Precisely how do the particular forms of the straining for superiority come into being in the individual? In order to answer this question, it is necessary to discuss Adler's concept of inferiority feelings. Adler put forth the idea of organ inferiority and overcompensation. At that time he was interested in finding the answer to the perennial question of why people when they become sick or suffer from infection become sick or affected in a particular region of the body. One person develops heart trouble another lung trouble and a third arthritis. Adler suggests that the reason for this type of particular affliction was a basic inferiority in that region and inferiority that existed either by virtue of heredity or because of some developmental abnormality. He then observed that a person with a defective organ often tries to compensate for the weakness by strengthening it through intensive training. The most famous example of compensation for organ inferiority is that of Demosthenes who stuttered as a child and became one of the world's greatest orators. Another more recent example is that of Theodore Roosevelt, who was a weakling in his youth and developed himself by systematic exercise into a physically stalwart man.

Adler broadened the concept to include any feelings of inferiority those that arise from subjectively felt psychological or social disabilities as well as those that stem from actual bodily weakness or impairment. The most general on that feeling of inferiority arise from a sense of incompletion or imperfection in any sphere of life. For example, the child is motivated by its feeling of inferiority to strive for higher level of development. When it reaches this level, it begins to feel inferior again and the upward movement is initiated once more. Adler contended that inferiority feelings are not a sign of abnormality; they are the cause of all improvement in the human lot. Of course, inferiority feelings may be exaggerated by special conditions such as pampering or rejecting the child. In this case certain abnormal manifestations may ensue, such as the development of inferiority complex of a compensatory superiority complex. But under normal circumstances, the feelings of inferiority or a sense of incompleteness is the great driving force of mankind. In other words, humans are pushed by the need to overcome their inferiority and pulled by the desire to be the superior. Although he believed that inferiority feelings were painful, he did not think that the relief of these feelings was necessarily pleasurable. Perfection, not pleasure, was for him the goal of life.

STYLE OF LIFE

This is the slogan of Adler's personality theory. It is a recurrent theme in all of Adler's later writings (for example, 1929a, 1931) and the most distinctive feature of his psychology.

Style of life is the system principle by which the individual personality functions; it is the whole that commands the parts. Style of life is Adler's chief ideographic principle; it is the principle that explains the uniqueness of the person. Everyone has style of life, but no two people develop the same style.

Every person has the goal, that of superiority, but there are innumerable ways of striving for this goal. One person tries to become superior through developing the intellect while another bends all of his or her efforts to achieving muscular perfection. The intellectual has one style of life, the athlete another. The intellectual reads, studies, thinks, he or she lives a more sedentary and more solitary life than the active person does. The intellectual arranges the details of existence, domestic habits, recreations, daily routine, relations to family, friends and acquaintances social activities in accordance with the goal of intellectual superiority. Everything done is done with an eye to this ultimate goal. All of a person's behavior springs from his or her to style of life. The person perceives, learns and retains what fits the style of life and ignores everything else.

The style of life determines how a person confronts the three "life problems of adulthood" social relations, occupation, love and marriage. Preliminary versions of these problems during childhood focus on friendships, school and opposite sex. When the individual's attempts to deal with these tasks is guided by social interest, he or she is on the useful side of life. If personal superiority displaces social interest as a goal, the person seeks distance from the life tasks and occupies the "useless" side of life.

What determines the individual's style of life? In his earlier writings Adler said that it is largely determined by the specific inferiorities, either fancied or real that the person has. The style of life is a compensation for a particular inferiority. If the child is a physical weakling its style of life will take the form of doing those things that will produce physical strength. The dull child will strive for intellectual superiority. Napoleon's conquering style of life was deter domination by his slight physical stature, and Hitler's rapacious craving for the world that appealed to so many of Adler's readers and was widely applied in the analysis of character during the 1920s and 1930s did not satisfy. Adler himself was too simple and too mechanistic. He looked for a more dynamic principle and found the creative self.

ORDER OF BIRTH

Adler observed that the personalities of the oldest, middle and youngest child in a family were likely to be quite different. He attributed these differences to the distinctive experiences that each child has as a member of a social group.

The first born or older child is given a good deal of attention until the second child is born then it is suddenly dethroned from its favourite position and must share its parents affections with the new baby. This experience may condition the oldest child in various ways such as hating people protecting him or herself against sudden reversal of fortune and feeling insecure. Oldest children are also apt to take interest in the past, when they were the centre of attention. Neurotics, criminals, drunkards and perverts Adler observes are often first born children. If the parents handle the situation wisely by preparing the oldest child for the appearance of a rival, the oldest child is more likely to develop into a responsible protective person.

The second or middle child is characterized by being ambitious. It is constantly trying to surpass its older sibling. It also tends to be rebellious and envious but by the large is better adjusted than either the older or younger sibling.The youngest child is the spoiled child. Next to the oldest child it is more likely to become a problem child and a neurotic maladjusted adult.

Alfred Adler introduced a series of important developments in therapy theory. Expressions such as feelings of inferiority and insecurity, sibling rivalry, the only child, compensatory behavior, the unity of the person and empathetic understanding.

Adler introduced the notions of organ inferiority, compensation, striving for superiority and feelings of inferiority. Adler became convinced that the explanation of behaviour could arise only from the analysis of the individual's own "inner nature". Rather than seeking antecedents of behaviour in objective events outside the individual Adler proposed that all behaviour was immediately determined by events occurring within (subjectively observable responses).Moreover, he proposed that the crucial internal determinants were values, attitudes, interests and ideas. Thus different kinds of thoughts, the individual interpretations of reality are primary determinants of the ways in which people behave. Events as viewed by objective observers do not directly determine the ways an individual will respond. Rather, it is the perception of thoughts about and interpretations of these events by the individual that are critical antecedents (internal causation). Adler called these perceptions and thoughts fictions

to emphasize that they were not completely accurate representations of events. It is what individual thinks is there and how he interprets or evaluates it (his fictions) rather than the "real" events, that directs his behaviour. Since thoughts and perceptions are the primary determinants they must be identified and analyzed if behaviour is to be understood and modified.

The normal inferiority feelings

Adler assumed that "every psychological life begins with deep inferiority feeling". Being human means "to feel inferior". Feelings of inferiority are considered inevitable from the beginning, they are universal and occur in every person and thus must be adjudged to be "normal". It would appear that judgmental or interpretative response should precede such inferiority feelings and Adler stated that a "self-evaluation" developed which produced "feelings of inferiority".

STRIVING FOR SUPERIORITY

Adler was impressed by the ceaseless way in which all living things behave to overcome a "minus state" and to arrive at a "plus state". He concluded this was a primary attribute of life itself and turned it a "striving for superiority" or a "striving to overcome". It was assumed to follow thoughts of inferiority and their concomitant negative effect. He considered it "the fundamental fact of our life". Adler uses the term compensation which defines an automatic attempt by an organism to re-establish an equilibrated state. Adler assumed the negative thoughts and affect responses were never completely terminated or reduced; rather they continued throughout a person's life- rising and falling as a individual went about his "striving to overcome".

Adler regards this basic response sequence (self-evaluation of inferiority-→feelings of inferiority---→striving for superiority) as extremely valuable to mankind. Adler views inferiority as not only inevitable but also a necessity if man were to survive and develop. It is upon a foundation of avoiding negative thoughts and feelings (inferiority) and expressing positive affection (social interest) that man's progress is built.

PARENTAL BEHAVIOUR

Adler was the first to emphasize the importance of influence that the responses of others held by the growing child. It was clear to him that there were obvious relationships between the way in which parents behaved toward the child and child's subsequent behaviour.

He explains that the parental behaviour affect the child. Specifically to be avoided were responses patterns of overindulgence and over protectiveness on the one hand, and hatred and acts of rejection on the other. Adler proposed that these tended to lead directly towards the pampered and the hated child and Adler saw them as the behavioral antecedents to antisocial and disordered behaviour.

The ideal parents responds with love, support and encouragement when he wanted to elicit certain kinds of responses in the child instead of punishment and bribery. “Discipline” and “punishment” were possible to use, but Adler stressed the necessity for applying them judiciously not to force the child to submit to authority, but rather to help shape the desired responses.

Adler says that parental behavior has to do with the responses in the child that the parents should be prepared to identify and to recognize a socially desirable and to which they should apply their support and encouragement. Social interest and a concern for others, initiative and self confidence in the face of tasks, “striving to overcome” when it developed along constructive and cooperative lines. Adler particularly stressed the importance of the mother, who represented the primary source of training in the family situation.

10.4 ERICH FROMM

Erich Fromm was born in Frankfurt, Germany in 1900 and studied Psychology and Sociology at the Universities of Heidelberg, Frankfurt and Munich. Fromm was highly Influenced by the writings of Karl Marx. Fromm compares Freud and Marx and says Marx as a profound thinker than Freud and used psychoanalysis mainly to fill in the gaps in Marx. Fromm(1959) wrote a highly critical, even polemical analysis of Freud's personality and influence and by way of contrast, an unconditional eulogy of Marx(1961).

The essential theme of all of Fromm’s writings is that a person feels lonely and isolated because he or she has become separated from nature and from other people. This condition of isolation is not found in any other species of animals it is the distinctive human situation. The child for example gains freedom from the primary ties with its parents with the result that it feels isolated and helpless. Fromm in his book Escape from freedom (1941) developed the thesis that as humans have gained more freedom throughout the ages they have also felt more alone. Freedom then becomes negative condition from which they try to escape.

What is the answer to this dilemma? The healthy strategy is for the person to unite with other people in the spirit of love and shared work. The unhealthy option is for the person to

attempt to “escape from freedom”. One can attempt to escape through three means. The first escape is through authoritarianism, either via a masochistic submission to powerful others or a sadistic attempt to become the powerful authority. A second escape is through destructiveness, the attempt to escape from powerlessness by destroying the social agents and institutions that produce a sense of helplessness and isolation. The more one’s urge to grow is frustrated, the more destructive he or she will become. The third mode of escape is through automation conformity in which one renounces selfhood by adopting a “pseudo self” based on the expectations of others.

According to Fromm a person is both a part of nature and separate from it, the contradiction consists of a person being both a part of nature and separate from it, of being both animal and a human being. As an animal one has certain physiological needs that must be satisfied. As a human being one possesses self-awareness, reason and imagination. Experiences that are uniquely human or feelings of tenderness, love and compassion, attitudes of interest, responsibility, identity, integrity, vulnerability, transcendence, freedom, values and norms. The two aspects of a person being both animal and human constitutes the basic conditions of human existence. “The understanding of man's psyche must be based on the analysis of man's needs stemming from the conditions of his existence”.

Five specific needs arise from the conditions of human existence; the need for relatedness, the need for transcendence, the need for rootedness, the need for identity and the need for a frame of orientation. The need for relatedness stems from the Stark fact that humans, in becoming human have been torn from the animal’s primary union with nature. The animal is equipped by nature to cope with the very conditions it is to meet, but humans with their power to reason and imagine have lost this intimate interdependence with nature. In the place of those instinctive ties with nature that animals’ posses’ humans have to create their own relationships, the most satisfying being those that are based upon productive love. Productive love always implies mutual care, responsibility, respect and understanding. The urge for transcendence refers to a person's need to rise above his or her animal nature, to become a creative person instead of remaining a creature. If the creative urges arethwarteda person becomes a destroyer. Fromm says that love and hate are not antithetical drives, they are both answers to a person's need to transcend his or her animal nature. Animals cannot love or hate, but human can.

Humans desire natural roots, they want to be an integral part of the world, to feel that they belong. As children, they are rooted to their mothers, but if this relationship persists past

childhood, it is considered to be an unwholesome some fixation. Humans also need to have a frame of reference, a stable and consistent way of perceiving and comprehending the world. The frame of reference that they develop may be primarily rational, primarily irrational, or it may have elements of both.

Fromm (1973) introduced a sixth basic need, the need for excitation and stimulation. In describing this need he drew a distinction between simple and activating stimuli. Simple stimuli produce an automatic, almost reflex, response and they are best thought of in terms of drives.

Fromm identified and described the five social character types that are found in today's society; receptive, exploitative, hoarding, marketing and productive. These types represent the different ways in which individuals can relate to the world and to each other. Only the last of these was considered by him to be healthy. Any given individual is a blend of these five types of orientations toward the world, although one or two of the orientations may standout prominently than others. Thus, it is possible for a person to be either a productive hoarding type or a non productive hoarding type.

Fromm (1964) also described a sixth pair of character types, the necrophilous, who is attracted to death, versus the biophilous, who is in love with life.

Fromm (1976) in his book added a distinction between the “having” and “being” orientations towards life. A having orientation reflects a person's competitive concern with possessing and consuming resources.

Many varieties of psychodynamic psychotherapy have developed today. All share certain aspects of Freud's approach, including the bringing of troublesome feelings into consciousness, the attribution of present troubles to the mental conflicts stemming from the past experiences, and the use of therapist-client relationship as a model for understanding the client’s relationships outside the therapy. The main purpose is the Freudian psychotherapy is very much time consuming and quite costly. It is a long-term psychotherapy but now the psychotherapies are based on a more here-and-now approach, the therapist concentrates on an individual’s current relationships and specific complaints. The non-Freudian psychodynamic therapies are based on alternative psychodynamic personality theories, such as Adler's, Jung's or Horney’s.

10.5 KAREN HORNEY

Karen Horney was born in Hamburg, Germany on September 16, 1885. She received her medical training at the University of Berlin and was associated with the Berlin psychoanalytic Institute from 1918 to 1932. She practiced psychoanalysis and taught at the New York psychoanalytic Institute. Becoming dissatisfied with orthodox psychoanalysis, she and others of similar convictions founded the association for the advancement of psycho analysis and American Institute of psychoanalysis.

Horney published a series of papers that criticized Freud and proposed her own feminine psychology. Following, Adler, Horney also believed that Freud's de-emphasis of the interrelationship among people led him to an erroneous overemphasis on sexual motivation and conflict. For Horney, concerns over security and over intrapsychic and interpersonal alienation provide the primary motivating forces for personality. These concerns may lead us to erect a protective structure in an attempt to provide what is doomed to be false sense of security.

According to Horney, children naturally experience anxiety, helplessness and vulnerability. Without loving guidance to help children learn to cope with threats imposed by nature and society they may develop the basic anxiety that is Horney's primary theoretical concept.

Basic anxiety refers to the feeling being isolated and helpless in a potentially hostile world. A wide range of adverse factors in the environment can produce this insecurity in a child; direct or indirect domination, indifference, erratic behavior, lack of respect for the child's individual needs, lack of real guidance, disparaging attitudes, too much admiration or the absence of it, lack of reliable warmth, having to take sides in parental disagreements, too much or too little responsibility, overprotection, isolation from other children, injustice, discrimination, un kept promises, hostile atmosphere, and so on and so on.

Horney's term for all of these adverse factors was basic evil. Horney suggested that anything that disturbs the security of the child in relation to his or her parents produces basic anxiety.

The basic evil experienced by the child naturally provokes resentment, or basic hostility. This inturn produces a dilemma or conflict for the child because expressing the hostility would risk punishment and would jeopardize his or her receipt of parental love. This

conflict between resentment and need for love replaces the Freudian conflict between instinctual impulse and internalized prohibition.

Children deal with their hostility by repressing it. Horney suggested that the repression may be fueled by three different strategies.

"I have to repress my hostility because I need you".

"I have to repress my hostility because I am afraid of you".

"I have to repress my hostility for fear of losing love".

Regardless of its cause, the repression exacerbates the conflict, leading to a viscous cycle. The anxiety produces an excessive need for affection. When these needs are not met, the child feels rejected and the anxiety and hostility intensifies. Because this new hostility also must be repressed in order to protect whatever sense of security the child has, anxiety increases and the need for repression leads to more hostility. Then the cycle begins again.

The child, and the later the troubled adult, is locked into a circle of intensifying distress and unproductive behaviour.

The insecure, anxious child develops various strategies by which to cope with its feelings of isolation and helplessness. It may become hostile and seek to avenge itself against those who have rejected or mistreated it. Or the child may become overly submissive in order to win back the love that it feels it has lost. It may develop unrealistic, idealized picture of itself in order to compensate for its feelings of inferiority. The child may try to bribe others into loving or may use threats to force people to like it. It may wallow in self-pity to gain people's sympathy.

If the child cannot get love, it may seek to obtain power over others. In that way, it compensates for its sense of helplessness, finds an outlet for hostility and is able to exploit people. Or the child becomes highly competitive in which the winning is far more important than the achievement. It may turn its aggression inward and belittle itself.

The neurotic needs

Horney presented list of ten needs that are acquired as a consequence of trying to find solutions for the problem of disturbed human relationships. She called these needs "neurotic" because they are irrational solutions to the problem.

1. The neurotic need for affection and approval.
2. The neurotic need for a partner who will take over one's life.
3. The neurotic need to restrict one's life within narrow borders.

4. The neurotic need for power.
5. The neurotic need to exploit others.
6. The neurotic need for prestige.
7. The neurotic need for personal admiration.
8. The neurotic ambition for personal achievement.
9. The neurotic needs for self-sufficiency and independence.
10. The neurotic need for perfection and unassailability.

Horney classified these ten needs under three headings (1) moving towards people, for example, need for love (2) moving away from people, for instance, need for independence and (3) moving against people, for example, need for power.

The essential difference between a normal and a neurotic conflict is one of degree "the disparity between the conflicting issues is much less great for the neurotic". Everyone has these conflicts but some people, primarily because of early experiences with rejection, neglect, overprotection and other kinds of unfortunate parental treatment, possess them in an aggravated form.

10.6 HARRY STACK SULLIVAN

Harry Stack Sullivan was born on a farm near Norwich, New York, on February 21, 1892. He received his medical degree from Chicago college of medicine and surgery in 1917. Served with armed forces during World War I. In 1922 Sullivan went to Saint Elizabeth Hospital in Washington, D.C where he came under the influence of William Alanson White, a leader in American neuropsychiatry. He began his formal analytic training with Clara Thompson, a student of Sandor Ferenczi. The journal Psychiatry began Publication in 1938 to promote Sullivan's theory of interpersonal relations.

Harry Stack Sullivan was the creator of a new view point that is known as the interpersonal theory of psychiatry. Its major tenent as it relates to a theory of personality is that personality is "the relatively enduring pattern of recurrent interpersonal situations which characterize human life. Sullivan believed, the individual as the object of study because the individual does not and cannot exist apart from his or her relations with other people. From the first day of life the baby is a part of an interpersonal situation and throughout the rest of its life it remains a member of a social field. Sullivan says that the interpersonal experiences of a person may and do alter his or her purely physiological functioning so that even the

organism loses its status as a biological entity and become a social organism with its own socialized ways of breathing, digesting, eliminating, circulating and so forth.

Sullivan insisted repeatedly that personality is a purely hypothetical entity "an illusion" that cannot be observed for study apart from interpersonal situations. The unit of study is the interpersonal situation and not the person. The organization of personality consists of interpersonal events rather than intrapsychic ones. A dynamism is the smallest unit that can be employed in the study of the individual it is defined as "the relatively enduring pattern of energy transformations, which recurrently characterize the organism in its duration as a living organism. An energy transformation in any form of behaviour. It may be overt and public, like talking, or covert and private, like thinking and fantasizing. Because a dynamism is a pattern of behaviour that endures and recurs, it is about the same thing as a habit. Sullivan's definition of pattern is it is an envelope of insignificant particular differences.

Self- system

Anxiety is a product of interpersonal relations, being transmitted originally from the mother to the infant and later in life by threats to one's security. To avoid or minimize actual or potential anxiety, people adopt various types of protective measures and supervisory controls over their behaviour. One learns for example, that one can avoid punishment by confirming to parent' wishes. These security measures from the self-system that sanctions certain forms of behavior (the good me self), forbid forms (the bad me self), and excludes from influence over attitudes towards other people. The good me personifications results from anxiety arousing situations. And like personifications of other people, these self-personifications tend to stand in the way of objective self-evaluation.

Cognitive processes

Sullivan's unique contribution regarding the place of cognition in the affairs of personality is his threefold classification of experience. Experience, he said, occurs in three modes prototaxic, parataxic and syntaxic .Prototaxic experience "may be regarded as the discrete series of momentary states of the sensitive organism". This type of experience is similar to what James called "the stream of consciousness" the raw sensations, images and feelings that flow through the mind of a sensitive being. They have no necessary conditions among themselves and possess no meaning for the experiencing person. The parataxicmode of thinking consists of seeing causal relationships between events that occur at about the

same time but are not logically related. We see causal connections between experiences that have nothing to do with one another. All superstitions, for instance, are examples of parataxic thinking.

The third highest mode of thinking is the syntaxes, which consists of consensually validated symbol is one that has been agreed upon consciousness still other forms that are too alien and disgusting to even be considered (the not me self). Through these processes, the self system acts as a filter for awareness. Sullivan employed the term selective attention for the unconscious refusal to attend to anxiety generating events and feelings.

The self-guards the person from anxiety, it is held in high esteem and is protected from criticism. The more experience people have with anxiety, the more inflated their self system becomes and the more it becomes disassociated from the rest of the personality.

Sullivan believed that the self system is a product of the irrational aspects of society. By this he meant that the young child is made to feel anxious for reasons that would not exist in a more rational society. It is forced to adopt unnatural and unrealistic ways of dealing with its anxiety.

Personifications

A personification is an image that individual has of him or herself or of another person. It is a complex of feelings, attitudes and conceptions that grows out of experiences with need satisfaction and anxiety. These pictures that we carry around in our heads are nearly accurate descriptions of the people to whom they refer. They are formed in the first place in order to cope with people in fairly isolated interpersonal situations, but once formed, they usually persist and by a group of people as having a standard meaning. Words and numbers are the best examples of such symbols. The syntaxic mode produces logical order among experiences and enables people to communicate with one another.

The Dynamics of personality

Sullivan conceived of personality as an energy system whose chief work consists of activities that will reduce tension. Sullivan said there is no need to add the term "mental" to either energy or tension.

There are two main sources of tension (i) tensions that arise from the needs of the organism and (ii) tensions that result from an anxiety. Needs are connected with physiochemical requirements of life. They are such conditions as lack of food or water or oxygen that produce a disequilibrium in the economy of the organism. Needs may be general in character.

Tensions can be regarded as needs for particular energy transformations that will dissipate the tension, often with an accompanying change of "mental" state a change of awareness, to which we can apply the general term satisfaction.

Anxiety is the experience of tension that results from the real or imaginary threats to one's security. It reduces the efficiency of the individuals in satisfying interpersonal relations and produces confusion in thinking Sullivan believed that anxiety is the first great educative influence in living.

10.7 SUMMARY

This unit has given a detailed account about the major Neo-Freudians and their contributions. Alfred Adler who has given a major contribution towards understanding personality gives a clear explanation about the various concepts like creative self, style of life, order of birth, inferiority complex , the reasons for inferiority complex, how an individual tries to overcome those i.e., striving for superiority , the importance of parental behavior in shaping the personality of an individual. In this unit we have discussed about the theory given by Erich Fromm, Karen Horney's theory ,the neurotic needs and how they affect the individual's personality is being discussed. Harry Stack Sullivan's theory, the self-system, the importance of cognitive processes in an individual's personality are being discussed.

10.8 KEYWORDS

Order of birth	Style of life
Inferiority complex	Superiority complex
Neurotic needs	Self-system
Cognitive processes	Personification

10.9 CHECK YOUR PROGRESS

1. Discuss the contributions of Alfred Adler.
2. How does order of birth affect the behavior of an individual.
3. Discuss Eric Fromm contribution in understanding personality.
4. Explain the neurotic needs given by Karen Horney.
5. Discuss Harry Stack Sullivan explanation about the personality.

10.10 ANSWERS TO CHECK YOUR PROGRESS

1. 10.3
2. 10.3
3. 10.4
4. 10.5
5. 10.6

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UNIT- 11: COGNITIVE AND BEHAVIOUR THERAPY

STRUCTURE:

11.1 OBJECTIVES

After going through this unit you will be able to explain

- Behaviour therapy and its techniques
- Cognitive behaviour therapy and its techniques

11.2 INTRODUCTION

This unit deals with the various forms of behavior therapy. Its techniques and how the behavior therapy is utilized to treat certain behaviours which may create problems for an individual. Behaviour therapy identifies problematic behavior, self- destructive and unhealthy behavior. It helps in changing those behaviours to help an individual deal more effectively and efficiently with his surroundings. The techniques like desensitization, extinction, flooding, aversive conditioning are being explained. Cognitive therapy and rational emotive behavior therapy its importance in changing the behavior of an individual is being discussed.

11.3 BEHAVIOUR THERAPY

In 1952 British psychologist Hans Eyesenck coined the term behaviour therapy. Behaviour therapy refers to treatments that favour changing maladaptive behaviours rather than providing insight into unconscious conflicts. Behaviour therapists ignore unconscious conflicts, emphasize present behaviour and assume that therapy can be accomplished in weeks or months. According to behaviour therapist abnormal behaviour like normal behaviour is learnedand therefore can be unlearned. Behaviour therapist change maladaptive behaviours by applying the principles of classical conditioning, operant conditioning and social learning theories. Behaviour therapists are more active than psychodynamic therapists, they concentrate on changing people's behaviour rather than on increasing their insight into their thoughts and feelings. They operate in a very short time.

Behaviourists believe that psychology should focus on observable, measurable behaviour rather than on thoughts, feelings and unconscious processes. They believe that if we can teach people to behave in more appropriate manner, they have cured the problem. Behaviour therapies are based on the belief that all behaviour both normal and abnormal is learned. For example, hypochondriacs learn that they get attention when they are sick, people with paranoid personalities learn to be suspicious of others. The therapist does not need to know exactly how or why a client learned to behave abnormally in the first place. The job of the therapist is simply to teach the person new, more satisfying ways of behaving. Behaviour

therapy approach was developed in the early 20th century. Its theory and practice originally derived from clinical and laboratory based research. The question "how do humans achieve and retain learning?" was the central focus of behaviour therapy. The scientists that were very influential in the early stages of behaviour therapy were Pavlov, Skinner, Eysenck, Wolpe, Marks and Bandura.

Behaviour therapy rests on a number of theoretical assumptions but consider concepts such as 'mind' and 'ego' as unscientific and of no help in solving behaviours that have got out of control. They do however, include 'thoughts' and 'sensations' in their therapeutic assessment and work, since they can be experienced as 'Natural events' rather than 'mysterious notions'. Behaviourists strongly believe that any natural event arises from other natural events not from mysterious notions of personality or ego.

Behaviour therapies are the therapeutic approaches that are based on the belief that all behavior, normal and abnormal, is learnt and that objective of therapy is to teach people new, most satisfying ways of behaving. John Hopkins University psychologist John. B .Watson started the behavioral movement. Watson argued that environmental influences not spirits, demons or intrapsychic forces shape our behavior. Behaviourists focus on two basic types of learning –classical conditioning and operant conditioning .

CLASSICAL CONDITIONING

Classical conditioning was discovered by chance. The Russian physiologist Ivan Pavlov was exploring the biological pathways of dog's salivary glands, but the animals fouled up his result by salivating apparently arbitrarily. Pavlov found that the animals were salivating not arbitrarily but in response to his assistant's footsteps. So Pavlov undertook a clever experimental program to show the dogs salivated to these events because these events were associated with feeding.

When the meat is put into dog's mouth it should salivate. Salivation in response to food is a reflex- a simple kind of unlearned behavior. Reflexes are not learned, but they can be conditioned to, or associate with other stimuli.

In this classical demonstration meat is an unconditioned stimulus(US). Salivation in response to meat is termed as unconditioned response(UR). "Unconditioned" means unlearned. Originally, the bell is a neutral meaningless stimulus. But after being associated repeatedly with the US(meat), the bell becomes a learned or conditioned stimulus(CS). The

bell is then capable of eliciting salivation. Salivation in response to the bell is termed a learned or conditioned response(CR).

CONDITIONING OF FEARS

John Watson conducted an experiment to show conditioning of fears. Little Albert experiment shows how fears can be conditioned. Little Albert, an 11 month old baby boy was left to play with rat, which he did ,after some time a harsh noise was created whenever the child reached out to play with the rat ,after few trials the child started to avoid playing with rat as it accompanied the harsh noise. Through classical conditioning the stimuli was associated with fear. This experiment showed that the fear can be conditioned in an individual.

OPERANT CONDITIONING

Classical conditioning is also referred as respondent conditioning because organisms learn responses that are largely responded to, or elicited by certain stimuli. In operant conditioning, organism learn to emit learned behavior because of the behaviours effect. In operant conditioning organisms acquire responses or skills that lead to reinforcement. Reinforcers are changes in the environment (stimuli) that increase the frequency of the preceding behavior. A reward is a pleasant stimulus that increases the frequency of behavior, and so it is a type of reinforce; But skinner found the concept of reinforcement to be preferable to that of reward because it is defined in terms of relationships between observed behaviours and environmental effects.

TYPES OF REINFORCERS

Positive reinforcers boost the frequency of behavior when they are presented.Food , money, social approval are examples of positive reinforcer. Negative reinforces increase the frequency of behavior when they are removed. Fear, pain and social disapproval are examples of negative reinforcers.

PUNISHMENT

Punishments are aversive stimuli that decrease or suppress the frequency of the preceding behavior when they are applied. Negative reinforcers by contrast increase the frequency of the preceding behavior when they are removed. Physical punishment may

suppress but not eliminate undesirable behavior. The behavior may return when the punishment is withdrawn.

REWARDING

Rewarding desirable behavior is generally preferable. Rewarding good behavior requires paying attention to it.

Classical conditioning involves the repeated pairing of a conditioned stimulus and unconditioned stimulus. If the conditions are right, the conditioned stimulus will eventually produce a conditioned response on its own.

11.4 DESENSITIZATION, EXTINCTION AND FLOODING

Systematic desensitization is a method for gradually reducing fear and anxiety, is one of the oldest behaviour therapy techniques. The method works by gradually associating a new response with stimuli that have been causing anxiety. A Behavioural technique for reducing a person's fear and anxiety by gradually associating a new response (relaxation) with stimuli that have been causing the fear and anxiety.

The therapist develops a hierarchy of fears for the individual. A list of situations from the least to the most anxiety provoking. After establishing a client's hierarchy of fears, the therapist teaches the person how to relax; to clear his or her mind, to release tense muscles and to be able to produce this relaxation response readily. In some cases, drugs or mild hypnosis aids relaxation. Once a client has mastered the technique of deep relaxation, he or she begins work at the bottom of the hierarchy of fears. The person is told to imagine the least threatening situation on the list and to signal when he feels the least bit tense. At the signal the therapist tells the person to forget the scene and to concentrate on relaxing. After a short time, the therapist instructs the client to imagine the scene again. This process is repeated until the person feels completely relaxed when imagining that scene. Then the therapist moves on to the next situation in the client's hierarchy of fears and trains the person to be completely relaxed when imagining that situation as well. Therapist and client advance up the hierarchy in this way until finally the person can imagine the most fearful situation at the top of the hierarchy without experiencing any anxiety whatsoever.

Systematic desensitization helps many people overcome the fears and phobias. The key to desensitization's success may not be the learning of a new conditioned relaxation response but rather the extinction of the old fear response through mere exposure.

In classical conditioning extinction occurs when the learned conditioned stimulus is repeatedly presented without the unconditioned stimulus being present. Hence, if a person repeatedly imagines a frightening situation without actually encountering danger, the fear or anxiety associated with that situation should gradually decline.

Extinction works best if exposure occurs soon, at full intensity, and for prolonged time. This is the technique of flooding, a less familiar, and more frightening, method of desensitization through exposure.

11.5 AVERSIVE CONDITIONING

Aversion therapy is a form of behaviour therapy that inhibits maladaptive behavior bypairing a stimulus that normally elicits adaptive response with an unpleasant stimulus. Aversive conditioning is a classical conditioning technique aimed at eliminating undesirable behaviour patterns, in which therapist teaches clients to associate pain and discomfort with the behaviour that they want to unlearn. This form of therapy is used to treat alcoholism, obesity, smoking.

At times the therapist uses real physical pain. For example, alcoholism is paired with drug inducing nausea and vomiting. Aversive conditioning is not used so much because it can create avoidance in the presence of the certainty of punishment, unwanted behaviour often continue in real life situations when no such threats exists. The goal of aversion therapy is to make a formerly pleasurable, but maladaptive, behaviour unpleasant. In aversion therapy a stimulus that normally elicits a maladaptive response is paired with an unpleasant stimulus, leading to reduction in the maladaptive response. Aversion therapy is used to treat a variety of behavioral problems, including smoking, bedwetting and overeating.

11.6 B. F. SKINNER

B.F. Skinner contributed in the development of behaviorism. Skinner was a behaviourist convinced of the importance of objective method, experimental rigor and capacity of elegant experimentation and inductive science to solve the most complex behavioral problems. Skinner, in his approach depends on the connection between stimulus and response.

Skinner was born in 1904. He received his Ph.D in 1931. Skinner's most important single Publication was his first volume The behaviour of organism (1938).

11.7 COGNITIVE BEHAVIOUR THERAPY

Cognitive behaviour therapies are those psychotherapies that emphasize changing people's perception of their life situation as a way of modifying their behaviour. Cognitive behavioral therapy has been widely researched and refers to more than 20 different approaches (Rational emotive behavior therapy, Cognitive analytic therapy, multimodal therapy, mindfulness-based cognitive therapy, acceptance commitment therapy, dialectical behaviour therapy, etc).

AARON BECK

Aaron Beck, a psychiatrist is the founding father of this cognitive therapy. He concluded that the notion and goal of the analytical approach that patients need to suffer was simply unnecessary and even damaging at times. Having applied psychoanalysis to patients sometimes for more than six years, without noticing striking improvements he became rather disillusioned, particularly as some of them even responded adversely to analysis. Beck defines cognitive therapy as "an active directive, time-limited, structural approach used to treat a variety of psychiatric disorders".

Cognitive behaviour therapy refers to a set of principles and procedures that share the assumption that cognitive processes affect behaviour and that these processes can be changed through cognitive and behavioral techniques. "Cognitions" include beliefs and belief systems, thoughts and images. "Cognitive processes" include ways of evaluating and organizing information about the environment and self, ways of processing information for coping or problem solving and ways of predicting and evaluating future events. Cognitive therapists believe that their clients suffer from misconceptions about themselves and the world, i.e., these misconceptions that cause them psychological problems. Cognitive therapists identify the erroneous ways of thinking and correct them. They focus on learning new ways of thinking, many professionals consider themselves to be cognitive behaviour therapists, therapists who combine both cognitive and behaviour therapies.

Cognitive behaviour therapy approach is active- directive but not imposing. Two way feedback is encouraged at any time. Goals for change are identified and agreed upon. The approach is time limited (on average one to four months, longer however for chronic cases).Therapists mistakes are admitted and clients can suggest solutions when therapy gets stuck. The client is trained to become a self-therapist.

Cognitive behaviour therapy mainly focuses on "here and now" and intends for the therapist to accompany the client towards chosen goals. This means cognitive behaviour therapy is client driven and thus the client chooses what they wish to work on throughout the whole therapy. Goals and strategies are developed together and therapeutic changes happen in session just as much as it does through the home practices the client is recommended to carry out.

Cognitive behaviour therapy examines the meanings that the individual assigns to events in order to understand their emotional and behavioral reactions to these events. Furthermore, it is established how these problems affect not only the clients thoughts and emotions but also their physical health, relationships and their daily functioning in general.

Cognitive therapists believe that events in themselves do not cause maladaptive emotions and behavior. Instead, they arise from our interpretation of events. Cognitive therapists believe that changes in thinking can produce changes in maladaptive emotions or behaviours. Because cognitive therapies can include aspects of behaviour therapy, they are commonly called cognitive behaviour therapies. They are effective in treating many kinds of disorders, including social phobia and panic disorder.

RATIONAL EMOTIVE BEHAVIOUR THERAPY

Albert Ellis, the developer of Rational emotive behavior therapy focuses on the ways in which people process information or encodes experience. Ellis believes people needlessly make themselves miserable by what they think about the events they experience and what they say to themselves about these experiences. The troubling events in themselves do not lead to anxiety depression or disturbed behavior. Rather it is the interpretation we place on unfortunate experiences that fosters negative emotions and maladaptive behavior.

Ellis used an "A-B-C approach" to explain the causes of misery. Activating events- Beliefs- Consequences. Ellis points out that apprehension about the future and feelings of disappointment are perfectly normal when people face losses. The adoption of irrational beliefs can lead to catastrophe the magnitude of losses and contribute to profound distress and depression. By intensifying emotional responses and nurturing feelings hopelessness, such beliefs impair coping ability. Such beliefs also lower self-efficacy expectations and distract people from trying to solve their problems. Rational emotive behavior therapists helps the clients dispute these irrational beliefs and substitute more rational ones.

Ellis notes that the desire for other's approval is undesirable, but it is irrational to assume you cannot survive without it. It would be marvelous to excel in everything we do, but it is absurd to demand it of oneself.

11.8 SUMMARY

To summarize, this unit has dealt with the various behavior therapies. Behavior therapy is a systematic way of unlearning the already learnt faulty behaviours. In this aspect behavior therapy provides a number of techniques to correct the behavior and also for the treatment purposes. Desensitization, extinction, flooding, aversive conditioning are being discussed here.

11.9 CHECK YOUR PROGRESS

1 . Write a note on behavior theraphy**.**

2. Explain different techniques of behavior therapy.

3. What is aversive conditioning?

4. Discuss cognitive behavior therapy.

11.10 ANSWERS TO CHECK YOUR PROGRESS

1. 11.3

2. 11.4

3. 11.5

4. 11.7

11.11 KEYWORDS

Behaviour theraphy	Desensitization
Extinction	Flooding
Aversive conditioning	Rienforcers
Punishment	Rewards

Rational emotive behavior therapy

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UNIT :12 - CLIENT CENTRED THERAPY AND OTHER THERAPIES

STRUCTURE:

12.1 OBJECTIVES

After going through this unit you will be able to explain

- Carl Rogers concepts of psychotherapy
- Psychodrama role playing and relaxation therapy

12.2 INTRODUCTION

Humanistic Psychology: Humanistic psychology is more hopeful and optimistic about humans. It believes that the person, any person, contains within him or herself the potentiality for healthy and creative growth. The failure to realize thispotentialities is due to constricting and distorting influences of parental training, education and other social pressures. These harmful effects can be overcome if the individual is willing to accept the responsibility for his or her own life. The Humanistic Psychology stresses the present rather than the past and conscious, rather than unconscious experience. It stresses the importance of subjective mental experience rather than objective environmental circumstances. It encourages the expression of emotion rather than its control.

12.3 CARL ROGER

Carl Rogers was born in 1902 in Illinois. After his graduation from University of Winconsin in 1924 he attended Union Theological seminary in New York city. Later he fell under the philosophical influence of John Dewey and was introduced to Clinical Psychology by Leta Hollingworth . He was awarded the Master's degree in 1928 and the doctorate in 1931 by Columbia. In 1945 Rogers went to the University of Chicago as Professor of Psychology and executive secretary of the counseling centre. There he elaborated his client centered method of psychotherapy, formulated a theory of personality and conducted research on psychotherapy.

Rogers theory of personality was originally presented in client centered therapy (1951), elaborated and formulated in a chapter written for psychology, a study of a science (1959).

Rogers wrote that it is "impossible for me to deny the reality and significance of human choice. To me it is not an illusion that man is to some degree the architect of himself". He emphasized that social change is based on "the human desire and potentiality for change, not on conditioning" and to acknowledge "the essential freedom and dignity of the Unique human person and its capacity for self-determination".

Client centered therapy

Carl Rogers is the founder of client centered therapy or person centered therapy. It was developed in the 1950s as one of the first alternatives to psycho analysis. Person centered therapy is non-directive in encouraging clients to find their own answers to their problems. Person centered therapist offers no advice, their goal is to facilitate the pursuit of self-actualization, not by offering expertise but by providing a climate in which clients feel comfortable being themselves. Person centered therapist do so by promoting self-acceptance. Humanistic psychologists assume that psychological disorders arise from an incongruence between a person's ideal self and actual self. This makes the person distort reality or deny feelings, trying to avoid the anxiety caused by failing to act in accordance with those feelings. Person centered therapy is to help individuals reduce this discrepancy by expressing and accepting their true feelings. The person centered therapists promote self-actualization through reflection of feelings, genuineness, accurate empathy and unconditional positive regard.

According to Rogers, the goal of therapy is to help people become fully functioning, to open them up to all of their experiences and to all of themselves. Such inner awareness is a form of insight, but for Rogers, it was more important to gain insight into current feelings than into unconscious wishes with roots in the distant past. Rogers called his approach therapy client-centered because he placed the responsibility for change on the person with the problem.

Rogers believed that people's defensiveness, rigidity, anxiety and other signs of discomfort stem from their experiences of conditional positive regard. They have learned that love and acceptance are contingent on confirming to what other people want them to be. Therefore, the cardinal rule in person-centred therapy is for the therapist to express unconditional positive regard that is to show true acceptance no matter what they say or do. Rogers felt that this was a crucial first step toward getting clients to accept themselves.

According to Rogers, every organism is born with certain innate capacities, capabilities or potentialities-“a sort of genetic blueprint to which substance is added as life progresses”. Roger believed that the goal of life is to fulfill this genetic blueprint, to become the best of whatever each of us is inherently capable of becoming. Roger called this biological push toward fulfillment the actualizing tendency. He said that human beings form images of themselves i.e., self-concepts. As we try to fulfill our inborn biological potential, so, too, we attempt to fulfill our self-concept, our conscious sense of who we are and what we want to do

with our lives. Rogers called this striving the self-actualizing tendency. When our self - concept is closely matched with our inborn capacities we are likely to become a fully functioning person. Such people or self-directed, they decide for themselves what it is they wish to do and to become, even do their choices may not always be sound ones. They are not unduly swayed by other people's expectations for them. They are also open to experience to their own feelings as well as to the world and other people around them and thus find themselves "increasingly building to be with greater accuracy and depth, that self which they most truly are" According to Rogers people tend to become more fully functioning if they are brought up with unconditional positive regard, the experience of being treated with warmth, respect, acceptance and love regardless of their own feelings attitudes and behaviours. But often parents and other adults offer children conditional positive regard, they value and accept only certain aspects of the child. The acceptance, warmth and love the child receives from others then depends on the child's behaving in certain ways and fulfilling certain conditions.

Rogerian Therapist try to understand things from the clients point of view. They are also emphatically non-directive. They do not suggest reasons why clients feel as they do or how they might better handle a difficult situation. Instead, they try to reflect client's statements, sometimes asking questions and sometimes heating at feelings that client's have not put in words. Rogers felt that when therapist provides an atmosphere of openness and respect clients can find them.

Reflection of feelings is the main technique of person-centered therapy. The therapist is an active listener who serves as a therapeutic mirror, attending to the emotional content of what the client says and restating it to the client. This helps clients recognize their true feelings. By being genuine, the therapist acts in a concerned, open and sincere manner rather than in a detached, closed and phony manner. This makes the clients more willing to disclose their feelings. Rogers stresses on the importance of therapist genuineness. The client also becomes more willing to share feelings when the therapist shows accurate empathy, which means that the therapist's words and actions indicate a true understanding of how the clients feels.

12.4 PSYCHODRAMA

Jacob L Moreno introduced psychodrama in United States in 1925. He worked in Vienna with theatre of spontaneity based on action methods. He claimed that he devised the term Group Therapy and group psychotherapy to emphasize the importance of the group in

the treatment of the individual. In his theatre of spontaneity he began to use play and role-playing techniques. His techniques reflect his approach to human behaviour. Moreno introduced psychodrama, he developed modifications of the method such a socialdrama, role-playing, sociometry and axio drama. He states that five instruments are used in his method of psychodrama.

The first instrument- the stage. The stage is intended to be an extension of life and is beyond the reality of life. It provides the patient with a "space for living". A circular stage may be seen as the aspiration levels of the patient on stage, as he moves from one circle to another.

The second instrument-the patient or subject. The patient is requested to be himself on stage. He is encouraged to share his thoughts and feelings and this is where the skill of the psychodrama director becomes very important. According to Moreno the patient is 'not' to perform but to respond as things come to his mind. This is related to the theory of spontaneity and Moreno states that spontaneity operates in the present. Moreno is striving for freedom of expression. Once the patient expresses himself a process of enactment occurs where the patient may present a current problem or discuss his concerns about the future problem or engage in role-playing to clarify fears or anxieties. The stress is upon the actional and emotional and the patient in psychodrama is actively discouraged from performing but encouraged to be what he is. The techniques used are mirror techniques, reversal of roles, double ego, auxiliary ego, etc. A very popular technique in psychodrama is role reversal. For example a father and son who are constantly bickering or overtly hostile to one another are encouraged to reverse roles - the father takes the part of the son and the son the part of the father. They are encouraged to feel, think and experience the behaviour of the person whom they are role- playing and role- reversing.

The third instrument- the psychodrama director. The director is a psychotherapist, he may attack, joke or laugh with the patient. He may decide to be passive or active or feel that it is wiser for the patient to dominate the psychodrama session. The director, a producer, keeps the action going. Through all this he maintains rapport with the audience which is always an integral part of the psychodrama. The director is an analyst, he integrates into his interpretation of the psychodrama information that he has obtained from the patient's family, friends or neighbours. He also integrates and interprets the responses of members of the audience who are watching the psychodrama.

The fourth instrument- the auxiliary egos. The use of auxiliary egos(staff of therapeutic aides)aides the director. The auxiliary egos are important since they serve as therapeutic actors and represent in the patients world ideals, delusions or absent people.

The fifth instrument- the audience watching the psychodrama. The patient may help audience participants as he re-enacts all of the combined problems of the members of the audience. The audience is very important because it serves as a sounding board for the patient. The audience is a mixed group and this heterogeneity elicits spontaneous responses from both audience and patient. In the psychodynamic approach to group therapy Moreno has effected mental catharsis by concentrating on the initial phase rather than the end phase of the drama. He believes catharsis to be embodied in every form of human activity and states that his technique and theory is devoted to finding both the different forms of catharsis and what catharsis means. He states that spontaneity is the principle behind catharsis. He also claims that he placed the psyche itself on the psychodramatic stage. According to his theory, the psyche, originally came from the group was transformed into a stage performance by an actor on the stage and now is returned to the group in the form of psychodrama.

Psychodrama is a treatment modality and theory has gone through many ups and downs. It has never really caught on as part of the mainstream of psychotherapeutic practice. Moreno has constantly struggled to spread his concepts in the field of psychiatry, psychology, social work and education.

12.5 ROLE PLAYING

Role playing is an excellent adjunct to behavioral therapy. As in Gestalt therapy (which incidentally often borrows from role therapy) the patient does and experiences rather than describes, talks and listens. Typically he is first asked to imagine himself in a particular role and then to play it in front of others and with proper behavioral feedback. The therapeutic techniques are designed to remove behavioral deficits in social interactions. The most gratifying aspect of this technique is that it is self-reinforcing in the sense that once the new responses are emitted in a socially acceptable (i.e., convincing) fashion, they are followed by the predictable responses of the audience. At first this may take place in the privacy of an office visit, then with therapeutic group and finally in real life. In preparing a patient who is about to be discharged for job interviews, it is seldom enough to impress him with the necessity of appearing competent and self-assured. Nor should one be satisfied with the patient’s assurance that he can manage the expected situation. Instead, the therapist

should invite the patient to play a game in which he, the therapist is the potential employee and the patient is the employer. At this stage the therapist has the choice of either overacting shortcomings in the expected performance of the patient or acting in the presumed ideal manner. The way in which the patient acts the role of the employer will tell the therapist much about what the patient really expects to encounter.

12.6 RELAXATION THERAPIES

An individual faces quite a number of stress and tension in everyday life. If they are not controlled and individual stays in stress and tension for longer duration it will lead to various psychological problems. Psychotherapy suggests certain techniques to overcome the stress and tensions.

Tension control

Tension activates many disturbing physiological and behavioural tendencies. More than anxiety, it registers its effects subversively through autonomic nervous system, influencing the functioning of various organs. It is the one of the earliest signs of emotional disturbance and once mobilized it may continue to torment the individual even after neurotic defenses have been established. Tolerance of the effects of tension varies. There are some persons whose repressive mechanism work so well that they are unaware of how tense they are even though their Physical health is affected by resultant physiological imbalances. There are others whose sensitivity to tension is so extreme that they are in a constant state of uneasiness and discomfort. Individuals with poor impulse control may release their tension in passionate outburst even though this leads to violence and behavioral improperties.

Tension is so discomforting that escape from it constitutes a chief preoccupation of human beings. There are a number of modes of regulating tension. Among them self-relaxation, self- hypnosis, meditation and biofeedback methods or more preferred.

Muscle relaxation exercises have been used for many years. Muscle relaxation, rest and mind training or also used. The best known exercises are those of E. Jacobson(1938) and Rippon and Fletcher (1946) D.H.Yates(1946) and Neufeld(1951) have described a series of exercises that enables the individual to gain voluntary control over tension.

Massage enhances muscle tone in addition to encouraging relaxation. Enforced rest also has a relaxing effect on the individuals Muscular System.

E. Jacobson's simple progressive relaxation of muscle groups (1938). It is a progressive relaxation of muscle groups from scalp to toes or vice versa. Such self-relaxation techniques can quite major muscle groups and ultimately lead to substantial tension control.

Autogenic Training (Schultz and Luthe, 1959) strives for reorganization of subconscious thinking patterns through the use of a technique of "passive concentration" or unstructured relaxed form of cognition and association. No formal muscle relaxation maneuvers are utilized, yet the technique promotes the sense of warmth and lightness over the entire body. Suggestions emphasize peacefulness and quietness and enjoin the subject to allow such feelings to develop without forcing them. Meditation as a long history, most frequently being associated with Buddhist religion. Experimental studies have shown that meditation can produce striking psychophysiological effects, including alleviation of tension, lowering of oxygen consumption and metabolic rate and decrease of cardiac output.

12.7 SUMMARY

This unit has dealt with the client centered therapy given by Carl Rogers. The core principles to be followed in client centered therapy, the process and its effectiveness in changing a person's behavior are being discussed. The other techniques like psychodrama, role playing relaxation therapies are also being discussed in this unit.

12.8 CHECK YOUR PROGRESS

1. Discuss the client centered therapy.
2. What is psychodrama?
3. Explain role playing.
4. Explain relaxation therapies.

12.9 ANSWERS TO CHECK YOUR PROGRESS

1. 12.3
2. 12.4
3. 12.5
4. 12.6

12.10 KEYWORDS

Client centered therapy	Fully functioning person
Psychodrama	Role playing
Relaxation therapies	Tension control

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UNIT: 13 - INDIVIDUAL AND GROUP THERAPIES

Structure:

13.1 OBJECTIVES

After reading this unit, you should be able to:

- Understand nature and meaning of psychotherapy
- Understand the difference between individual and group therapies
- Get a fair knowledge on different types of therapies
- Understand patient selection process and therapeutic factors
- Know more about social skills training and self-control techniques

13.1 INTRODUCTION

The term psychotherapy is loosely employed to connote, helping, treating, advising, guiding, educating, and even influencing. Definitions of psychotherapy are often narrowed down to fields of disciplinary e.g. Psychiatry, psychology, casework, etc., sanctuaries (place) for such characterizations being sought in specialized societies.

Psychotherapy is the treatment, by psychological means to problems of an emotional nature in which a trained person deliberately establishes a professional relationship with the patient with the object of (1) removing, modifying, or retarding existing symptoms, (2) mediating disturbed patterns of behavior, and (3) promoting positive personality growth and development.

Psychotherapy constitutes a form of treatment. Such terms as reeducation, helping process, and guidance are merely descriptive of what happens in the course of treatment and do not really disguise the therapeutic nature of the process.

Objectives of psychotherapy:

Everett Shostrom is of the view that the objective of psychotherapy is that the patient has to become an actualizer, a person who appreciates himself and others as persons rather than things and who has turned his self-defeating manipulations into self-fulfilling potentials. Shostrom also feels that awareness is the goal of psychotherapy, "the reason is that change occurs with awareness." Shostrom feels that awareness is a form of non-striving achieved by being what you are at the moment.

Individual therapy

Individual therapy involves of a situation that is therapeutic in nature, where the individual or person (usually referred to as a "*client*") is involved with the therapeutic process under any circumstance with one therapist. A therapist can be a clinician, psychologist, social worker, counselor, marriage and family counselor, etc. The therapist is formally trained in therapy, and is authorized by a regulating board and only then they practice the profession of therapy.

Individual therapy offers many advantages:

- The confidentiality of the client's issues is maintained.
- The client gets one-on-one attention from the therapist, helps the therapist to understand the particular issues of the client and in building up an individualized way to help the client.
- The level of analysis and therapy is more serious and complete.
- The pace and speed of the therapy can be customized to the particular client
- The *therapeutic alliance*, the working relation between the client and therapist, is most strong in individual therapy.

A few disadvantages of individual therapy include:

- More costly
- Some clients may have a strong need to relate to others who share comparable issues/problems. This need can be best tended to in a group situation.
- Clients who are not committed to changing, doing the work, and applying principles learned in therapy may struggle when they are the center of attraction.

Group therapy: Group therapy can be characterized as having more than one client treated simultaneously by at any least one therapist. A few groups will have more than one therapist; there are two therapists attending to the group simultaneously and once in a while more than that. Group sizes can fluctuate upon the sort of group therapy being utilized.

Advantages

Some of the advantages that we observe in group therapy include:

- Group therapy guarantees people that others share comparative issues and problems.

- Group therapy offers the opportunity to both get uphold from others and to offer help to other people. Accepting help from others, offering support to others allows development and learning.
- The therapeutic alliance takes into account the consolidation of a wide range of perspectives.
- Group therapy assists people with creating relational abilities and socialization aptitudes.
- Group therapy permits people to create mindfulness
- Group therapy gives a wide security net to people who may somehow be reluctant to talk about their sentiments, perceived weaknesses etc.,
- Group therapy is normally more affordable than individual therapy.

Disadvantages

A few drawbacks to group therapy are:

- The client is not the focus of attention, the degree of mediation is not as engaged and serious for any single person as individual therapy.
- Groups may permit unmotivated people to conceal their issues and dodge responsibility.
- Although the restorative partnership is more extensive, it is not as engaged and strong in group therapy.
- Groups commonly meet at specific times.
- Group therapy might be improper for particular sorts of people, for example, people who are very solitary, incredibly modest, impulsive, passive-aggressive, psychotic, etc.

Regardless, the two formats of therapy have advantages and disadvantages. Deciding on which one to participate in is an individual decision that relies upon one's personal issues, objectives, and the kinds of therapists/groups that are accessible.

COMMONALITIES AND DIFFERENCES IN THERAPIES:

Treatment for psychological disorders encompasses both the psychological therapies and biomedical therapies. The major psychotherapies derive form the psychoanalytic, humanistic, behavioral, and cognitive perspectives on psychology.

Psychoanalysis: psychoanalysts try to help people gain insight into the unconscious origins of their disorders and to work through the accompanying feelings. To do this an analyst depends upon techniques namely free association and dream analysis and interprets resistance and the transference to the therapist of long-repressed feelings.

Humanistic therapies: the therapist focuses on patient's current conscious feelings and on their taking responsibility for their own growth. Carl Rogers. In his person centered therapy, used active listening to express gaminess, acceptance and empathy. Fritz, in Gestalt therapy sought to break down people's defenses and to make them accept responsibility for their feelings.

Behavior therapies: In this approach, the therapists have less focus on promoting self-awareness. The focus is more about directly modifying problem behaviors. The therapists may counter condition behavior through systematic desensitization or aversive conditioning. Or they may apply operant conditioning principles with behavior modification techniques, such as token economies.

Cognitive therapies: These therapies – Albert Ellis's rational-emotive therapy, Aaron Beck's cognitive therapy, aim to change self-defeating thinking by training people to look at themselves in new and more positive ways.

13.3 CLASSIFICATION OF THERAPIES

To describe the countless permutations of therapy that exists today would be an almost impossible task, since all practitioners evolve a unique form influenced by their background and character structure. Nevertheless, there are identifiable pools within which practitioners flexibly use.

The varieties of psychotherapy may conveniently be divided into three main groupings:

- Supportive therapy
- Analytical
- Behavioral
- Transactional

13.3.1 SUPPORTIVE THERAPY

The objective in supportive therapy is to bring the patient to an emotional equilibrium as rapidly as possible, with amelioration of symptoms, so that he can function at a level

approximating his norm. An effort is made to strengthen existing defenses as well as to elaborate better "mechanisms of control."

Coordinately, one attempts to remove or to reduce detrimental external factors that act as sources of stress. There is no intent to change personality structure, although constructive characterologic alterations may develop when mastery has been restored and successful new adaptations achieved.

In all patients receiving supportive therapy, consequently an effort should be made to motivate them toward some kind of re-educative or reconstructive therapy, in order to insure greater permanence of results.

Supportive measures may thus be utilized as the principal treatment or as adjuncts to reductive or reconstructive psychotherapy. They are employed as:

1. A short-term exigency for basically sound personality structure momentarily submerged by transient pressures that the individual cannot handle.
2. A primary long-term means of keeping borderline and character logically dependent patients in homeostasis.
3. A way of "ego building" to bring a person to a point where he can devote himself to more reiterative psychotherapeutic tasks
4. A temporary expedient during insight therapy when anxiety becomes too strong for existing coping capacities.

An understanding of how and when to do supportive psychotherapy is therefore indispensable in the training of the psychotherapist.

Supportive therapy does not work in many cases where the problems with authority are so severe that the patient automatically goes into competition with any authoritative person, depreciating, seeking to control, acting aggressive and hostile, detaching himself, or becoming inordinately helpless. These reactions, appearing during therapy, may act as insurmountable resistances to the acceptance of even supportive help.

Among procedures employed in supportive therapy are:

- Guidance
- Tension control and release
- Environmental manipulation
- Externalization of interests

- Reassurance
- Prestige suggestion
- Pressure and coercion
- Persuasion
- Inspirational group therapy

13.3.2 PSYCHOANALYTIC APPROACH

This approach developed by Sigmund Freud in the early 1900s, involves analyzing the root causes of behavior and feelings by exploring the unconscious mind and the conscious mind's relation to it. Psychoanalysis can take on a variety of forms, varying from practitioner to practitioner. Psychoanalytical and psychodynamic therapies are based on an individual's unconscious thoughts and perceptions that have developed throughout their childhood, and how these affect their current behavior and thoughts.

Psychoanalysis focuses on an individual's unconscious, deep rooted thoughts that often stem from childhood. Through free association, dreams or fantasies, clients can learn how to interpret deeply buried memories or experiences that may be causing them distress.

i) View of Human Nature

The Freudian view of human nature is dynamic. According to him, human nature could be explained in terms of a conscious mind, a sub conscious and an unconscious mind. The conscious mind is attuned to the events in the present, to an awareness of the outside world. The subconscious mind is an area between the conscious and unconscious mind which contains aspects of both. Within the subconscious are hidden memories or forgotten experiences that can be remembered if a person is given the proper cues. Finally beneath the subconscious mind is the unconscious mind, the most powerful and least understood part of the personality. The instinctual, repressed and powerful forces of the personality exist in the unconscious.

ii) Id, Ego and Super Ego

Id is a concept equivalent to a demanding child and it is ruled by the pleasure principle. It refers to the raw, unorganized, inherited part of the personality. Its main goal is to reduce tension created by our primitive drives such as hunger, sex, aggression and irrational impulses.

Ego is a concept analogous to a traffic policeman and it is ruled by the reality principle. Ego's job is to meet the needs of the id, while taking into consideration the reality of the situation. The ego is sometimes called "the executive" of an individual's personality. It is responsible for the higher cognitive functions such as intelligence, thoughtfulness and learning.

Superego is the third concept which can be equaled to that of a judge and it is ruled by the moral principle. Superego represents the rights and wrongs of the society. It has two subparts: the conscience and the ego-ideal. The conscience prevents us from doing morally wrong or bad things. The ego ideal is that part of the superego that includes the rules and standards for good behaviors. These behaviors include those that are approved of by parental and other authority figures. Obeying these rules leads to feelings of pride, value, and accomplishment.

The ego ideal motivates the person to do what is morally proper. The superego helps to control the id impulses, making them less selfish and more morally correct.

iii) Ego-Defense Mechanisms

Ego-defense mechanisms are normal behaviors which operate on an unconscious level and tend to deny or distort reality. They help the individual to cope up with anxiety and prevent the ego from being overwhelmed. They have adaptive value if they do not become a style of life to avoid facing reality. Some of the major defense mechanisms described by psychoanalysts are the following:

1) ***Repression****:* It is the withdrawal of an unwanted idea, affect, or desire from consciousness by pushing it down, or repressing it, into the unconscious part of the mind.

2) ***Reaction formation****:* It is the fixation of an idea, affect, or desire in consciousness that is opposite to a feared unconscious impulse.

3) ***Projection****:* It is a form of defense in which unwanted feelings are displaced onto another person.

4) ***Regression****:* When confronted by stressful events, people sometimes abandon coping strategies and revert to patterns of behavior used earlier in development.

5) ***Sublimation****:* It is the diversion or deflection of instinctual drives, usually sexual ones, into non-instinctual channels. It allows us to act out unacceptable impulses by converting these behaviors into a more acceptable form.

6) ***Denia****l:* It is used to describe situations in which people seem unable to face reality or admit an obvious truth.

7) ***Rationalization****:* It is the substitution of a safe and reasonable explanation for the true, but threatening cause of behavior.

8) ***Displacement:*** Displacement involves taking out our frustrations, feelings and impulses on people or objects that are less threatening.

9) ***Intellectualization:*** It allows us to avoid thinking about the stressful, emotional aspect of the situation and instead focuses only on the intellectual component.

iv) Role of a Counselor

Counselors who practice psychoanalysis play the role of experts. They encourage their clients to talk about whatever comes in their mind, especially childhood experiences. After a few face to face interactions such an environment is created, often have the client lie down while the analyst remains out of view, in which the client feels free to express difficult thoughts. The role of the analyst is to let the clients gain insight by reliving and working through the unresolved past experiences that come into focus during sessions. The development of transference is encouraged to help clients deal realistically with unconscious material.

Psychoanalytic counselors also use diagnostic labels to classify clients and help develop appropriate plans for them.

v) Goals

The goal of psychoanalysis varies according to the client, but they focus mainly on personal adjustment, usually inducing a reorganization of internal forces within the person. In most cases, a primary goal is to help the client become more aware of the unconscious aspects of his or her personality, which include repressed memories and painful wishes. A second major goal is to help a client work through a developmental stage, not resolved in primary goal. If accomplished, clients become unstuck and are able to live more productively. A final goal is helping clients cope with the demands of the society in which they live. Psychoanalysis stresses environmental adjustment, especially in the areas of work and intimacy.

vi) Techniques

Free Association: Client reports immediately without censoring any feelings or thoughts. The client is encouraged to relax and freely recall childhood memories or emotional experiences. In this way, unconscious material enters the conscious mind, and the counselor interprets it. At times clients resist free association by blocking their thoughts or denying

their importance. Psychoanalysts make the most of these moments by attempting to help clients work through their resistance.

Dream Analysis: Dream analysis is considered the first scientific approach to the study of dreams. In this clients report dreams to counselor on regular basis. Freud believed that dreams were a main avenue to understanding the unconscious. Counselor uses the "royal road to the unconscious" to bring unconscious material to light. Clients are encouraged to remember dreams. The counselor analyze two aspects; The Manifest Content (obvious meaning), and the Latent Content (hidden but true meaning).

Analysis of Transference: Transference is the client's response to a counselor as if the counselor were some significant figure in the client's past, usually a parent figure. This allows the client to experience feelings that would otherwise be inaccessible. The counselor encourages this transference and interprets positive or negative feelings expressed. Analysis of transference allows the client to achieve insight into the influence of the past.

Counter-transference: It is the reaction of the counselor towards the client that may interfere with objectivity.

Interpretation: Interpretation should consider part of all above mentioned techniques. When interpreting, the counselor helps the client understanding the meaning of the past and present personal events. It consists of explanations and analysis of a client's thoughts, feelings and actions. Counselor points out, explains, and teaches the meanings of whatever is revealed. Counselors must carefully time the use of interpretation.

13.3.3 BEHAVIORAL THERAPY

This approach is based on the premise that primary learning comes from experience and applies learning principles to the elimination of unwanted behaviors. The initial concern is to help the client analyze behavior, define problems, and select goals. Behavioral Therapy is effective for individuals who require treatment for some sort of behavior change, such as addictions, phobias and anxiety disorders. It concentrates on the 'here and now' without focusing on the past to find a reason for the behavior. The behavioral approach says that people behave in the way that their environment has taught them to behave, e.g., through rewards and punishments, modeling, etc. So this approach attempts to change the way the environment reinforces particular behavior and works at applying learning principles to help people to learn new behaviors by behavioral experiments, role playing, assertiveness training, and self-management training.

Four Aspects of Behavior Therapy

1) Classical Conditioning

In classical conditioning certain respondent behaviors, such as knee jerks and salivation, are elicited from a passive organism.

2) Operant Conditioning

It focuses on actions that operate on the environment to produce consequences.

If the environmental change brought about by the behavior is reinforcing, the chances are strengthened that the behavior will occur again. If the environmental changes produce no reinforcement, the chances are lessened that the behavior will recur.

3) Social Learning Approach

It gives prominence to the reciprocal interactions between an individual's behavior and the environment.

4) Cognitive Behavior Therapy

It emphasizes cognitive processes and private events (such as clients self-talk) as mediators of behavior change.

i) View of Human Nature

As the behaviorist views human nature, humans are neither good nor bad but are living organisms capable of experiencing a variety of behaviors. Their personality is composed of traits. The behaviorist believes that people can conceptualize and control their behavior and have the ability to learn new behaviors. In addition, people can influence the behavior of others as well as be influenced by the behavior of others. Behaviorists concentrate on behavioral processes as they are closely associated with overt behavior and believe that all behavior is learned, whether it is adaptive or maladaptive. They also believe that learning and development occur in one of the three ways:

- Respondent learning,
- Operant conditioning and
- Social modeling.

ii) Role of a Counselor

A counselor may take one of the several roles, depending on his or her behavioral orientation. The counselor functions as a consultant, teacher, advisor and facilitator. The behavior counselor tries to help the individual to learn new and more adaptable behaviors and to unlearn old non adaptable behaviors. The behavior counselor focuses attention on the individual's ongoing behaviors and their consequences in his own environment. He tries to restructure the environment so that more adaptable patterns of behavior can be learned and

non-adaptable patterns of behavior can be unlearned. An effective behavioral counselor operates from a broader perspective and involves the client in every phase of counseling.

iii) Goals

Basically behavioral counselors want to help clients make good adjustments to life circumstances and achieve personal and professional objectives. A major step is to reach mutually agreed upon goals. Blackham and Silberman(1971) suggests four steps in this process:

1) Defining the problem

The clients are asked to specify when, where, how and with whom the problem arises.

2) Take a developmental history

Knowledge about how the client has handled past circumstances.

3) Establish specific goals

Counselors help clients break down goals into small, achievable goals.

4) Determine the best method for change

Helping the client to reach desired goal by choosing the appropriate method. Continuous assessment of the effectiveness of method is must.

iv) Techniques

General behavioral techniques are applicable to all behavior theories, although a given technique may applicable to a particular approach at a given time in a specific circumstance.

***Systematic desensitization*:** This is a technique used specifically with phobias. It helps the client to pair relaxation with previously feared stimuli.

***Aversive therapy*:** It is almost the opposite of systematic desensitization and has the client pair some aversive stimuli (e.g., nausea, pain, disturbing images, etc.) with some behavior that he/she is having difficulty giving up. For example, a person trying to quit drinking might take a drug that makes her nauseous whenever she drinks alcohol. Both systematic desensitization and aversive therapy make use of classical conditioning learning principles—learning that occurs when things get paired together. Systematic desensitization "teaches" the client a new thing by pairing relaxation with something they fear whereas Aversive therapy "teaches" a new thing by pairing a bad experience with some behavior they want to eliminate.

Behavior Modification programs: These approaches try to increase positive behavior and decrease negative behavior by using reinforcements and punishments in the most effective ways based on learning principles. The counselor will try to help the parents identify in what ways the undesired behavior is being reinforced and eliminate that reinforcement and help them develop ways to reinforce desired behavior

***Use of Reinforcers*:** Reinforcers are those events which increase the probability of occurrence of a desired behavior in the future by applying consequences that depend on the behavior in question.

***Positive Reinforcement*:** The administration of positive consequences to workers who perform desired behaviors- Pay, promotions, interesting work, praise, awards.

Negative Reinforcement: The removal of negative consequences when workers perform desired behaviors-Nagging, complaining.

***Punishment*:** Administering negative consequences to undesirable behaviors in an effort to decrease the probability that the behavior will occur again in the future.

***Shaping*:** It is a process in which undifferentiated operant behaviors are gradually changed into a desired behavior pattern by the reinforcement of success approximations, so that the behavior gets closer and closer to the target behavior.

***Extinction*:** When pairing of conditioned and unconditional stimulus stops then association weakens and conditioned response becomes less frequent till it disappears.

***Generalization*:** Conditioned response occurs in response to stimuli which are similar to the conditioned stimulus.

Discrimination: Conditioned response does not occur to all possible similar stimuli-learned difference between stimuli.

The cognitive behavioral approach examines the patient's beliefs and behaviors. Individuals hold beliefs about themselves and relationships that affect behavior. Negative beliefs lead to maladaptive behaviors. By examining and challenging these beliefs with new information, subsequent new behaviors can change. This approach also examines behaviors directly so that new, more adaptive behaviors can be developed. This approach is especially beneficial for changing habits, learned behavioral patterns, phobias, and many forms of depression.

Key concepts in Behavioral Group Counseling

- The assessment of the problem is oriented towards behavioral formulation and treatment. It provides a baseline of the behaviors to be targeted in counseling.
- The assessment phase ends with each member of the group identifying specific behavior(s) they want to change or learn. Goals are ideally limited and realistic.
- After clients have identified their goals for treatment, they take the group leader's help and formulate and plan of action. Behavior counseling is usually short term, and so the plan of action also needs to be brief.

- The techniques of behavior counseling are aimed at changing behaviors and thoughts, and not at achieving insight. Social learning approaches like modeling, rehearsal and coaching are particularly relevant in group work.
- The outcome of counseling is objectively evaluated, to see if the baseline behaviors have changed.

Techniques and stages of counseling

Initial Stage

1. Group members are given all the pertinent information about the group process.
2. The first one or two sessions focus on exploring members' expectations and helping them decide whether they want to join the group or not.
3. In this stage, the main tasks are to build up group cohesiveness and identify problem behaviors.
4. The leader strives to make the group attractive to the members.
5. They may create group situations that require social competence.
6. They may also create functional roles that members can play in the group.
7. Delegate the leadership responsibility to the members in a gradual and appropriate manner.
8. Create situations where members act as therapeutic partners for each other.
9. Control excessive group conflict.
10. Ensure that all members participate in the group interaction.
11. Complex problems are not avoided, but broken down into smaller components.

Working stage

To create the treatment plan, the most effective strategies for achieving each goal are analysed and chosen. The choice is based on individual formulation of each client's problem and on research identifying efficacious treatments. Some of the commonly used techniques include:

Reinforcement: this refers to any stimulus that increases the likelihood of a behavior being performed. It can be provided by the group leader, as well as other group members. Reinforcement usually takes the form of praise, approval, support and attention. Each session can be started with members reporting their successes rather than their failures. Participants are also taught how to reinforce themselves and increase their self-control.

Contingency Contracts: these are written or spoken documents that detail the behaviors to be performed, changed or discontinued; the rewards associated with the achievement of these goals, and the conditions under which the rewards are to be received. They should include a clear description of the specific behaviors to be performed, immediate reinforcement that the individual can get, group reinforcement and a description of the means by which the assignment is to be observed, measured and recorded.

Modeling*:* group work allows each participant a variety of social role models to imitate. The group leader and each member of the group can be seen as a model. A model that is similar to the observer in age, sex and attitudes is more likely to be imitated. Models that are competent in their performance and warm towards others are also more likely to be imitated. Thus, the group leader can identify appropriate models for any member who may need extra help in one area.

Behavior Rehearsal: the aim of behavior rehearsal is to prepare members to perform the desired behaviors outside the safety of the group. Basically it means practicing the new behaviors or skill in an environment where they cannot have negative consequences and will surely receive positive reinforcement. It should be done as far as possible in a similar context to the real world situation so that generalisation can take place. This method is most useful for teaching social skills.

Coaching: group members may sometimes require additional coaching apart from the modeling and behavioral rehearsal. This process involves providing the members with the general principles of performing the desired behavior effectively. This can be done by the leader or by other members who have mastered that particular skill. As the member progresses in learning the skill the amount of coaching should be reduced. The member must have one or two independent rehearsals in the group, before trying out the skill in the outside world.

Feedback: after members demonstrate a new skill other team members give them feedback on how they performed. Positive feedback is always given first. Criticizing is done in a sensitive manner, with members focusing on what could be the changes made, rather than on what was wrong. Feedback focuses on behaviors and not on personality. Members are taught how to give and receive feedback before they are allowed to speak to each other. Overly harsh criticism is blocked by the group leader.

Final Stage

During this stage, the focus is on transfer changes from group environment to everyday environment. Members can use practice sessions to rehearse what they want to say to significant others in their lives. Clients are encouraged to take more and more responsibility for their behavior, treatment and outcome. Various situations from the real world are tried out. Members are prepared to deal with non-reinforcing environments and possible regression to old patterns of behavior. Follow up or booster sessions are planned.

Role and functions of a group leader

- The group leader conducts intake interviews with prospective members during the assessment and orientation phase.
- The group leader assumes the role of a teacher, who structures the sessions and sets up lessons for members to learn from each other.
- They teach participants about the group process, explaining the purpose and activities of a group. They review progress with individual members and guide them on how to make group work more effective for them.
- They take an active, directive and supportive role, and share their knowledge of behavioral principles and skills to enable members to resolve their problems.
- As modeling is an important technique used, group leaders are the primary models. They need to be aware of the impact of their values, attitudes and behaviors on the members of the group.
- They conduct an ongoing assessment of member problems. They determine the best treatment for each member, and monitor progress. If a member is not showing adequate change, the leader reevaluates the formulation and the planned treatment strategy.
- Leaders provide reinforcement for members in their newly developing behaviors and skills by making sure that even small achievements are recognized.
- They encourage members to actually try out new behaviors and skills, both in the group context and outside. They create homework assignments that enable members to generalise what they have learnt to their real life.
- They help members prepare for termination, by discussing reactions, consolidating what they have learnt and practicing new skills.

13.3.4 TRANSACTIONAL ANALYSIS PSYCHOTHERAPY

Transactional Analysis Psychotherapy (TA) is an integrative, relational, psychodynamic therapy grounded in humanistic psychology. TA is described in the International Transactional Analysis Association, ITAA´s training and examinations handbook (ITAA website, 2011) as "a theory of human personality, a theory of social behavior, and a comprehensive system of psychotherapy".

TA was introduced in the late 1950´s by the Canadian/American psychiatrist Eric Berne (1910 – 1970), who founded the basic ideas of the theory and method. From Berne's conceptualization and form of therapy, TA has developed and changed in different directions. One direction is the Redecision Therapy, created by Bob and Mary Goulding (1976, 1979).

The one-year long Transactional Analysis group therapy studied in this dissertation has its main reference in this with Gestalt Therapy (Perl's, 1969, 1973) integrated form. Three different parts of Transactional Analysis have been investigated with support of three different approaches. These are:

Diagnosis/ Client assessment with TA´s Script Analysis as a reliability study (Study I), Identification of different components in TA´s psychotherapy method with Discourse Analysis (Study II) and Study III investigating the therapeutic alliance with a psychodynamic approach, the CCRT method (Luborsky, 1990, 1998) and the Plan – Diagnosis method according to Weiss and Sampson (1986)

The overall aim has been, based in TA´s theoretical concepts, to increase and renew the practical understanding of the active ingredients of TA. Additionally to define and establish elements in TA that makes it a distinct and replicable treatment method.

Berne stressed that psychotherapy should not be only about gaining insight and making progress without curing people. Today Transactional Analysts connect "cure" to completing the treatment contract and describes the goal in terms of change. The contracts are initially mostly focused on the social control of dysfunctional behaviors and changes over time to autonomy in relation to the Script. Berne (1961, 1972) originally classified curing the client based to four different progressive levels:

1. ***Social control:*** The client's first step to recovery was to control the dysfunctional behavior in a social context even if he still felt bad about his problems.

2. Symptomatic relief: The next step was not only to control his behavior, but also to feel relief of confusion and anxiety.

3. Transference cure: In this step, the client can free himself from his script as long as he has the therapist as support in his consciousness. He uses the therapist as a supportive Parent ego state.

4. Script cure*:* Finally, the client owns his integrated Adult, who can take over the internalized therapist from the transference cure. He can now permanently move away from the Script and improve the skilled and personally responsible person that can feel, think and act autonomously in relation to the current reality.

13.4 PATIENT SELECTION AND PREPARATION

Planning and assigning a patient to a treatment that optimizes gains and fits the patient's needs is a shared objective among clinicians. Selecting the most appropriate treatment for each patient can be a difficult task varying by the clinician's biases and theoretical training and with uncertain or unmeasured results.

The contemporary approach that best represents this method of assigning treatment is Systematic Treatment Selection (STS; Beutler, Clarkin, &Bongar, 2000). STS is an integrative model of assessment and treatment delivery that draws on the roles of individual dispositional factors (patient characteristics) and corresponding or matching interventions.

Process of therapy:

This is achieved in four phases of therapy:

1 Establishing a relationship
2 Gathering information in order to understand the client
3 Giving insight
4 Encouraging reorientation

1. ESTABLISHING A RELATIONSHIP

The first phase is to establish a relationship in which the partners have equal respect, equal rights and equal responsibilities. The therapist acts as a good parent, accepting the client unconditionally, developing with the client an understanding of who she is and encouraging the client by pointing out her strengths and abilities and believing that the client can make changes if she wishes. The client needs to feel safe to explore her innermost

thoughts and express deep feeling with the therapist. The therapist will also expect respectful behavior from the client so that agreements about appointments and payments are kept. The client and therapist will need to be sure that they share common goals for the therapy.

2. GATHERING INFORMATION

The second phase, of understanding the person, will start as soon as the client enters the room. Adler was reported to be expert at gathering information about the client by observing the way the client entered the room and how he sat down and how he spoke and behaved in the sessions. Direct questions are asked by the therapist, not only about why the person has come for therapy but also about himself generally; a great deal can be learned about a client by what he tells and does not tell, as well as by the content of his answers. The therapist will be interested in his participation in the workplace, his friends and social life and if he has an intimate relationship and how it is going on. The therapist will also want to know about the person's family of origin. It was in this family that the client developed his lifestyle containing his thoughts, goals and feelings. The therapist will ask him to describe his siblings and parents when he was a child. He chose to be a particular child in this family through trial and error. His siblings were also making choices about the sort of children they would be. The personality that the child developed. Was this client and eldest child who was threatened by a younger brother or sister who had decided to strive to be better than his or her siblings and in the process lost no time in putting the other siblings down? Or was this client a pampered youngest child who had two parents and older siblings doing things for him and over-protecting him? It is now necessary for the therapist to gather information from another source The client will be asked to give a few early memories: Adler discovered that people remember things that reinforce the beliefs and ideas in their private logic; the memories are symbolic representations of these ideas and beliefs. The memory may be of an insignificant occurrence in the client's childhood and yet out of all the things that have happened to him, he produces that memory; that memory is produced because it has particular significance to him and symbolizes a belief may be about himself or about the world or about how he should behave in his perceived worlds. Dreams are also used for interpretation as they too contain symbolic representations of a person's private logic. Together the therapist and the client interpret the early memories and dreams.

3. GIVING INSIGHT

The third phase is giving insight. The therapist will have formed some hypotheses about the clients' view of themselves, their view of the world and their unconscious decisions about how to move through life. These guesses need to be checked out with the client. The client can agree or disagree. The feelings, beliefs and ideas are recognized by the client, may recognize how his private logic has restricted him and may want to change his ideas and goals. The therapist may have to challenge the client's goals and ideas so that the client can align his goals with common sense and not with his private logic. The therapist will help the client see how his presenting problems fit in with his lifestyle.

4. ENCOURAGING REORIENTATION

The reorientation phase then starts and this is where the client has the hardest work. The therapist will be there guiding and encouraging as the client finds a way to change. The therapist will encourage the client by pointing out the client's strengths and by believing that the client will find a way to move on. Progress can be rare. Attainable assignments are set with the client; the therapist will be able to hear how the client experienced a new behavior and will congratulate the client on achieving such a change. There is no set format for a session. Adlerian therapy respects the individual and so clients can lead the session at the beginning if they wish, bringing to the session what they want to talk about.

13.5 THERAPEUTIC FACTORS

13.5.1 Group Cohesion

Group cohesion is usually defined as feelings of interpersonal trust, attraction to, and involvement with the group (Bednar et al., 1974; Yalom, 1975). Group cohesion is a broad concept, encompassing the client's relationship to the group leader, to the other group members, and to the group as a whole (Yalom, 1975). Cohesion appears to develop from shared group experience (Bednar et al., 1974), and provides a feeling of safety, allowing meaningful self-exploration, the giving and receiving of feedback, and a feeling of being understood and accepted.

Three studies attempted to assess the influence of cohesion in outpatient therapy groups (Dickoff&Lakin, 1953; Yalom, Houts, Zineberg, & Rand, 1967; Yalom, Tinklenberg & Gilula, 1975). All used retrospective self-report analyses of degree of improvement and perception of cohesion. The results uniformly implied that symptomatic improvement was

related to group cohesion, and that clients rated cohesion as an important change-related variable.

Cumulatively these findings, although few in number, indicate that cohesion can be a determinant of positive outcome. In addition to the above research, considerable indirect evidence stemming from research with other types of groups exists. In summary, it has been demonstrated that members of cohesive groups (a) try harder to influence other group members, (b) are more Influence able by other group members, (c) are more willing to listen to others, (d) participate more readily in meetings, (e) continue membership in groups longer, (f) adhere more to group norms and exert more pressure on individuals deviating from the norms, (g) place greater value on the group goals, and (h) are absent less often from group meetings (Bednar & Lawlis, 1971; Goldstein, Heller, & Sechrest, 1956).

Attempts to Increase Group Cohesion

A number of investigators have conducted experimental studies attempting to delineate factors that are conducive to increasing group cohesion. The factors investigated included: self-disclosure, feedback, pregroup structuring, leadership style, and reinforcement. First, several reviews indicated that the level of self-disclosure of group members contributed to cohesion and intermember attraction (Kirshner, Dies, & Brown, 1978; Yalom, 1975). In an analogue study, Ribner (1974) utilized written contracts concerned with the definition and practice of self-disclosure in his experimental groups.

The self-disclosure produces perceived cohesion and that cohesion increased over time. The use of positive behavioral feedback did increased levels of cohesion in structured groups. The most important single factor having a positive effect on group interaction patterns was pretherapy training or structuring. The appropriate use of structure, particularly in the early stages of group interaction, was a powerful means of influencing participants' attitudes and behaviors.

13.5.2 Collective transference

Hopper (2002) adds a group's 'collective' transference to objects who the group hold in common, such as the conductor, the dynamic matrix of the group, various sub-groups, etc. The transference and counter transference to general, historical and group-as-a-whole issues, make up the co-creation of the "microcosms".

Neri (1998) quotes Bejerano who specifies four transference objects:

- The therapist (who functions as a father image: at archaic levels (as the infantile Super-ego or Ego Ideal)
- The group which functions as a mother-image (Oedipal level) but even more as an archaic mother (the horde)
- The others (lateral transference) as a fraternal image
- The external world, as a place for the projection of individual destructiveness or productiveness.

ABREACTION

Ever since the publication of *Studienuber Hysterie* by Breuer and Freud, the phenomenon of abreaction has been familiar to psychotherapists; indeed the observation of this phenomenon was the foundation of all analytical theory and practice.

These observers, while treating certain patients by hypnosis, discovered certain forgotten memories whose revival was accompanied by considerable emotional reaction. This in itself was of great therapeutic benefit, and for a time constituted the method of cure adopted by Freud himself. Later, he found that this alone was not enough, and proceeded to develop from it the elaborate technique of psycho-analysis.

Dr. Brown regards psychocatharsis or abreaction as an essential part of the cure of neurotic symptoms. He holds that "the emotional tone of the individual experiences is retained in the mind in the same way in which these experiences themselves are retained". He also speaks of the bottling-up of energy at the time of the original trauma, and the freeing of this bottled-up energy by means of the abreaction.

In psychotherapy the phenomenon of abreaction is only incidental in the therapeutic process, and that it is not the so-called freeing of bottled-up emotion which does the good.

13.6 IN-PATIENTS VS. OUT-PATIENT GROUPS

- **Inpatient**- A person who is formally admitted to a health-care facility and is discharged after one or more days
- **Outpatient**- A person who goes to a health-care facility for a consultation, and who leaves the facility within three hours of the start of consultation, an outpatient is not formally admitted to the facility.

Group psychotherapy has been applied in clinical settings since around 100 years ago. While the psychoanalytic methodology was shadowed on individual and group psychotherapy in the first part of the 20th century, other techniques, especially, cognitive, existential, and interpersonal approaches emerged and improved later.

The inpatient group psychotherapy technique differs from outpatient in many factors. With respect to group members' differences, hospitalized patients for the most part have more serious illnesses and are more likely to have a comorbid personality disorder. According to the limited duration of admission, the available time for inpatient psychotherapy is usually short. A third significant distinction is that in inpatient settings, the clients are living in a small common environment, accordingly the out-of-group communications and interactions are substantially more than what happens in outpatient settings. Psychotherapy is a complex cycle, and dependent on such differences, the inpatient variety is most likely more complex.

Inpatient group therapy offers a unique platform for therapists to work intimately with clients to take a look at interpersonal relationships, the tensions and clashes that emerge out of them, and explore issues about the manners by which people interact with, and inside, their environment. It requires a strong and containing environment for staff as they attempt to give that to the client group. In contrast to long term, outpatient groups, inpatient groups require the therapists involved to embrace an unmistakably more dynamic and directive stance, intervening more and emphasizing cognitive processes. In addition, they can offer nurses a therapeutic role and help establish a safe and containing environment on an acute inpatient ward.

13.7 SOCIAL SKILLS TRAINING- ASSERTIVESNESS TRAINING- SELF CONTROL TECHNIQUES-CORRESPONDENCE TRAINING

Social skills

Social skills may be viewed as the coping process by which social competence is achieved. Social skills include affective, cognitive and motorist domains of functioning. They comprise the transactions between people that result in the attainment of some goal. Socially skilled individual is attuned to the realities of the situation and is aware how he is likely to be rewarded for efforts. It is effectiveness in social interactions. Social skills produce personal effectiveness through communication. Skills required for social competence include a) accurate social perception, receive appropriate and relevant information b) cognitive

processing translating of social perceptions into alternate course of action, c) implementing or sending the chosen alternative response back to the person using appropriate verbal and non-verbal behaviors. Building competence and coping is believed to displace symptoms.

Social skills training is based on learning theory principles which you have studied in the previous year and also in other papers of this year. The process of training includes the following steps:

1. Problem definition. Counselor must translate the patient's obvious presenting symptoms into deficits of socially appropriate behavior

2. Inventory of assets. During evaluation, patient's strengths and capabilities in social relations are assessed.

3. Establishing a reinforcing therapeutic alliance. Rehabilitation team engages the patient and the family in a warm, accepting and mutually respecting relationship.

4. Goal setting. It is important to move quickly from patient's problems to formulating positive goals to be achieved in training session.

5. Behavioral rehearsal. Much of the training takes place in simulated situations that approximate roughly patient's real life situation

6. Use methods such as positive reinforcement, shaping, prompting, modeling, homework and in- vivo practice to teach skills.

Several social skill training modules are available. This training has demonstrated its value in building the competence of patients.

Definition of assertiveness training

Assertiveness training is a type of behavior therapy focused on increasing assertive, self-assured behavior in individuals and teaching a more confident, effective communication style. Assertive-ness training places an emphasis on respecting the wants and needs of both parties in a conversational exchange through effecting changes in both verbal and nonverbal assertive behavior.

Assertiveness training focuses on increasing assertive behavior in individuals to help alleviate interpersonal problems. One of the most cited dentitions of assertive behavior was posed by Alberta and Emmons (1990), which states that assertive behavior allows individuals

to express feelings directly, comfort-ably, and honestly, and to stand up for themselves without unreasonable anxiety, while simultaneously taking into account the personal rights of both parties. In short, the main objective of assertiveness training is to help individuals respond productively to challenging interactions in their day-to-day life. Assertiveness training can be applied to many different social situations, including personal and occupational. At its core, assertive behavior involves directly expressing one's own feelings, opinions, and thoughts while respecting the feelings, attitudes, and wishes of the conversation partner. To this end, assertive-ness training is conducted to alter individuals' nonverbal and verbal behavior to match a more assertive response style. Aspects of nonverbal assertive behavior targeted include modulation of tone, infection, volume, and facial expression to parallel the given situation. Other nonverbal behaviors targeted include eye contact, body language, maintaining an upright and strong posture, and managing distance and physical contact with the conversation partner. The focus on verbal assertive behavior includes the actual words and con-tent used in the interpersonal exchange.

Format of Assertiveness training

Assertiveness training is ideally conducted in a group format of 6–10 members who are similar in terms of group characteristics (e.g., gender) and meets for 10–12 sessions. A group format is more effective than individual training sessions because participants can practice using assertive behavior techniques with each other. In addition, group members can provide examples of their engagement in assertive behavior and will tend to be more receptive and accepting of the assertive behavior exhibited by members of the group. While assertiveness training may function as a standalone treatment, it has also been used as a facet of other treatment programs. For example, assertiveness training has been used as a component of evidence-based cognitive behavioral therapy and functional family therapy protocols for adolescent problems, including interventions for anger management, low self-esteem, and substance use disorders.

Components

The main phases of assertiveness training include Psychoeducation, teaching assertiveness skills, and practicing assertive behavior. Psychoeducation focuses on defining assertive-ness and teaching clients about different types of response options employed in interpersonal communication. This includes an explanation of what assertiveness is and how

that behavior is useful, followed by correcting any misconceptions or misinformation the person may have about what it means to be assertive.

Next, three responses to interpersonal exchanges are typically discussed: aggressive, passive, and assertive. Aggressive responses include yelling, threatening, and putting one's own needs above the conversational partner's, or blatantly disregarding the conversational partner's needs. Passive responses involve putting the conversation partner's wants and needs above their own, or doing what someone wants them to do, even if they do not want to. And lastly, assertive responses consist of the person placing his/her own needs first in a direct, firm, and respectful manner while taking the conversational partner's needs and rights into account.

Therapists also cover individual fundamental rights such as both members of the conversation having the right to change their minds, having the right to say "I don't know," being treated with respect, and expressing their feelings. The second main focus is teaching several assertiveness skills. The purpose of teaching assertive skills is to add assertive behavior into people's repertoires. Clients learn how to respond to unreasonable demands, make requests, say "no," and express dissatisfaction. This involves direct instruction in nonverbal and verbal assertive skills such as body language, eye contact, modulation of tone and volume, and word choice. The therapist or facilitator serves as a competent model of the desired behavior. Clients may also receive training in specific assertiveness techniques such as the broken record technique, empathic assertion, escalating assertion, or fogging. With the broken record technique, the client reaffirms a point by repeating the same statement in light of repeated requests while maintaining the same tone and not becoming unduly upset. For example, imagine you are out at a stores hopping when a salesperson approaches you to see if you would be interested in buying their new product, but you are not interested. You say, "I don't need that right now." The salesperson asks you again about buying the product, and a broken-record response would be: "I don't need that right now" while maintaining the same tone and not giving in and buying the product.

Empathic assertion focuses in on the other person's feelings while remaining assertive. Escalating assertion would involve practicing a sequence of responses that increase in assertiveness. Or lastly, clients may practice fogging. This is a technique that can be used in response to verbally aggressive behavior such as an insult, and it tends to defuse conflict by confusing the aggressor.

Fogging involves agreeing with the other person's statement without actually meaning it. This tends to defuse the situation because the aggressor is expecting a defensive or aggressive response rather than some level of agreement and it can reduce the tension by turning it into a joke. For example, imagine your spouse is upset because you have not washed the dishes, but you are tired and do not want to wash the dishes right now, and your spouse says, "You're so lazy, I can't believe you haven't washed the dishes yet. This place is a pigsty!" A fogging response would be: "You're right, I must be lazy. I want to sit down and relax for a few minutes after work, so I'm not going to do the dishes right now. If it bothers you so much, you are welcome to wash them." These are just a few examples of specific techniques or skills that may be covered in assertiveness training. In addition, cognitive restructuring techniques may be used to modify clients' self-speech that could deter assertive behavior such as fear of negative consequences or fear of failure.

A final key component of assertiveness training is practicing the assertiveness skills through behavioral rehearsal, role-playing, and response practice. This allows clients to practice assertive skills in increasingly difficult situations, such as saying "no," or refusing after being asked multiple times. Clients may practice hypothetical situations or practice what they want to say for a current challenging or uncomfortable social situation. Crucially, during role-plays, self-feedback, video feedback, and coaching are employed to improve upon assertive behavior. Verbal praise is used to strengthen assertive responses, which may at first feel awkward or uncomfortable for clients. In addition, homework is given to help generalize skills. This could require clients to practice assertiveness skills in real-world scenarios. Of note, initial homework assignments should focus on relatively non-threatening situations where clients are likely to be successful.

13.8 SELF-CONTROL TECHNIQUES

Self-control is defined as "restraining one's actions or feelings of rage and anger or undesirable behavior." Many things in the work place can cause feelings of anger which may lead to a person's losing his/her self-control. For example, criticism, untruths, lack of sleep, personal conflict with someone, or just plain bad luck can cause you to lose your temper. Once we allow ourselves to become angry, our temper seems to control us. However, you can regulate and maintain your self-control by using the following methods:

1. Try to control your temper by bringing your positive traits into play. Personal characteristics such as patience, cheerfulness and sense of humor are very valuable in helping you to react properly.

2. Learn to "count to 10" before responding--Wait until you are in control of your negative emotions.

3. You must depersonalize the situation and not let things “get under your skin,” or bother you.

4. Try to view the bright side of every situation.

5. Learn to laugh at yourself and your mistakes

The above techniques may sound very simple, but in actuality, they are not easy to put into practice. Have patience and make a conscious effort to become a more well-adjusted employee. Try to learn something from the experience. Determine where your shortcomings lie and then try to improve yourself. Decide upon specific ways in which you need to change your behavior and then implement those changes. Self-control is based upon mental discipline and personal will power.

The Nature of Self-Control

All behavior is learned. The behavior that is shown in a given situation is influenced by that person's learning experiences in similar situations. Thus, one’s ability to control temper is a learned response. In order to achieve self-control, one needs to learn new behaviors appropriate for the situation. It is possible to develop techniques to decrease undesirable behaviors.

Self-Control Techniques

The following techniques can be utilized to help develop appropriate behaviors:

1. **Self-Observation**--In order to change a behavior, one must monitor and collect information about the problem behavior. It is very helpful to keep a chart or a notebook and record the situation and results when the control is tested.

2. **Reward Technique**--Reward oneself when the person exhibits the desired behavior. Make sure the reward is meaningful, is readily available, and provides a strong incentive for maintaining self-control.

3. **Punishment Technique**--Penalize oneself each time one exhibits loss of control.

4. **Extinction**--Stop providing a reward for the desirable behavior. For example, if someone loose temper, don't pamper the person after work to feel better.

5. **Alternate Behavior**--Train oneself to turn to an alternate behavior when the person is confronted with a problem where one would normally behave poorly

6. **Stimulus Control**--Learn to recognize the stimulus which triggers one's negative behavior. Then one must try an alternate behavior, as in step 5, each time the stimulus, appears. Also, use rewards or punishments as appropriate. Eventually this will help bring one's behavior under control.

13.9 SUMMARY

When we compare between individual and group therapies, the research finds that both group therapy and individual therapy are relatively equivalent in their effectiveness in addressing a large number of issues. This is an individual choice that can be made by clients who are able to try both types of therapy and decide for themselves which is best for them. Nonetheless, both formats of therapy have advantages and disadvantages. Deciding on which one to engage in is a personal choice that depends on one's personal issues, goals, and the types of therapists/groups that are available.

13.10 KEY WORDS

Psycho-therapy: the intricate art and science of improving the condition of clients. Beyond these tasks lies always implicitly at least, but increasingly at an explicit level, the important problem of prevention.

Individual therapy: is a psychotherapy implemented by a trained professional, usually a therapist or psychologist, to help a client work through a problem

Group therapy: Presence of a therapist in which several patients discuss and share their personal problems

Cohesion: Group cohesion is a positive bond that exists between all group members. One cannot have group cohesion if one or more members of the group are ostracized or subdued into compliance

Abreaction: the expression and consequent release of a previously repressed emotion, achieved through reliving the experience that caused it

Social skills: Techniques used to communicate with others daily in a variety of ways including verbal, nonverbal, written and visual. Social skills are also referred to as interpersonal or soft skills.

Assertive training: based on the principle that we all have a right to express our thoughts, feelings, and needs to others, as long as we do so in a respectful way. When we don't feel like we can express ourselves openly, we may become depressed, anxious, or angry, and our sense of self-worth may suffer.

Self-control: an aspect of inhibitory control, is the ability to regulate one's emotions, thoughts, and behavior in the face of temptations and impulses. As an executive function, self-control is a cognitive process that is necessary for regulating one's behavior in order to achieve specific goals

13.11 CHECK YOUR PROGRESS

1. What is psycho-therapy? How do you classify the therapies?
2. Give a detailed note on Patient selection and preparation
3. Explain the role of Cohesion and collective transference in therapy
4. What is Social skills training? Describe with suitable examples
5. What is self-control? Explain various Self-control techniques

13.12 ANSWERS TO CHECK YOUR PROGRESS

1.13.2 & 13.3 2. 13.4 3. 13.5 4. 13.7 5. 13.8

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UNIT :14 - GROUP EDUCATION: PSYCHO-EDUCATIVE THERAPIES & CONTINUING EDUCATION

STRUCTURE:

14.1 OBJECTIVES

After reading this unit, you should be able to:

- Understand nature and meaning of psychoeducation
- Get to know about bibliotherapy and processes involved
- Get a fair knowledge on disaster management and specific issues
- Understand in detail about self-help groups and their functioning
- Know more about social case work and its modalities

14.1 INTRODUCTION

Anderson and few of his colleagues coined the term "Psychoeducation" which was used to describe the therapeutic concepts which mainly consisted of 4 features; to outline the illnesses of the clients, to teach them decision making and problem solving efficiently, to improve and enhance their communication skills, and self-assertiveness training, where the family members and close relatives are included in the therapy also. The Psychoeducation (PE) is described as an intervention with systematic, structured, and didactic knowledge.

Psychoeducation (PE) can be explained as an intervention with methodical, structured, and informative knowledge transfer to an individual suffering from illness and its treatment, integrating both the emotional and motivational aspects to help clients to cope with the illness and to improve its treatment adherence and effectiveness. Psychoeducation was originally considered as a combination of various therapeutic elements within a complex family therapy intervention. Clients and their relatives were, by means of preliminary briefing concerning the illness, supposed to develop a fundamental understanding of the therapy and further be convinced to commit to more long-term involvement.

Since the mid-1980s, Psychoeducation especially in German-speaking countries has evolved into an independent therapeutic program with a focus on the didactically skillful communication of key information within the framework of a cognitive-behavioral approach. Through this, clients and their relatives should be empowered to understand and accept the illness and cope with it in a successful manner.

Achievement of this basic-level competency is considered to constitute an "obligatory-exercise" program upon which additional "voluntary-exercise" programs such as individual behavioral therapy, self-assertiveness training, problem-solving training,

communication training, and further family therapy interventions can be built. Psychoeducation combines the factor of empowerment of the affected with scientifically founded treatment expertise in as efficient manner as possible.

It is recommended that psychoeducation, in the form of an obligatory-exercise program, should be made available to all clients suffering from a schizophrenic disorder and their families. Interventions through psychoeducation usually accompanied by a higher level of compliance, lower rate of relapse, and improved psychopathological status. In the context of the currently internationally recognized vulnerability-stress–coping model, with its assumption of a biopsychosocial cluster of causes, psychoeducational interventions as an "obligatory-exercise" program provide the foundation for numerous further treatment measures.

Goals of Psychoeducation

- Certifying clients' and their relatives' attainment of basic competence
- Facilitating an informed and self-responsible handling of the illness
- Deepening the clients' role as an "expert"
- Cotherapists—strengthening the role of relatives
- Optimal combination of professional therapeutic methods and empowerment
- Improving insight into illness and improvement of compliance
- Promoting relapse prevention
- Engaging in crisis management and suicide prevention
- Supporting healthy components
- Economizing informational and educational activities

Psychoeducation: Focus in India

Psychoeducation in India is still in its infancy. Lack of man-power, funding, lack of expertise can all be taken as the reasons for this. Considering the chronic nature, impairment due to illness, no cure with medications and effectiveness of Psychoeducation it should be provided to maximum number of clients. Francesc Colom (2011) has suggested that an open-door policy team effort and therapeutic relationship founded on trust, rather than authority might prove helpful in increasing the benefits of Psychoeducation to the clients and caregivers.

In India, there is scarcity of mental health professionals. The existing mental health units are overburdened. Due to these major issues structured Psychoeducation for clients or caregivers attending outpatient clinics seems impracticable in individual level. In this context the group Psychoeducation seems more valid and practicable. India being a multi-linguistic country, language stands as a major barrier to proper Psychoeducation. There is a need to develop Psychoeducation material in different languages keeping in view the cultural factors.

14.3 BIBLIOTHERAPY

Bibliotherapy is a creative arts therapies modality that involves storytelling or the reading of specific texts with the purpose of healing. It uses an individual's relationship to the content of books and poetry and other written words as therapy. Bibliotherapy is often combined with writing therapy. According to Gladding; Bibliotherapy is a dynamic three-way interaction involving the use of a book, a counselor, and a client. "The counselor and the client consider problems or stress areas in the client's life; then the counselor 'prescribes' a book or story for the client to read".

The concept of reading as a way to help facilitate the healing process and meet therapeutic goals is a common strategy found in many treatment approaches. Bibliotherapy as a therapeutic approach, it as an adjunct part of the treatment process. It is often used to support other forms of therapy, it is appropriate for both individual and groups, and people of all ages. It's common to see a therapist use stories when working with a younger client such as a child or adolescent. In a group therapy setting, bibliotherapy allows participants to give and receive feedback about their interpretations of the literature and how it relates to their issues. It also helps improve communication and encourages more in-depth conversations and connections for participants.

How Bibliotherapy helps the clients: Through the use of stories via fiction and nonfiction books, poetry, plays, short stories, and self-help materials, a therapist can help the clients gain a deeper understanding of the concerns that brought them into counseling sessions in the first place.

Person Challenges: Bibliotherapy allows the clients to gain insight into the personal challenges they're dealing with and helps them develop strategies to address the most concerning issues. It can also help promote problem solving, understanding, and self-awareness.

Receiving Benefits Outside of Treatment: Agreeing on a book to read in-between sessions gives the therapist a format for assigning homework outside of treatment. This can help deepen the meaning of a therapeutic session and facilitate greater learning. Gladding says that it can serve as a prevention model, which can help people learn ways of coping with life's challenges.

The Stories Provide Perspective: One of the more compelling reasons for using bibliotherapy is that it can help the clients see how other people, such as characters in a book, address and deal with similar issues. When they identify with a fictional or non-fictional character, especially on an emotional level, they're able to see that there are others who are also navigating and coping with personal struggles.

Common Issues Treated With Bibliotherapy

While reading, in general, is beneficial to just about everybody, Perman says targeted bibliotherapy can be specifically useful for the following issues:

- Anxiety
- Depression
- Substance abuse
- Eating disorders
- Relationship issues
- Existential concerns such as isolation, meaninglessness, freedom, and death

Gladding adds that bibliotherapy may be especially relevant for issues that involve interpersonal relationships, such as managing anger or socially appropriate behavior and intrapersonal relationships, such as shyness or depression. “Issues regarding how to handle grief, rejection, or almost any of the negative ‘isms’ such as racism, sexism, ageism, may also be addressed through bibliotherapy,” says Gladding.

When using bibliotherapy, a therapist might choose a self-help reference such as a workbook of calming exercises for a person with anxiety or other mental health concerns. Or, they may select a story with a fictional character that is dealing with the grief and trauma from losing a loved one for a client who recently experienced a death in the family.

14.4 DISASTER MANAGEMENT

Disaster, as defined by the United Nations, is a serious disruption of the functioning of a community or society, which involves widespread human, material, economic or environmental impacts that exceed the ability of the affected community or society to cope using its own resources. Disaster management is how we deal with the human, material, economic or environmental impacts of said disaster, it is the process of how we "prepare for, respond to and learn from the effects of major failures".

Disaster management, at the individual and organizational level, deals with issues of planning, coordinating, communication and risk management.

Types of Disaster

Natural Disasters

- Geophysical (e.g. Earthquakes, Landslides, Tsunamis and Volcanic Activity)
- Hydrological (e.g. Avalanches and Floods)
- Climatological (e.g. Extreme Temperatures, Drought and Wildfires)
- Meteorological (e.g. Cyclones and Storms/Wave Surges)
- Biological (e.g. Disease Epidemics and Insect/Animal Plagues)

Man-Made Disasters

- Environmental Degradation
- Pollution
- Accidents (e.g. Industrial, Technological and Transport usually involving the production, use or transport of hazardous materials)

Complex Emergencies

- Food Insecurity
- Epidemics
- Armed Conflicts

Pandemic Emergencies

Pandemic (from Greek πᾶν pan "all" and δῆμος demos "people") is an epidemic of infectious disease that has spread across a large region, which can occur to the human population or animal population and may affect health and disrupt services leading to

economic and social costs. Pandemic Emergencies may occur as a consequence of natural or man-made disasters. These have included the following epidemics:

- Ebola
- Zika
- Avian Flu
- Cholera
- Dengue Fever
- Malaria
- Yellow Fever
- Coronavirus Disease (COVID-19)

Aspects of Disaster Management: The International Federation of Red Cross & Red Crescent Societies defines disaster management as the organization and management of resources and responsibilities for dealing with all the humanitarian aspects of emergencies, in particular preparedness, response and recovery in order to lessen the impact of disasters

Disaster Prevention: Disaster Prevention as the concept of engaging in activities which intend to prevent or avoid potential adverse impacts through action taken in advance, activities designed to provide protection from the occurrence of disasters. WCPT similarly highlight that while not all disasters can be prevented, good risk management, evacuation plans, environmental planning and design standards can reduce risk of loss of life and injury mitigation.

Disaster Preparedness: According to ICRC, Disaster Preparedness refers to measures taken to prepare for and reduce the effects of disasters, be they natural or man-made. This is achieved through research and planning in order to try to predict areas or regions that may be at risk of disaster and where possible prevent these from occurring and/or reduce the impact those disasters on the vulnerable populations that may be affected so they can effectively cope. Minimization of loss of life and damage to property through facilitation of effective disaster response and rehabilitation services when required. Preparedness is the main way of reducing the impact of disasters. Community-based preparedness and management should be a high priority in physical therapy practice management

Disaster Response / Relief*:* Focused predominantly on immediate and short-term needs, the division between this response/relief stage and the subsequent recovery stage is not clear-cut. Some response actions, such as the supply of temporary housing and water supplies, may

extend well into the recovery stage. Rescue from immediate danger and stabilization of the physical and emotional condition of survivors is the primary aims of disaster response/relief.

Coordinated multi-agency response is vital to this stage of Disaster Management in order to reduce the impact of a disaster and its long-term results with relief activities including:

- Rescue
- Relocation
- Provision Food and Water
- Provision Emergency Health Care
- Prevention of Disease and Disability
- Repairing Vital Services e.g. Telecommunications, Transport
- Provision Temporary Shelter

Disaster Recovery: Vulnerability of communities often continues for long after the initial crisis is over. Disaster Recovery refers to those programs which go beyond the provision of immediate relief to assist those who have suffered the full impact of a disaster and include the following activities:

- Rebuilding Infrastructure e.g. Homes, Schools, Hospitals, Roads
- Health Care and Rehabilitation
- Development Activities e.g. building human resources for health
- Development Policies and Practices to avoid or mitigate similar situations in future

Role of mental health professionals in disaster management

Mental health professionals contribute in various ways in different phases of disaster management. In the immediate aftermath of disaster, psychiatrists can provide vital information on mental health issues to administrators, policy makers, governments, community groups and non-governmental organizations involved in disaster management (RANZCP, 2000). Providing such information help to ensure mental health needs, whereby problems are recognised and appropriately managed and/or referred to specialist mental health professionals, so as to prevent prolonged suffering and morbidity (RANZCP, 2000).

At the disaster site, mental health professionals support disaster workers to establish psychologically supportive relief operations. During the early post-disaster phase, information resource centres can be set up to provide practical assistance and psychologically important information. Disaster workers can be trained to support the victims emotionally,

and to triage persons in need for referral to mental health professionals who can help with the assessment of those who have been referred. Mental health professionals can help the disaster workers in dealing with victims with severe psychological reactions and dissocial behaviour and can provide crisis intervention and other necessary psychotherapeutic support. They can also debrief disaster workers who are overwhelmed by the situation providing them psychological support.

Role of mental health professionals in the recent and remote post-disaster phases include mostly the management of post-disaster psychiatric disorders. However they should also contribute to mental health care policies and mechanisms for the transition of disaster victims to long-term psychosocial care or recovery systems, and to address chronic needs of the affected population. Mental health professionals should advice and liaise with policy makers to put in place systems for long term care for victims, considering that in a majority of the victims' symptoms and disabilities will be chronic.

14.5 HANDLING SPECIAL CASES AND S ITUATIONS

Addictions and compulsions

An **addiction can be defined as** a persistent need to consume a substance or commit an act is distinct from a **compulsion**, which is an overwhelming and irresistible impulse to act. Usually, a compulsive act is preceded by obsessive, intrusive thoughts that compel the person to act, whereas an addiction is more of a habit that is not necessarily accompanied by obsessive thinking. An individual experiencing either addiction or compulsions may find it helpful to speak to a mental health professional.

Identifying signs and symptoms

Compulsive behaviors include chronic gambling, substance abuse, sexual addictions, unrestrained shopping and spending, hoarding, excessive exercising, Internet gaming, eating issues, and other behaviors. Any compulsive behavior can become an addiction when the act is no longer able to be controlled and impairs a person's ability to function socially, academically, and professionally. The distinction between "addiction" and "compulsion" can sometimes become unclear, as a person might think frequently about the object of the addiction, and it may become near-compulsive to pursue the addictive behavior.

Determining whether a habitual behavior has become problematic begins with evaluating the benefits associated with the activity and the feelings and beliefs surrounding it. The distinction between a passionate hobby and a compulsive behavior may be difficult to discern. For example, is running 10 miles every day—rain, shine, or snowstorm—an addiction, or is it good athletic discipline? Is a monthly trip to Vegas to play the slots a gambling problem, or just an escape from daily life? Addiction or compulsivity may be indicated when the behavior results in feelings of distress, guilt, or shame or when abstaining from the behavior provokes anxiety or proves to be impossible.

Symptoms that suggest a compulsive behavior has become problematic include:

- Interpersonal and professional relationship problems
- Concealment of the behavior
- Denial of a problem
- Inability to stop the behavior
- Alternating feelings of anxiety, confusion, shame, or elation that revolve around the behavior
- Withdrawal from or a lack of enjoyment in other activities
- Desire only for the company of others who pursue the activity or, to an opposite extreme, the urge to conduct the activity only in isolation
- Fear surrounding the potential repercussions associated with discontinuing the activity

Therapy: Compulsive behaviors and addictions may provide a person with a sense of power, euphoria, confidence, validation, or other feelings that may otherwise be lacking in their lives. Psychotherapy is designed to help people identify uncomfortable feelings and sources of distress in order to change and grow. People who struggle with compulsivity and addiction are unlikely to conquer those behaviors unless they work to address the underlying causes of their addictive and/or compulsive behaviors, such as trauma, stress, past abuse, and others.

Working with a therapist is one of the most effective treatments for managing compulsive behaviors and addictions, and there are many types of therapy suited to addressing behaviors that a person may want to change. A person is likely to achieve the most benefit from consulting with a therapist who is qualified to address the particular area of addiction or compulsion experienced, as well as the underlying cause of the

issue. For example, a person who uses drugs to dull the intensity of posttraumatic stress may benefit from treatment for PTSD as well as drug addiction, but resolving the PTSD may also help significantly with treatment for the addiction. Self-help, support groups, and 12-step programs may also facilitate recovery from addiction and compulsivity.

Internet addiction: John 22, is a college student. He spends several hours on the Internet each night, sometimes staying awake until sunrise, which generally causes him to experience difficulty functioning in class the next day. He has friends at school but finds he is isolating himself from them and becoming absorbed in the virtual world of the web. Morgan obsessively plays games and engages in chats, and he does little else with his free time. His social life and grades suffer, but he cannot seem to stop. He reports feeling like he is in a daze and says he is bored and anxious when he is not on the computer. Therapy reveals ambivalence about his major and the ensuing career it implies, as well as homesickness, social anxiety, and perhaps some chemical issues that tend toward depression. At the suggestion of his therapist, Morgan begins to involve friends in computer activities, watching movies with them and playing games in a group. This leads to extended social activities, and Morgan's confidence improves. Career counseling steers him toward a more fulfilling path, and a few family sessions with his mother and brother uncover old grief that, once resolved, allows a better mood to prevail and socializing to become enjoyable again.

14.6 SELF-HELP GROUPS

Self-help groups are informal groups of people who come together to address their common problems. While self-help might imply a focus on the individual, one important characteristic of self-help groups is the idea of mutual support people helping each other. Self-help groups can serve many different purposes depending on the situation and the need. For example, within the development sector, self-help groups have been used as an effective strategy for poverty alleviation, human development and social empowerment, and are therefore often focused on microcredit programs and income-generating activities

Over the past 20 years, self-help groups have been used in various forms in the disability sector, and self-help groups of people with disabilities and their families are engaged in a whole range of activities including health care, rehabilitation, education, microcredit and campaigning. Self-help groups can facilitate empowerment; belonging to a group (or organization) is one of the principal means through which people with disabilities can participate in their communities, and it is through the involvement in groups that they can

begin to develop their awareness and the ability to organize and take action and bring about change

Characteristics of Self-help groups

Some common characteristics of self-help groups

- Self Help Groups (SHGs) are informal groups that consist of people who face similar problems.
- These people come together to form a group to overcome their common problems to improve their standard of living.
- They are mostly from a similar socio-economic background and are involved in undertaking small savings amongst themselves in a bank. This amount acts as the fund for the SHGs and is used to provide loans to its members.
- It is a vital tool to alleviate people from below poverty line and improve social status through the promotion of self-employment.
- Voluntary nature – they are run by and for group members, have regular meetings, and are open to new members;
- Generally being formed in response to a particular issue, e.g. No access to education for children with disabilities, limited income-generating opportunities;
- Clear goals, which originate from the needs of group members and are known and shared by all members;
- Informal structure and basic rules, regulations and guidelines to show members how to work effectively together;
- Participatory nature – involving getting help, sharing knowledge and experience, giving help, and learning to help oneself;
- Shared responsibility among group members – each member has a clear role and contributes his/her share of resources to the group;
- Democratic decision-making;
- Governance by members, using an external facilitator only if necessary in the formation of the group;
- Evolution over time to address a broader range of issues;
- Possibility of joining together to form a federation of groups across a wider area.

Functioning of SHGs

- An ideal SHG should have about 10 to 20 members.
- This is because if the group is bigger, it will be difficult for an individual to undertake equal participation in a large group.

- The SHG shouldn't have more than one member from a particular family.
- This allows the inclusion of many families.
- It should also have either only men or only women because it is found that the mixed groups are not successful.
- It is also found that the women SHGs are more successful because the members are better at savings and that they are making use of the loans more efficiently than men.
- The members of the SHGs must have similar problems and backgrounds for it to be successful.

SHG Meetings:

- Ideally, the meetings should be held weekly or monthly so that the members become closer to each other.
- All members must attend the meetings for it to become successful.
- Membership register, minutes register, savings and loan register, etc., must be kept up to date so that it is easy to know about the SHGs and that there is transparency within the group.

Functions of the SHG

- ***Initiate and maintain savings within the group:*** All members must regularly save at least a small amount. These savings allow them to get future credits for their group.
- ***Lending loans to the members:*** The savings made by the SHG must be used to provide loans to members of the group. Everything related to the loan must be decided within the group.
- ***Solving common problems:*** SHGs mostly consist of individuals who face similar problems. The grouping should essentially help the individual overcome these problems through discussions and interactions within the group and overcoming the problems and finding a common and united solution to the problems.
- ***Bank Loans:*** SHGs must work on getting a collective guarantee system so that they can avail loans from official sources.

Advantages of the SHG

The advantages of SHGs are as follows:

- ***Combating social evils****:* The SHGs play a crucial role in overcoming social evils like alcoholism, drug addiction, gambling, etc.
- ***Women empowerment***: Women SHGs make its members independent from social constraints and allow them to make independent decisions. They can even actively participate in the gram sabha.

- ***Active participation in democracy***: SHGs can actively participate in the aspects of local governance. This would mean the inclusion of weaker and marginalized sections of the society in the local governance.
- ***Increase employment opportunities in rural India***: It allows for micro-level entrepreneurship within the rural society and reduces too much dependence on agriculture.
- ***Easier access to government schemes***: The government schemes are mostly meant for the marginalized sections of the society. The inclusion and identification of these people are highly difficult. If they are grouped together, it is easier for the government to identify those who are in need of assistance quickly and efficiently. It also prevents the exploitation and corruption of the government at the ground level.
- ***Improves the standard of living***: The collective team effort by the SHGs for financial inclusion allows for the improvement in the living standard, family planning, healthcare, of the vulnerable sections of the society.
- ***Financial discipline***: The members of the SHGs are encouraged to open savings accounts in banks. This assures improved living conditions, increased spending on education, health, etc.

Limitations of SHGs

- ***Too much dependence on government and NGOs***: Many SHGs are dependent on the promoter agencies for their survival. In case these agencies withdraw their support, the SHGs are vulnerable to downfall.
- ***Lacks qualified facilitator***: The facilitators do not have professional training with regards to organizing SHGs.
- ***Lacks up-gradation of skills***: Most SHGs are not making use of new technological innovations and skills. This is because there is limited awareness with regards to new technologies and they do not have the necessary skills to make use of the same. Furthermore, there is a lack of effective mechanisms that promote skill developments in rural areas.
- ***SHGs are run by non-professionals***: There is no professionalism within the SHGs. This does not promote the expansion and improvement of the SHGs. This does not allow for the increase of wages of the members and improvement in their living conditions. This also leads to error in accounting and mismanagement of the funds.

- ***Lacks security***: SHGs are mostly not registered. They are run based on the trust between the members. The savings made by the SHG members may not be safe, which brings in the mistrust between the members.

14.7 PSYCHO-SOCIAL THERAPIES

Many types of psychotherapeutic interventions are used for the victims depending upon the need and symptoms that are observed. Psychological first aid, crisis intervention, debriefing, supportive therapies, assertiveness training (especially relevant for the female victim in the community), relaxation therapy, grief or bereavement counseling, psycho education for the specific conditions, trauma focused cognitive behaviour therapy, and psychodynamic psychotherapy have been used for post-disaster mental health care (Kar & Misra, 2008). Most of these interventions can be provided to the communities in group sessions, role plays, video-conferencing through the internet (Kar & Misra, 2008; Klein et al., 2010). A few victims however would require individual therapies. Eye movement desensitization and reprocessing (EMDR) therapy have been used for PTSD following disasters (Ponniah & Hollon, 2009). During disaster work, it is possible to identify persons who would need further psychotherapeutic or medicinal treatment and a referral to mental health professionals. If there are very severe symptoms of any kind, persistent symptoms in spite of providing emotional help, multiple problems, disruptive, suicidal, homicidal or psychotic behaviour then the person should be referred for psychiatric evaluation and treatment.

Supportive Interventions Psychological First Aid: Psychological first aid encompasses identifying the psychological reactions, re-establishing contact with family, friends and relatives, taking care of physical needs and communicating with victims to instill a sense of reality. Prompt and firm support, personal attention to make the victim feel less desolate, quiet supervision, suggestion to carry out simple routine tasks, helping others who are less fortunate than themselves, simple explanations, reassurance are the cornerstones of psychological first aid (D'Netto, 1963; Kar, 2010b; Rao, 2004). The use of drugs like sedatives and tranquilizers are also advocated during this stage in the event of extreme reactions. Supervised care should continue till the reaction subsides.

Psychological supportive mechanisms used in post-disaster situations include listening, facilitating ventilation and emotional support. Providing information about available resources and tackling rumors are helpful. Discussions regarding possible psychological symptoms, providing information and assurance regarding those are essential

components. It needs to be stressed that it is normal to have distressing symptoms following extremely catastrophic disasters. Irrational guilt feeling should be assessed and dealt with. Family members and relatives are encouraged to stay together, listen and support one another. Discussions on positive coping mechanisms are immensely important (Kar, 2002; Murthy et al., 2003).

Practical support for tracing missing relatives is an important component in the immediate aftermath of disaster. Help for the bereaved may involve notification, identification, support and viewing the bodies of those who died in the disaster, information about the circumstances of death, visiting the site of death, and later the conducting of appropriate private and public services (RANZCP, 2000).

Following disasters many people are moved to temporary shelters. The secondary stressors associated with moving and staying at a strange situation should be taken care of. Sometime these temporary shelters continue for a long spell because of lack of resources to move to permanent places. A displaced status makes victims more vulnerable (Math et al., 2008a). It is essential that family members and relatives are kept together throughout the process. There has been an innovative approach to support victims during this phase. Short-stay homes housing foster families consisting of one or two widows and few children have been attempted with local counsellors initially trying to address the emotional needs (Kar, 2002; Murthy et al, 2003). The residents of these houses who either belong to same community or being relatives have helped the process. However more information is needed on its effectiveness

Cognitive Behaviour Therapy: CBT has been effective treatment for both acute and chronic PTSD with short and long term benefits following a range of disasters (Forbes et al., 2007; Garakani et al., 2004; NICE, 2005). It has been found to be equally or more effective than various other kinds of psychological interventions. CBT has been used in children and adolescents suffering from PTSD, even in preschoolers, with positive outcomes (Kar, 2009). Preventive potential of CBT for PTSD has been recognized, when instituted early, in the at risk population; however the evidences for definitive recommendations are not satisfactory (Kornor et al., 2008). CBT has been culturally validated, and has been used successfully by community therapists following brief training, in individual and group settings (Hamblen et al., 2010).

Interventions for children: Children and adolescents are particularly vulnerable to disaster trauma. Though a majority of the children are likely to be resilient, some children require

specific and specialized interventions (Kar, 2009; Vijayakumar et al., 2006a). Most of the post disaster mental health interventions for children can be provided in the community by the local disaster workers. Supportive counselling, cognitive behaviour therapy, brief trauma/grief-focused psychotherapy, play therapy are the commonly utilized methods of psychological intervention, which can be given in groups (Kar, 2009). Substance abuse, hyperactivity and conduct problems can be particularly challenging in this age group (Vijayakumar et al., 2006a).

Play therapy keeps children engaged in activities for a considerable period of time, helps in distraction, and ventilation is easily achieved regarding trauma experiences (Murthy et al., 2003). Facilitating a return to normal activity, including games, and 'back to school' help children to move on quickly. School based mental health programs, and the training of teachers in identifying and supporting children who are in need are helpful (Kar, 2009).

Growing resilience: The term resilience refers to the ability to retain competence after an adverse event (Masten & Coatsworth, 1998). Focused effort to enhance resilience in children is seen as one way to effectively prepare for, respond to and perhaps reduce the consequences of traumatic experience of disasters (Koplewiez et al., 2004). Resilience has been identified as emerging from at least three sources:

a. Internal or personality attributes

b. Family structure

c. Extra-familial support systems.

Most of the components of these sources can be strengthened to facilitate growth of resilience following disaster trauma. Similarly, building community resilience, strengthening prevention science, and improving surveillance will be critical to ameliorating the long-term health impact of future disasters (Yun et al., 2010).

PARENT TRAINING METHODS AND PROCEDURE

1) Acquiring Parenting Skills and Behaviors (e.g., increased use of effective discipline, nurturing behavior) and 2) Decreases in Children's Externalizing Behavior (e.g., aggressive behavior).

Acquiring Parenting Skills and Behaviors

- Teaching parents emotional communication skills

This component covers the using of communication skills that enhance the parent-child relationship. This includes teaching parents active listening skills, such as reflecting back what the child is saying. This component also teaches parents to help children recognize their feelings, label and identify emotions, and appropriately express and deal with emotions. Emotional communication skills may also involve teaching parents to reduce negative communication patterns, such as sarcasm and criticism, and allowing children to feel like they are part of the conversation, equal contributors to the communication process.

- Teaching parents positive parent-child interaction skills

This includes teaching parents to interact with their child in non-disciplinary situations (e.g., every day activities) and engaging in a child's selected and directed play activities. This might also include showing parents how to demonstrate enthusiasm and provide positive attention for appropriate child behavior and choices. Additionally, parents may be taught to offer appropriate recreational options and choices for their child that encourages positive play and interaction, such as activities that are creative and free flowing.

- Requiring parents to practice with their child during program sessions

Having parents practice with their own child during training sessions was consistently associated with more effective programs. This is in contrast to training programs where no practice takes place or where parents are asked to role play with another parent or the group leader.

Teaching emotional communication skills to parents that target relationship building should improve the parent-child bond and increase child compliance to parental requests. Parents who learn positive interaction skills can help to develop their child's self-esteem, providing attention and demonstrating approval for what they are doing. Requiring parents to practice with their own child during program sessions is helpful due to the complicated nature of the skills being taught. This type of practice allows the training facilitator to provide immediate reinforcement and corrective feedback to ensure parents' mastery of the skills. These results on parental practice are also consistent with the educational literature, which suggests that learning in context is more effective (Hattie et al. 1996).

Decreases in Children's Externalizing Behaviors

- Teaching parents the correct use of time out

This component covers the correct application of time out, such as using it as an alternative to physical discipline, removing all forms of attention or reinforcement, and using a designated location when possible. Parents are taught that time out reduces the need for other forms of discipline when used correctly and consistently.

- Teaching parents to respond consistently to their child

Within this aspect of the disciplinary component, parents are taught the importance of consistent responses to child behavior. Parents learn to use consistent rules across settings. For example, if there is a "no hitting" rule, that rule should be constant whether the child is at home, at school, at the playground, etc. Ideally, family members and other caregivers learn to apply the same rules and consequences when caring for the child.

- Teaching parents to interact positively with their child

  This component was also related to better parent outcomes. See previous section for a detailed description.

- Requiring parents to practice with their child during program sessions

This component was also related to better parent outcomes. See previous section for a detailed description.

Teaching parents disciplinary skills such as the correct use of time out and consistent responses is helpful not only for the current interactions with their children, but for the future as well. When parents learn to use time out correctly, they allow themselves and the child a moment to calm down. In addition to calming down, children learn what desirable and undesirable behavior is. Similarly, consistent responding eventually takes strain off of the parent because they no longer have to negotiate each infraction with the child. The rules and discipline techniques should change and be more age appropriate as the child matures. As discussed above in the section on parent outcomes, enhancing parental skills in emotional communications and positive interactions should improve parent child relationships and children's compliance with parental requests.

14.8 SOCIAL CASE WORK

Social work in its theoretical aspects is based on the knowledge of human relations with regard to the solution of psycho social problems. Social work is a professional service based on scientific methods and skills. In the field of social sciences, social work occupies a very important role. Every social problem is the outcome of many external and internal

factors. Therefore, when to deals with the individual problems, it is essential to deal with their experiences and reactions towards the problems. Besides, proper recognition of individual is also essential with regard to the solution of a problem. The main task of social worker is to develop the self-direction and self-dependence of an individual. In social case work an individual, group, situation or phenomena is recognized as unit of study and various aspects of the units are studied properly.

Meaning, Definition, Objectives and Nature of Social Case work

The social case worker is oriented towards the principle of social justice. Social justice provides everyone equal right to prowess. Social case work does not believe on the survival of the fittest. It is based on the assumption of human welfare. It provides help to every needy and disabled person. Its ultimate aim is to establish harmonious relationship between the client and the society to which he belongs.

Thus in the social case work individual client is treated as a total unit. Internal and external forces are motivated in such a manner so that they may solve the clients' problems. Social case work covers the individual aspect of assistance as such; the method adopted in it is purely psychological. Social worker has to understand the various aspects of human behavior. He must establish workable combination between the available social services and the psychological understanding. Social case work gives much emphasis on environmental reorganization and thereby attempt to bring about a change on clients attitude and behavior. Social case work does not make a person entirely free from their disabilities through social assistance. Besides, in certain favorable circumstances social case work makes prevention and treatment of pathological problems.

Definition

Social case work means Social treatment of a maladjusted individual involving an attempt to understand the clients' personality, behavior and social relationships and to assist him in working out a better social and personal adjustment. Taft (1920).Social case work is a process concerned with the understanding of individuals as whole personalities and with the adjustment of these individuals to socially healthy lives.

The objectives of social work are :

- To understand and solve the internal problems of the individuals
- To strengthen the clients' ego power

- Remediation of problems in social functioning
- Prevention of problems in social functioning
- Development of resources to enhance social functioning

Components of Social Case work

The person is a man, woman, or child, anyone who finds himself, or is found to be in need of help in some respect of their social emotional living, whether the need be for tangible provisions or counsel. As begins to receive such help, they are called a "client". The problem arises from some obstacle or accumulation of frustrations or maladjustments, and sometimes all of these together which threatens or has already attacked the adequacy of the person's living situation or the effectiveness of their efforts to deal with it. The place is a social service agency or a social service department of another kind of human welfare agency. Its purpose is to help individuals with the particular social handicaps which hamper good personal or family living and with the problems created by faulty person-to person, person-to-group, or person-to-situation relationships. The process named, "social work" to denote its center of attention and its individual aspect; is a progressive transaction between the professional helper (case worker) and the client. It consists of a series of problem-solving operations carried on within a meaningful relationship.

The person: The client of a social agency is like all the other persons we have ever known, but they are different too. No one of us can ever know the whole of another person. They operate as a physical, psychological and social entity. They are a product-in-process of their constitutional make up, their physical and social environment, their past experience, their present perception and reactions, and even their future aspirations. It is that they bring to every life-situation they encounters. The essence of social case work help is that it aims to facilitate the individual's social adaption, to restore, reshape, or reinforce the clients' functioning as a social being. To do this is to affect a person's behavior. The person's behavior has their purpose and meaning to gain satisfactions, to avoid or dissolve frustrations and to maintain the clients' balance-in-movement. Human beings strives by their behavior to achieve that internal sense of comfort or satisfaction which makes them feel in tune with their world, balanced, and open to new experiences.

The problem: The problem within the purview of social case work are those which vitally affect or are affected by a person's social functioning, e.g. some unmeant need of economic, medical, educational and recreational nature. In the process of development human being develops certain attitude, beliefs, ideas and ways of reacting and expressing in different

situations. The problem is a situation, event or anything which impairs the normal functioning of the individual and makes them handicapped. Problems arise from some needs or accumulation of frustration or maladjustment, and sometimes all of these together. Paul B. Horton says that a problem is a situation which exists anywhere, any time and effects any person. When these hurdles are there, the individuals become conscious of it and try to find out a solution. Sometimes the problems is solved by one's own efforts but sometime they need external help. That external help is given by social worker at individual, group and community level.

The problem can be differentiated into two parts;

Intrapersonal: The meaning of intrapersonal is in mind or relating to internal aspects of a person, especially the emotions. It is the problem which does not affect other people but the concerned person himself alone. For example, if she is depressed and this depression is disturbing her, she is having an intra-personal problem.

Interpersonal

The meaning of interpersonal is between persons or something concerned or involving the relationship between people. Interpersonal is that problem which affects more than one person. It affects others as well. For example, if a person is addicted to drugs, it not only affects him but other people around him as well. Crime, theft, burglary, delinquency are few examples of interpersonal problems. Jealousy is an intrapersonal problem but it is responded it becomes interpersonal problems.

Types of problem

Physiological problem :This problem is related to physique of the person. All the physical disabilities of the body are this type of problems. Blindness, hearing impairment, speech impairment, organically handicapped, both internal and external are such kinds of problem.

Economic Problem: All individual on this earth is facing economic problem. Economically the society is divided into three class. Lower, Middle and upper. But we divide as "Haves and Have not". 'Have' means those people who have chances for development or getting to be developed. 'Have not' means those people who are deprived from having the chances to develop themselves. Economic problem related to the management of needs and resources a person have. If a person has managed their needs to the resources then they will be facing no economic problem.

Psychological Problem*:* Psychological problem occurs when a person is disturbed by some external circumstances. Anxiety, Schizophrenia, depression, anger is some of the examples of psychological problem.

Relationship problem: Human being is a bio psycho social entity. Man lives in the society. They are engaged in different interpersonal relationship like family, neighbors, colleagues etc. sometimes there comes some problem in maintaining these relations. Divorce, family disturbances are the outcomes of all these problems. When a person is unable to solve this problem by their own they comes to the social worker in an agency and get helped by the professionals.

The place: The place to which the person comes for help with their problems is known as a social agency. When it gives social work help it is known as a social work agency. The social agency is an organization fashioned to express the will of a society or of a group in the society as to social welfare. Each social agency develops a program by which to meet the particular areas of need with which it sets to put to deal with the person's problems. The social agency has a structure by which it organizes and delegates its responsibilities and tasks, and governing policies and procedures by which it stabilizes and systematizes its operations. Every staff members in the agency speaks and act for some part of the agency's function, and the case worker represents the agency in its individualized problem solving help. There are three kinds of agencies

- Governmental agency
- Nongovernmental agency
- Semi-governmental agency

Social Case Work Treatment Process

Social case work treatment process begins with the initial contact with the client. The process of treatment passes through many phases, i.e,

I. Initial Phase: The main task of social case worker in the initial phase is to examine how the problem was brought to their attention. The case workers would attempt to focus on various aspects of the problem that seem fit to case work treatment. The initial phase of social case work treatment will be though to be completed when the case worker meets the following conditions.

1. The issues have been sufficiently identified so as to substantiate that they are appropriate to the purposes and goals of the service.

2. The participants understand the nature and meaning of the problem enough with explicitness to permit engagement and participation.

3. The problem is appropriate to program, resources and serviced of the setting.

4. The problem fits the practitioner's skill and capabilities

II. Motivation: One of the most important tasks of social case worker at the beginning of the treatment process is to build and develop the therapeutic relationship between himself and the client. Workers empathy, warmth and genuine feelings are highly motivating force for the client to take part in the treatment process. At this phase the case worker explores clients' perception of why they are involved in the treatment and how they feel about being in the agency. The social case worker also encourages the client to specify their expectations of treatment and feelings about seeking help. They attempt to clarify the roles and responsibilities of both them self and the client

III. Primary Contract: The objective of this phase is to develop a preliminary contact with the client. By making psychological contract or relationships the case worker sets the stage to move towards more formal assessment

IV. Diagnosis and Assessment: Diagnosis and Assessment process are ongoing throughout the entire treatment. Social case worker provides detail information about the problem situation that will help in establishing the treatment goal, strategy of treatment. The case worker assesses the client's ego strength, 'skillfulness, capabilities and capacities in relation to the clients; problem. He assess whether the client needs advise, counseling behavior modification, crisis intervention or consultancies services like teaching, consultation, interpretation, supervision or provision of material help etc.

V. Establishing treatment goals: After diagnosis the social case worker establishes goals for the solution of the problem. Though the client has the major say in deciding on goals the case worker plays and important role by clarifying a variety of alternative goals for their consideration.

VI. Developing Treatment Plan:Treatment planning involves three major dimensions that is:

- Formulating of a strategy

- Selection of specific treatment procedures
- Developing a method for evaluating the impact of the treatment program.

VII. Preparation for Actual treatment

This phase involves several specific steps such as: Collecting all possible information, formation of action system, preparation of mediators if needed, change of significant elements in the clients' environment to increase the probability of getting desired result.

VIII. Application of Treatment Methods

The following methods of social treatment are followed in order to achieve the goals set by the case worker.

1. Administration of practical services.

2. Indirect treatment

3. Direct treatment

Administration of practical services means to help the client in such a way that he could use and select the resources available in the community. Social case worker helps the client for an adequate knowledge of available resources through the techniques of discussion, information, clarification and direction. The use of services is essential to solve any kind of problem and if the problem is of social nature than it becomes more essential for the worker to help the client in this direction. These services take the form of treatment as they satisfy their needs and give satisfaction. Money, medical care, nursery schools, scholarship, legal aid etc. are such type of services that any person may need in order to resolve a given problem in their daily living.

Indirect treatment is also called environmental manipulation which means to change the social condition of the client so that he may be relieved from excessive stress. The case worker plans with the client as to their emotional, professional and recreational activities. He gives an appropriate advice to members of their environment and modifies their attitude favorably. When social resources and systemized social conditions are used as main sources for the solution of problem it becomes social treatment. Home services, camps, group activities, training and livelihood employment are such types of programme. The purpose of such activities is always to minimize the tension of the client.

Direct treatment is given through counseling, therapeutic interviewing, clarification and interpretation to an insight. Counseling is a personal help directed towards the solution of the problem which a person find that he cannot solve it by himself and therefore seeks the help of a skilled person whose knowledge, experience and general orientation can be brought into play in an attempt to solve the problem. It is a psychological help in which information and clarification are used for making the client aware about the problem. It is always used for some particular purposes like marriage counseling, family counseling etc. Counseling is not possible without rapport and effective communication. Counseling enables the counselee to solve his future problem on his own. The counselor like the case worker work with the counselee to adjust to the situation though he never tries to change the situation of the counselee. The counselor neither undertakes home visits nor renders concrete services to the client as the social case worker does

IX. Monitoring and evaluating the effects of treatment Monitoring and Evaluation:

Monitoring provides crucial feedback to case worker and the client regarding

1. Whether the treatment program is succeeding as desired, Importance of Monitoring and Evaluation in Case Work

2. Whether established goals have been achieved,

3. Whether modifications in the program are necessary and

4. Whether the client is being helped in real sense.

Importance of Monitoring and Evaluation

- The purpose of Evaluation is to see if the efforts of the case worker are yielding any result or not, if the techniques used are serving the purpose, and if the goals are being achieved.
- Evaluation is the process of attaching a value to the social work practice. It is the method of knowing what the outcomes are.
- It is a continuous process.
- Evaluation of the approach used and result should be taken up with the client so that the efforts are meaningfully utilized.
- Evaluation will further strengthen the relationship between the caseworker and client and motivate the client to work towards his goal.

- Casework practices need to be evaluated from time to time. The subject needs to be tested and researched and most importantly needs ongoing validation. They need to be proved to the public that they are effective and beneficial to the clients.
- Casework practice should be subjected to critical review. Workers need to be held accountable for what they do and for their social work competence. Workers need to win approval for their programs.
- They may sometimes have to be told that their services are overlapping and ineffective.
- Workers have to enhance their own image and also of the agency to develop public relations. The clients need to give a feedback on the effectiveness of the services

X. Planning of follow-up termination of therapeutic relationship

Follow-up and Termination:

- At the end, i.e. termination, the worker should discuss the original as well as revised goals and objectives, achievements during the helping period, factors helpful or obstructive in achieving the objectives, and the efforts needed to maintain the level of achievement and the feelings aroused by disengagement.
- It is neither wise nor necessary for the termination to be an abrupt one.
- It is best to discuss termination and its ramifications (implications) several times before the final interview.
- The frequency and amount of contacts should be gradually decreased.
- Termination of the helping process brings up in both the case worker and client(s) many feelings – both positive and negative – which must be verbalized and discussed.
- Follow-up is done to help client maintain the improvement.
- During follow-up, the client is helped to discuss the problems he faces in maintaining the improvement.
- Work is done with the people significant for his improved social functioning.
- If required, he is referred to the proper source for needed services and help.
- The follow-up should be planned on a diminishing basis – after two weeks, then a month, then three months, six months and a year following the termination of the formal program. Social Case Work Process Intake (First Psycho-Social Psycho - Social Treatment M&E Follow-up Interview) study exploration/ diagnosis (Problem- and Termination Rapport Building Investigation) (Assessment) solving process) The

components of social casework are -The Person -The Problem -The Place -The Process -The worker - client relationship -The Problem solving work.

14.9 SUMMARY

In the present unit, we have discussed about psychoeducation and its goals; how Bibliotherapies can be used to treat and help clients. The various aspects of disaster management and how therapists can play a role in assisting individuals affected by disasters. The main elements of Self-help groups, their functioning and their respective advantages and limitations of their effectiveness. Many forms of psychosocial therapies were briefly explained to help in understanding their basis of working and the role of social case workers were highlighted to help understand the objectives, nature and the treatment process of social case work.

14.10 KEY WORDS

Psychoeducation: The term psychoeducation comprises systemic, didactic-psychotherapeutic interventions, which are adequate for informing patients and their relatives about the illness and its treatment, facilitating both an understanding and personally responsible handling of the illness and supporting those afflicted in coping with the disorder.

Bibliotherapy: Bibliotherapy is a creative arts therapies modality that involves storytelling or the reading of specific texts with the purpose of healing. It uses an individual's relationship to the content of books and poetry and other written words as therapy. Bibliotherapy is often combined with writing therapy.

Disaster management: It is the organization and management of resources and responsibilities for dealing with all humanitarian aspects of emergencies, in particular preparedness, response and recovery in order to lessen the impact of disasters.

Self-help groups: Self-help groups are informal groups that people come together to overcome their common problems and improve their standard of living.

Social case work: Social casework is the method employed by social workers to help individuals find solutions to problems of social adjustment that are difficult for individuals to navigate on their own.

14.11 CHECK YOUR PROGRESS

1. What is psycho-education? Give a detailed note on bibliotherapy.
2. What is disaster management? Add a note on handling special cases and situations

3. Describe the nature and functioning of self-help groups
4. Explain various parent training methods and procedure
5. What is social case work? Delineate the process of social case work.

14.12 ANSWERS TO CHECK YOUR PROGRESS

1. 14.1 & 14.2 2. 14.3 & 14.4 3. 14.5 4. 14.6 5.14.7

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UNIT - 15 : FAMILY THERAPIES

STRUCTURE:

15.1 OBJECTIVES

After reading this unit, you should be able to:

- Understand concept, nature and meaning of family therapies
- Understand the interlocking concepts of Bowen to explain family development
- Understand various viewpoints regarding family systems approach
- Master goals and applications of network therapy
- Understand nature, types and applications if marital therapy
- Undersatnd Goals, Indications & Contra Indications of conjoint therapy

15.2 INTRODUCTION

Family therapy can be defined as "a psychotherapeutic endeavor that explicitly focuses on altering the interactions between or among family members and seeks to improve the functioning of the family as a unit" (Gurman, Kniskern & Pinsof, 1986). It is based on systemic theory which emphasizes the importance of the interactions between members rather than the personalities of each individual. The issues are present in the interaction between members rather than in the individuals themselves. It is only in the area of violence and abuse that responsibility for the violence is placed firmly on the perpetrator of the violence. Explanations of being 'provoked' into violence are not preferred to family therapists and counselors.

A family counseling session typically includes the husband and wife and the children. In homes where more family members live together (such as grandparents) can also be included. The counselor can decide which members of the family to be included based on the initial assessment session. Sessions can last for 45 minutes to 90 minutes and can be held once or twice a week based on how much intervention the case requires.

Descriptions of family problems and their impact have already been discussed in earlier units and the current unit will focus on issues and process in the management of family problems. This unit will begin with a description of the indicators and contra indicators for family counseling.

Family counseling is required

- When a child or adolescent is the referred person,

- When family members define problems as a family issue, such as relationship or communication difficulties,
- When relationship difficulties threaten the future of couple relationship or the adequate care of children,
- When the family has experienced recent stress such as death, serious injury or injury
- When psychological symptoms have secondary gain effects
- When family members become organized into 'helping' with the problem in such a way that the attempted solutions become problematic themselves.

Family therapy is not require:

- By practical limitations, such as the un-availability of key members or an experienced counselor
- When motivation of the families to participate together in therapies is low,
- When the family presents 'too late' for meaningful change to be made,
- When individual members of the family are in too delicate an emotional state to cope with family discussions.

15.3 BOWEN'S MODEL

Family Therapy is an approach to counseling which looks at the problem a client is having as a symptom of dysfunction in the entire family. Family therapy believes that an individual is best understood within the context of his/her family relationships. It does not assign blame on either the individual or the family but attempts to change the faulty pattern in which the family members have been interacting.

Family counselors look at the entire family as a system. A system is one in which the whole is more than the sum of its parts. Family therapy says that a family is a living system and change in one member causes changes in all the other parts of the family system. Family therapy has many different approaches and Bowenian Family Therapy is one of the most popular.

Bowen Family Systems Therapy was proposed by Murray Bowen, a psychiatrist working at the Menninger Clinic in the last 1940s. The basic tenet of this theory is that all human relationships are driven by two counterbalancing forces, individuality and togetherness, i.e, our contrasting needs for companionship and independence. These opposing forces often lead us through patterns of closeness and distancing from the people in our lives.

The degree of success with which we reconcile these two forces depends on the 'differentiation of self'. Bowen explains differentiation of self as 'the capacity to think and reflect and not be reactive to internal or external emotional pressures.'

Bowen's theory focuses on helping the clients get insight about their problems than on taking action to solve these problems in contrast to other family theories. Bowen stresses that our family of origin (the family we were born to) has a big influence on our ability to differentiate. Through his work with schizophrenics, Bowen discovered that there is a sensitive emotional bond between mother and child which causes them to react emotionally to one another. This bond or tie often influences the entire family. Such families hold on so strongly to all their members that many of them do not get any personal freedom. This reactiveness also led to a repetitive pattern of cycles of closeness and distance dependent on the shifts in emotional tension between the mother and child.

Bowen introduced eight interlocking concepts to explain family development and functioning, each of which is described below.

1. Differentiation of Self: The first concept is Differentiation of Self, or the ability to separate feelings and thoughts. Undifferentiated people cannot separate feelings and thoughts and often have difficulty separating their own from other's feelings. They look to their family to define how they think about issues, feel about people, and interpret their experiences. Differentiation is the process of freeing yourself from your family's emotional processes to define yourself. This means being able to have different opinions and values than your family members, but being able to stay emotionally connected to them, being able to calmly reflect on a conflicted interaction afterward, realizing your own role in it, and then choosing a different response for the future. For example, Swapna might repeatedly fight with her mother, Kanchana, saying her mother is too critical of her while Kanchana says her daughter is too touchy. Swapna gets upset and the cycle repeats. She has not achieved differentiation.

2. Triangles: Two people in a relationship might vacillate between closeness and distance. When distressed or feeling intense emotions, they will seek a third person to triangulate or ease the tension between them. For example: Shilpa and Arunare a married couple who are constantly fighting. Arun calls his mother or best friend to talk about the fight. His mother might either help them reduce their anxiety and take action, or calm their strong emotions and reflect, or sometimes make the conflict permanent by becoming the third wheel in their

relationship. People who are more undifferentiated are likely to triangulate others and be triangulated.

3. The Nuclear Family Emotional Processes: These are the emotional patterns in a family that continue over the generations. In families, the parent can pass on an emotional view of the world (the emotional process), which is taught in each generation, from parent to child. Reactions to this process can range from open conflict, to physical or emotional problems in one family member, to reactive distancing. Problems with family members may include things like substance abuse, irresponsibility, depression etc. For example: Shridhar's parents see their environment as hostile and always trying to make them suffer and Shridhar looks at the world the same way.

4. The Family Projection Process*:* This is an extension of The Nuclear Family Emotional Process in many ways. The family member who "has" the "problem" is triangulated and serves to stabilize an unstable relationship between two people in the family. For example: Bharath rejects his mother's pessimistic views and finds that his mother and sister have become closer, as they agree that he is immature and irresponsible. The more they share this view with him, the more it makes him feel excluded and shapes how he sees himself. He may act in accord with this view and behave more and more irresponsibly. He may reject it, constantly trying to "prove" himself to be mature and responsible, but failing to gain his family's approval because they do not attribute his successes to his own abilities.

The family member who serves as the "screen" upon which the family "projects" this story will have great trouble differentiating. It will be hard for Bharath or his sister to hold their own opinions and values, maintain their emotional strength, and make their own choices freely despite the family's view of them.

5. The Multigenerational Transmission Process: This process entails the way family emotional processes are transferred and maintained over the generations. This captures how the whole family joins in The Family Projection Process, for example, by reinforcing the beliefs of the family. As the family continues this pattern over generations, they also refer back to previous generations Ex: "He's just like his Uncle Bhushan – he was always irresponsible too."

6. Sibling Position: Bowen stressed sibling order, believing that each child had a place in the family hierarchy, and thus was more or less likely to fit some projections. The oldest sibling was more likely to be seen as overly responsible and mature and trying to dominate the

younger sibling and the youngest as overly irresponsible and immature or more open to experiences as he/she has had to find a place for himself/herself in the family after they were born.

7. Emotional Cutoff: This refers to an extreme response to The Family Projection Process. This entails a complete or almost-complete separation from the family. The person will have little, if any, contact, and may look and feel completely independent from the family. However, people who cut off their family are more likely to repeat the emotional and behavioral patterns they were taught. In some cases, they have the same values and coping patterns in their adult family that they were taught in their childhood family without realizing it. They do not have another internal model for how families live, and so it is very hard to "do something different." In other cases, they consciously attempt to be very different as parents and partners; however, they fail to realize the adaptive, healthy characteristics of their family and role models, as well as the compensatory roles played in a complex family. Because of this, Bowen believed that people tend to seek out partners who are at about the same level of differentiation. Ex: Ramya says 'I am so glad I moved to the US and stopped keeping in touch with my parents. Now, they can never make me unhappy again'. Ramya is cut off from her family emotionally and physically but not differentiated.

8. Societal Emotional Processes: These processes are social expectations about racial and class groups, the behaviors for each gender, the nature of sexual orientation… and their effect on the family. Families that deal with prejudice, discrimination, and persecution must pass on to their children the ways they learned to survive these factors. The coping practices of the parents and extended family may lead to more or less adaptive emotional health for the family and its members.

Bowen believed that optimal family development occurs when family members are differentiated, feel little anxiety regarding the family, and maintain a rewarding and healthy emotional contact with each other.

15.4 FAMILY SYSTEMS APPROACH

Over the past three decades, family systems approaches to practice have become essential to the understanding and treatment of individual and relational disorders. These approaches are guided by a developmental, multi-systemic conceptual orientation to human problems and processes of change, attending to the family and social context of functioning

and well-being. Current research evidence supports involving families in assessment and treatment (Heru 2006).

We will begin with a description of basic principles of a systemic orientation to practice and a framework for assessment of family functioning. We offer a brief outline of foundational models and more recent advances in family therapy theory and practice. Next, we describe the utility of an array of systems approaches, including family or couple assessment, consultation, brief interventions, multisystem approaches, multifamily groups, and more intensive therapy. We then consider how to combine family systems with other therapeutic modalities and how to use systemic thinking more generally in a variety of psychiatric treatment settings and specific psychiatric diagnoses.

Family Systems Orientation: A family systems orientation is distinguished by its view of the family as a transactional system. Stressful events and problems of an individual member affect the whole family as a functional unit, with ripple effects for all members and their relationships. In turn, the family responses how the family handles problems contributes significantly to positive adaptation or to individual and relational dysfunction. Thus, individual problems are assessed and treated in the context of the family system. Relational problems are addressed directly in couple and family sessions with those involved.

Biopsychosocial Orientation: The practice of family therapy is grounded in a biopsychosocial orientation, recognizing the complex interplay of individual, family, and social processes (Engel 1980; von Bertalanffy 1969). The family is viewed as an open system that functions in relation to its broader sociocultural context and evolves over the life cycle (Minuchin 1974). Family systems theory advanced conceptualization of human functioning and dysfunction from a linear, dyadic, deterministic view of causality in traditional psychoanalytic theory to the recognition of multiple, recursive influences within and beyond the family that shape both individual and family functioning over the life course. This approach considers the family's interface with larger systems, such as school, the workplace, and health care systems. It attends to cultural and socioeconomic influences, including the impact of racism and other forms of discrimination for poor minority families and other marginalized groups (Boyd-Franklin 2003;McGoldrick and Hardy 2008). From an ecological perspective, individual dysfunction cannot be adequately understood and treated apart from its psychosocial context. Regardless of the origin of problems, or genetic predisposition, the family is regarded as an essential partner in treatment, with the potential for fostering optimal adaptation.

Multigenerational Family Life Cycle Perspective: In a systemic model of human development, individual and family developments are seen to coevolve over the life course and across the generations (Carter and Mc Goldrick 1999). Relationships grow and change, boundaries shift, roles are redefined and new members and losses require adaptation. Each developmental phase presents salient challenges; distress often occurs around major transitions such as the birth of the first child, entry into adolescence, launching young adults, or needs for elder care. All families must cope with stressful events, including both the predictable, normative stresses, as with child-rearing, and unexpected, disruptive circumstances, such as raising a child with disabilities (Walsh, in press). Divorce, single parenting, and stepfamily integration pose additional challenges for many families (Hetherington and Kelly 2002). Over an expanded life course, family members may transition in and out of single status, couple bonds, and varied family configurations, adding complexity to all relationships.

The increasing diversity of family forms, lifestyle options, and timing of nodal events makes it imperative that no single model or life trajectory be deemed as essential for healthy child development (Walsh 2003b).

Systemic Lens: Patterns That Connect: Family therapy is not simply a therapeutic modality in which all members are treated conjointly. In fact, individuals may be seen separately or brought together for some sessions in different combinations. A family systems approach is distinguished less by who is in the room and more by the clinician's attention to relationship systems in assessment and treatment planning. We consider how family members may contribute to—and are affected by—problem situations. Most importantly, regardless of the source of problems, we involve key family members who can contribute to needed changes. Therapy may focus on strengthening a couple's relationship; it might combine individual sessions with an adolescent and sessions with the whole family or with parents, siblings, or extended kin. Interventions are aimed at modifying dysfunctional patterns, tapping family resources, and strengthening both individual and family functioning.

Mutual Influences: Family members are interrelated such that each individual affects all others and the group as a whole in turn affects the first member in a circular chain of influence. Even for psychiatric conditions, such as depression, that are largely biologically based, it is important to understand how depression affects family interaction, how those transactions contribute to or reinforce symptoms, and how interactional changes can improve individual—and family—functioning and well-being. A circular tracking process is a key

element in a systems-oriented assessment, providing an interactive view of the biological and relational influences to guide interventions.

In a chain of influence, every action is also a reaction: a mother's overly harsh response to a child's tantrum may exacerbate the child's out-of-control behavior. In tracking the sequence of interactions around a presenting problem, we often find repetitive patterns involving other family members. For example, if the father then criticizes the mother and sides with the child, it is likely to make matters worse. Regardless of how a sequence began, parents can be helped to pull together as a team to handle challenges more effectively. Skilled intervention involves interrupting vicious cycles to promote "virtuous cycles" and problem resolution.

Although processes may be circular, not all participants have equal power or influence. Clinicians are cautioned not to take a neutral stance or a "no fault" position in cases in which an abusive spouse or parent must be held accountable for any harmful behavior. Moreover, therapist neutrality tends to support the status quo and can perpetuate destructive patterns.

Clinicians should not reflexively type a family by the diagnosis of a member, such as an "alcoholic family." Such labels carry faulty attributions of blame. Individual disturbance may have social influences or a strong genetic predisposition. Family distress should not be presumed to have played a causal role in individual symptoms; it may result from unsuccessful attempts to cope with an overwhelming situation that has a significant genetic or other biological etiological component. For instance, marital conflict between parents of an adolescent with bipolar disorder may have been fueled by repeated unsuccessful attempts to deal with their child's emotional outbursts. With multiple influences, the impact of external stressors and socioeconomic conditions should be taken into account. For instance, a child's plummeting school grades must be seen in the context of his father's recent job loss and related family tensions. Sensitive family therapy intervention acknowledges family stress and frustrations and helps members find more effective ways to approach challenges and prevent problem behavior.

Brief Family Therapy: Brief family or couples therapy has been particularly useful when the chief complaint is a focal problem. Sometimes the complaint involves a problematic behavior, conflict, situation, life transition, or major life challenge, such as a serious chronic illness. A preventive, early intervention consultation-oriented approach with a family can

avert a major crisis or spiraling of distress. Problematic behaviors can be helped by attention to the web of surrounding interactions. In the case of a child's sudden drop in school performance, intervention with the parents around their escalating conflict and threat of divorce would be imperative. Frequently, with focal problems, the therapist and family contract for a certain number of sessions, in which the goals are clearly delineated and progress can be objectively monitored. This approach is similar to individual brief treatment models. Depending on the kind of problem, structural, systemic/strategic, behavioral, and intergenerational models of family therapy are all well suited to brief, focal treatment. At completion of the contract, the therapist and family can renegotiate a new contract or in complicated cases shift to more intensive long-term therapy. Some families learn to use family consultations and treatment in a periodic, time- and cost-effective way when family strains emerge over the life course. This approach is particularly useful for families coping with recurrence or exacerbation of psychiatric or physical disorders, who simply want to go on with their lives during periods of remission.

Intensive Family Therapy: More intensive family therapy may be needed in cases of multiple and chronic or entrenched difficulties. There is a myth that working with family members together is inherently more superficial than in one-to-one treatment. In fact, the experience is quite powerful, and lasting change can occur more rapidly than in individual therapy. First, in focusing only on the individual in pain, one is frequently trying to treat symptoms of a relationship problem involving others. In attending to the system, the therapist can anticipate reactivity to change and has more power to alter symptom-maintaining patterns. Second, intrapsychic issues are also interpersonal; the systems therapist working at the interactional level finds that behavioral change in the system is easier to bring about and facilitates intrapersonal change, regardless of the origin or chronicity of the problem. Third, direct intervention and change with significant family members, whether planned to occur in sessions or between sessions, has potential therapeutic benefit for all members, not only the current symptom-bearer.

Therapy may selectively focus on specific problems and those members most critically involved for problem solving. Different members may be brought in at different phases of intervention. Situations when involvement of additional members is indicated include 1) when they are part of the problem-maintaining system and 2) when they can be helpful in attaining treatment goals.

A family presenting with a child- or adolescent-focused problem is generally treated conjointly, including parents, siblings, and any other significant members of the household or extended family. In these situations, any marital problems identified during the assessment are best approached by strengthening the coparental alliance around solution of the presenting problem in the child's or adolescent's behavior or functioning. After the presenting child-focused issues are improved, the couple has established a working therapeutic alliance with the clinician, and there is a greater likelihood they will be willing to face their marital difficulties. With child or adolescent-focused issues, it is often preferable to have a single therapist meet individually with the identified patient and conjointly with the family.

Family therapy is useful for a range of other clinical situations. Separation, divorce, and remarriage involve myriad issues for a family that are often best addressed by conjoint sessions. Other clinical situations include chronic psychiatric and medical conditions, major stressful life events such as loss through death and work difficulties, and situations involving substance, sexual, or physical abuse. Problems identified as strongly connected to unresolved issues from the family of origin and in which key family members can participate are typically best treated conjointly.

Evidence-Based Multisystemic Intervention Models: The development of several evidence-based, multisystemic, multidimensional intervention models offers highly effective approaches with high-risk and seriously troubled youth through involvement of families and larger community systems (Henggeler et al. 1998, 2002; Liddle et al. 2002; Sexton and Alexander 2003; Szapocznik and Williams 2000). These family-centered approaches with adolescent conduct disorders and drug abuse also yield improvements in family functioning, including increased cohesion, communication, and parenting practices, which are significantly linked to more positive youth behavioral outcomes than in standard youth services. Multi-systemic interventions may take a variety of forms and involve school counselors, teachers, coaches, and peer groups; these individuals may work with police officials, probation officers, and judges to address adolescent and family legal issues. They might help a youth and family access vocational services, youth development organizations, social support networks, and religious group resources.

With families that are often seen as unready, unwilling, or unmotivated for therapy, these approaches engage family members in a strengths-oriented, collaborative alliance. They develop a shared atmosphere of hope, expectation for change, a sense of responsibility (active agency), and empowerment (Sexton and Alexander 2003). Rather than troubled youths and

their families being viewed as "resistant" to change, attempts are made to identify and overcome barriers to success in the therapeutic, family, and social contexts. Therapeutic contacts emphasize the positive and draw out systemic strengths and competencies for change. Clinicians maintain and clearly communicate an optimistic perspective throughout the assessment and intervention processes.

15.5 STRUCTURAL APPROACH

Structural family therapy is a body of theory and techniques that approaches individuals in their social and relational contexts. It was developed in the context of therapeutic work with families and young people. It is predicated on family systems theory, and brings with it many of the strengths and weaknesses associated with the appropriation of general system theory (von Bertalanffy, 1968) into the realm of social behavior. The central creative thesis of structural family therapy is embodied within the paradigm shift of the relational therapies, that distress can be understood not only in the context of the relationships within which it arises and is maintained, but also in seeing the potential for relationships to be the cause of distress.

The excitement and challenge of structural family therapy is in the focus on family members' interaction and in the broad definition of communication to be more than what we say and the way in which we say it.

Structural family therapy is an approach mainly identified with the work and writing of Salvador Minuchin, although many other influential thinkers have worked in association with the development of the ideas, such as Jay Haley, Braulio Montalvo, Lynn Hoffman, Marianne Walters, Charles Fishman and George Simon. Many of the concepts are familiar, such as family rules, roles, coalitions, triangulation of conflict, subsystems and boundaries, organization, feedback, stability and change. However, the thinking and practice of a structural family therapist will likely be characterized by formulation of family members' difficulties in terms of family structure and dynamic organization and a preference for working in the here and now. In the UK, few working family therapists adhere rigidly to one school of thought; rather an integrated pragmatic approach to conceptualization and practice is more likely, with a consideration of the fit between family members' style and preferences, therapist style and the nature of the difficulties driving the dominance of one family therapy model over another.

Model of change: The term structure refers to the organizational characteristics of the family at any point in time, the family subsystems, and the overt and covert rules that are said to influence interpersonal choices and behaviors in the family. Thus an aim of this therapy is to alter the organizational patterns, particularly where the modes of communication are thought to be unhelpful and where behaviors are considered to be abusive and neglectful or to have the potential to be so. When the structure of the relational group changes, the positions of members in the group changes. Thus it is said; each individual's experience changes and therein lies the potential to alleviate symptomatic distress. Structural family therapy works with the processes of feedback between circumstances and the people involved, tracking how changes made to our circumstances feedback into choices and decisions about further change.

This is a competence model, encouraging people to explore the edges of their known repertoires of responding; assuming that family members have the ability to innovate and draw on less tapped interpersonal and intrapersonal resources. Enactment as a structural family therapy technique is seen as central to this model of change (Simon, 1995) i.e., encouraging family members to problem solve and generate alternative responses to each other in the relative safety of the therapeutic relationship. Thus intervention is promoted at three levels: challenging symptomatic behavior, challenging the family structure, and challenging family belief systems. The therapy is based on the tenet of action preceding understanding, and vice versa, with the use of cognitive techniques such as reframing. Family members are encouraged to think beyond symptomatic behaviors and current complaints and see their behavior and choices in the context of family structures and process and in the relationships between the family group and other societal systems. The structural family therapy model of change does not exclude other models of change and structural therapists can work alongside other therapeutic approaches to change as part of a co-ordinated package of care.

Principal features of structural family theory: The theory is based on the clinical experience of Minuchin and his associates with families in distress. The development of the theory can be traced through their major publications: Families of the slums (1967), which focused on issues of parental authority and leadership in Black American women who headed lone parent families where children were in trouble with the law; Families and family therapy (1974), which outlined the key constructs, such as enmeshment and disengagement; Psychosomatic families (1978), where conflict, its avoidance and resolution, and styles of parent-child interaction are described; Family therapy techniques (1981), which detailed the

different techniques of structural family therapy; Family kaleidoscope (1984), which brought family systems thinking to a general readership; and Mastering family therapy (1996), which provided a revision of some of the earlier principles and methods of the approach.

The key features of the approach can be summarized thus:

- The family is seen as a psychosocial system, embedded within wider social systems, which functions through transactional patterns: these transactions establish patterns of how, when and to whom to relate, and they underpin the system;
- The family tasks are carried out within bounded subsystems;
- Such subsystems are made up of individuals on a temporary or more permanent basis, and members can be part of one or more subsystems, within which their roles will differ;
- Subsystems are organized hierarchically in a way that regulates power within and between subsystems;
- Cohesiveness and adaptability are key characteristics of the family group, within which the balance between emotional connectedness and developing autonomy is seen to change as family members mature and live through life cycle transitions.

Minuchin writes about family structure metaphorically, as a device for describing family interaction in the here and now. His writing is less concerned with how family members evolve their interactional style and negotiates their interpersonal tasks and expectations. The boundaries of a subsystem are said to be the rules defining who participates and how. The function of boundaries is to protect the differentiation of the subsystem. Every family subsystem is said to have specific tasks and make specific demands on its members; and the development of interpersonal skills achieved in these subsystems is predicated on the subsystem's freedom from interference by other subsystems, as might be seen with a diffuse subsystem boundary. According to this approach, proper functioning within subsystems implies clear boundaries. Clarity is seen as more important than composition, for example, the responsibility for proper supervision and care of the children needs to be identified with persons able to sustain and discharge such responsibilities. Family subsystems might include: parental, couple, parent-child, grandparent, male, female, organized by history, power, hobbies, and interests and so on. Relationships between and within subsystems can be described as affiliations, coalitions, with patterns of conflict resolution, detouring, enmeshment and disengagement.

The notion of a couple subsystems straddles different modes of family household composition and recognizes the needs of adults for affection, confiding relationships, shared decision making and is seen as the primary mediator between the household group and the outside world. The parental or executive subsystem is vested with the authority for the care and safety of the children and fulfills major socialization requirements within the family. If more than one person is responsible for caring for the children, this approach stresses the importance of teamwork and the ability to negotiate conflicting interests.

Adaptability is seen as necessary because of developmental changes in the children and pressures of age related expectations from societal institutions. The parent-child subsystem is the context for affectional bonding, gender identification and modeling, and where children learn to develop a degree of autonomy within unequal power relationships. The sibling subsystem was highlighted as an important social group early in the writings of Minuchin and colleagues, long before it attracted the interest of current researchers (see Brody, 1996). This is seen as the social context within which children learn to co-operate, compete, resolve conflict, cope with jealousy, and prepare for peer related activities and friendships as they mature.

The structural approach assumes families and family members are subject to inner pressures coming from developmental changes in its own members and subsystems, and to outer pressures coming from demands to accommodate to the significant social institutions that have an impact on family members. Inherent in this process of change and continuity are the stresses of accommodating to new situations. The strength of the family system depends on the abilities of family members to mobilize alternative transactional patterns when internal and/or external conditions of the family demand restructuring. A family is said to adapt to stress in a way that maintains family continuity while making restructuring possible. If family members respond to stress with rigidity, for example, by reapplying ‘old’ solutions, unhelpful transactions may ensue. Symptomatic behavior is seen as a maladaptive reaction to changing environmental and developmental requirements, and thus the presence or absence of problems does not define normality.

Thus we can see that the ‘as if’ notion of structure is helpful in providing a framework for thinking about belonging and loyalty, proximity, exclusion and abandonment, power, aggression (as reflected in subsystem formation), the relative permeability of boundaries, working alliances and coalitions. In the 1996 publication Mastering family therapy, Minuchin

and colleagues made a commitment to the original formulation of family functioning, with a shift in perspective in the following areas of therapist functioning:

- Modified intensity of therapeutic encounters;
- A more fluid commitment to a key 'alphabet of therapist skills';
- An increased use of the self of the therapist in therapy, with a greater emphasis on feedback to family members of the effects of interaction on the therapist, aimed at offering more information about their interactions with one another;
- An increased interest in supervision, aimed at developing the therapist's under-utilized skills;
- Admission of his own impatience and speed in reading non-verbal cues;
- The recognition of relative perspectives, with the structural frame as an organizer of therapists' perceptions rather than universal truths;
- The role of the therapist in activating the family members' own alternative ways of relating: 'While the therapist has ideas and biases about family norms, and about the best family fit, she can only go in the direction that the family indicates when they enact their drama and show possible alternatives' (Minuchin, Lee, & Simon, 1996).

15.6 SOCIAL NETWORK THERAPY-GOALS AND APPLICATIONS

The development of online therapies for mental health is a growing field that presents challenges both for mental health researchers and technology designers. It has proven complex to develop systems that deliver effective therapy, are non-harmful for users, and encourage on-going use. These components reinforce each other, creating a dynamic environment that promotes on going participation and engagement. We locate our work within the field of Positive Computing, aimed at advancing human wellbeing.

Drawing from previous research and from focus group interviews conducted with patients and clinicians at a youth mental health clinic, our multi-disciplinary team of psychologists, human computer interaction (HCI) experts and system designers developed a design for an online therapy and social networking website for first episode of psychosis (FEP). To inform the design we used research tools from both HCI and the social sciences to develop a rich description of the target group.

In prior work we discussed some aspects of our results for a psychiatric audience in terms of usage data and reduction in psychiatric symptoms. In this section we discuss the user experience of the therapy. We apply theories from HCI to understand how people interact

with therapy, focusing in particular on how the principles of Supportive Accountability can be implemented to encourage user engagement in online therapy. We conclude with reflections on the adequacy of our system, and discuss implications for how the high rates of attrition currently experienced in the use of online therapies can be reversed through design that takes user characteristics into account.

Background: Significant effort has been devoted to developing effective online therapies for mental illnesses.

This is motivated by a number of factors:

- Mental illnesses have a devastating effect on many people.
- Young adults in particular are susceptible to mental illness and are thereby at risk of severe disruption during a critical period of social and intellectual development.
- Young adults are enthusiastic users of Internet technologies and social networking and might more easily be reached via an online treatment.
- Mental illness carries a significant stigma, so that young people do not want to be identified as mental health clients.
- There is a need to supplement existing 'face-to-face' therapies, which are time-consuming, expensive and require leave from school or work to travel to a clinic at a stage when patients are trying to re-engage in society.

Thus solutions need to be found urgently for interventions that supplement face-to-face care during the full period of relapse risk. Prior research indicates that the Internet can be a powerful source of information and support for patients. This has the potential to significantly influence health-related behaviors and decisions as well as engagement with mental health services to provide long-term maintenance of treatment effects.

To be effective, Internet-based interventions for psychosis will need to take account of the characteristics and needs of patients. These include:

- Possible cognitive deficit. Patients with FEP may suffer impairment in speed of processing ranging up to severe and this could indicate a broader diversity of cognitive deficits. However, the severity and pattern of cognitive deficits is unclear, and varies between individuals.

- Lack of engagement. Patients with psychotic illness are often difficult to engage. Additionally, many teenagers are protective of their privacy and reluctant to open up to an adult therapist.
- Experience of stigma. Many people who would benefit from mental health services opt not to pursue them, or fail to fully participate once they have begun, in order to avoid the label of mental illness and the social harm it can bring. Stigmatised mental health consumers are more likely to avoid interaction with people outside their family and to avoid seeking help from psychiatric services. This problem is particularly severe amongst vulnerable social groups such as adolescents and the socially disadvantaged.
- Responsiveness to treatment. Patients with first-episode psychosis are more responsive to treatment compared to patients with more enduring forms of psychosis, and so it is important to develop specific interventions for this phase of the disorder.

Additionally, the needs and experiences of young technology users in general need to be considered in order to prevent the high rates of attrition that have been evident in other online therapy use.

Online Therapy and Psycho-education:

Previous attempts to offer online cognitive behavior therapy (CBT) for depression provide a number of lessons for researchers wishing to implement similar treatment for psychosis. In depression studies researchers have found that: a system should be interactive so that users can respond to CBT content through exercises; a system should allow the user to share personal information with a therapist; positive results can be achieved by combining therapy with moderation; a system is preferred by young people when they can see that there are other users, even if they are not connecting directly with them.

A substantial body of research has provided evidence that psycho-education improves medication compliance, reduces relapse rates, promotes social functioning, and increases satisfaction with mental health services. Computer-based psycho-education can be acceptable and in some cases as effective as face-to-face or paper-based methods. Online interventions which provide clear and engaging information and cater for cognitive deficits and levels of insight about their condition are also likely to produce improved outcomes.

Psycho-education delivered via the web has been found to be effective when patients spend enough time on the website to complete required modules. However a drawback of

online treatments is that many users do not persist in viewing all the available material and many sites have high dropout rates. In self-guided treatments, with no human moderation, only about 1 in 8 participants have demonstrated clear benefits.

Online Community Forums

Research into user-led services has found robust associations between peer support, empowerment and recovery in people suffering from psychosis. Online self-help forums providing peer support health networks have evolved as a strong Internet presence for both mental and physical health. These may be unstructured discussion groups or may be led by an individual, usually a non-professional, who shares the problem that the group addresses.

The online self-help groups and community forums has been useful in treating eating disorders and depression. Recent surveys have further shown that age can be a factor in participation: young people are more likely to trust mental health information websites and perceive them as helpful compared with their older counterparts.

Both outside and within the health community certain general factors can affect engagement in on-line forums: for example applications designed for use by a group may not support the level of improvisation that can characterize group activity. Poor design can also occur because intuition in development tends to be poor for multi-user systems. Certain types of user input are more likely to encourage a response from other members of an online community, such as posts that express either negative or positive emotions or which describe feelings or personal testimonials. Millen and Patterson, studying a local community forum, found that encouraging members of a community to observe the activities of the community promoted use of the forum, as did notification processes such as emails which alerted users to new posts.

Engagement can be engendered through belonging to a specific patient group. A number of organizations run online forums that provide specific support for mental health issues or simply an outlet for young people to discuss youth-centred issues which may involve mental health.

Webb et al have studied design guidelines and the role of moderators in these communities. These forums provide a safe environment for discussion; however they are not paired with online therapies and moderators are encouraged to emphasize that forums are a secondary form of support, designed to encourage users to seek help in face-to-face counselling.

Social Behaviour and Network Therapy aim and principles

The overall aim of the treatment is to mobilise and/or develop positive social network support for a change in drinking behavior. The therapist's task is to work towards this goal in collaboration with a person with a drinking problem and with those members of the problem drinker's social network who are willing to support actively his/her efforts to change. Network members can include family members, friends and work colleagues. The work can be conducted either in network sessions or working unilaterally via the person with the drinking problem. In addition, once the treatment starts the therapist can continue to work with network members even in situations when the person with the drinking problem has stopped attending.

Any specific strategy used within the treatment sessions has to be selected in order to work towards the overall aim of developing positive social network support for change. Central to the philosophy of SBNT is the notion that everyone involved in treatment becomes a client in his/her own right. In order to acknowledge this the person with the drinking problem is referred to as the focal person whereas others are referred to as network members.

A secondary aim of the approach is to explore how to minimise the influence of those parts of the social network that support the continued problematic use of alcohol. This is only undertaken once work has successfully focused on the development of positive social network support for change.

Basic principle and underlying assumptions: SBNT is a pragmatic and assertive approach based on the key principle that a critical condition for successful addiction treatment and maintenance of change is the availability of social network support for change. SBNT can be used both to pursue a goal of abstinence or moderation. Three underlying assumptions inform the treatment.

Social network support for change is relevant to everyone presenting for alcohol treatment

SBNT is concerned with the development and consolidation of a 'social network for change' using as a baseline the social network as it exists for each individual problem drinker at the time of presentation for treatment. For some problem drinkers, with a group of very supportive close relatives and friends, the work may involve inviting these people to the treatment sessions and developing plans for action. For other problem drinkers the work may involve creating the conditions for the network to function in a supportive way, where the effects of drinking over time may have strained relationships. Some problem drinkers will

have no network. For them the work may involve creating a network in such a way that what might be achieved by the end of the treatment is the involvement of one new supportive person for those individuals who were previously totally isolated. What follows from this assumption is the fact that the treatment components are equally relevant and could be applied with people with available social contacts as well as people who are isolated at the time of treatment entry.

Family members and concerned others are central to the treatment process

Given the emphasis on social network support for change, SBNT sees the involvement and contribution of family members and concerned others as central to treatment and as important as the involvement and contribution of the individual experiencing the alcohol problem. Some of the approaches already covered in the Introduction have demonstrated the key role that social networks can play in terms of engagement in treatment and support for change.

The role and influence of network members is so crucial in SBNT that therapists can continue to meet with concerned network members who continue to attend the sessions even in the absence of the focal person. This is a very important component of SBNT and it contrasts with what normally takes place in most individually based treatments. It allows therapists to continue working even when faced with a situation that other approaches would define as treatment dropout.

The work during treatment aims to create the conditions for future maintenance and support of change

The therapist needs to work with a positive part of the client's social network to provide a coherent set of coping strategies for both the person with a drinking problem and network members. These coping strategies can be used both within the treatment period and following treatment completion. In this respect, the intervention attempts to develop systems that will continue to operate beyond the therapy period. The treatment period is therefore the first step in a longer journey and attempts are made to empower the focal person and network members to continue with a process of change and mutual support. The support mechanisms that operate beyond the therapy are not necessarily different to those that may occur naturally in other cases. The treatment aims to strengthen and develop these natural processes.

The Therapists skills

Thinking network: 'Thinking network' refers to the therapist's ability to think/understand/select any aspect of the intervention in a way that constitutes a step towards an increase in positive network support for the focal person. Whereas 'thinking network' may be easier when there is a network of people in the room, the ability to think in this way becomes particularly important for those problem drinkers who may be isolated. The specific skills that may be developed within a session of SBNT may be those developed in a general way in social skills training. The context within which this work is done and the purpose are different, e.g., nonverbal communication including body posture, tone of voice, eye contact, etc., are explored and developed within the context of approaching a particular person (either known or a new individual) in order to increase positive support for the focal person rather than as a general approach to training someone in social skills. The emphasis of this work is therefore not on the development of social competence in general but only social competence in relation to the development of positive social support for change.

Focus on positive support: The second core skill involves sustaining a focus on 'positive support' for the focal person. This involves being able to keep a clear focus on opportunities to develop positive support and to minimise the opposite, i.e., high conflict and problematic relationships that may interfere with the focal person receiving positive support for change. The therapist is trained to focus attention during the sessions on positive support and away from potential disagreements or conflict, e.g., a network member's criticism can be reframed as concern and the group can be invited to consider ways of turning that concern into positive support.

The therapist as an active agent of change: The therapist needs to be an 'active agent of change' focused on the development of positive support for the focal person. This orientation is in sharp contrast to other approaches (e.g., nondirective counselling) and may involve, for example, telephoning network members on behalf of the focal person, visiting a network member together with the focal person, or writing to potential network members to invite them to the sessions. In addition, therapists are encouraged to use role play and skill practice in the sessions. Therapists are encouraged to ask themselves throughout the intervention whether they have done everything they possibly can to engage and involve network members in treatment.

The therapist as a task-oriented team leader: As defined by Galanter (1993a, 1993b) in relation to Social Network Therapy, the therapist's relationship to the network is that of a 'task oriented team leader'. There is a clear task for the network to work towards, which involves supporting the focal person to obtain his/her chosen goal. In contrast to network therapy, however, the goal could be either abstinence or moderation. The role of the therapist is to direct and lead the network towards the achievement of the chosen goal in a similar way to that used when leading any team of people with a common goal or task.

Intervention structure: As used in UKATT, SBNT consists of eight sessions conducted over a period of 12 weeks. The treatment is divided into three phases. Phase 1 is concerned with the identification of the network and therapists aim to complete this task within the first session. Phase 2 comprises Sessions 2 to 7 and focuses on building/engaging/mobilising the social network. The aim for the final Phase 3, conducted within the last session, is to consolidate the work carried out in previous sessions and preparing for the future. Each phase is described below.

Phase 1: identification of the network: The first step in SBNT is to identify who is in the social network and which network members are supportive of change in the focal person's drinking. Once identified, provided that the person with the drinking problem thinks that the latter network members will be supportive, the next step is to make contact with them and invite them to take part in supporting his/her efforts to change.

Phase 2: building/engaging/mobilising the social network: The structure of Phase 2 is based on a combination of core and elective topics. This type of structure has been used in both the 12-step Facilitation Therapy (Nowinski, Baker, & Carroll, 1995) and the Cognitive Behavioral Coping Skills (Kadden et al., 1995) manuals developed as part of Project MATCH. Topics are broad in that the material is presented in ways that can be used when network members are present or also used with the focal person in order to engage potential network members or to develop networks from scratch. Core topics include material on communication, coping, increasing social support and dealing with possible lapse or relapse.

Phase 3: preparing for the future: The final phase covered within the last session is common to all cases and focuses on planning for the future and maintenance of the progress achieved as well as responding to changed circumstances in the future. The aim of this phase is therefore to create the conditions necessary for the network to continue to provide 'positive support for change' and hence increase the chances of long-term success. The therapist

encourages both the focal person and the network members to share responsibility for the success of treatment. Future roles in supporting the maintenance of change as well as responses to possible drawbacks are discussed in detail.

15.7 MARITAL THERAPY

Marital therapy refers to the treatment of couples who are having difficulties 'getting along' with each other. It involves the therapist meeting with both partners simultaneously to help them discuss and arrive at a solution for their problems. The basic aim of marital counseling can be stated to be arriving at a solution for marital problems that satisfies the needs of both partners. This section will focus on treatment for issues in a marital relationship. Marital counseling is now known as couple counseling, as it has been noticed that not all the couples who come for counseling are married.

History of Couples Therapy: Gurman and Fraenkel (2002) describe the theoretical and clinical history of couples therapy as having emerged in four phases. Phase I, which they call atheoretical marriage counseling formation, began in 1929 with the emergence of several pioneers who eventually established the American Association of Marriage Counselors. Phase I was also marked by the first legal recognition of marriage counseling as a profession in 1963 and the first publication of professional literature broaching the subject (Gurman and Fraenkel 2002). During that time, most clinicians were professionals who did not primarily identify themselves as psychotherapists, such as clergy and social workers (Broderick and Schrader 1991). Phase II, which Gurman and Fraenkel call psychoanalytic experimentation, saw the development of couples therapy primarily as a conjoint approach, beginning with both spouses participating in therapy individually but being treated by the same therapist (Greene, 1965). In Phase III, there was then an expansion of the theoretical breadth of couples therapies. The most recent era (Phase IV) has included the development of empirically supported treatment.

Couple Processes: Couple treatment builds on the emerging science of couple relationships, a field in which John Gottman is arguably the world's most influential contributor. In his work he has explicated the differences between satisfied and unsatisfied couples and how couples move toward dissatisfaction and divorce (Asher and Gottman 1973; Gottman 1990, 1993, 1994, 1999; Gottman and Carrere 1994;Gottman and Krokoff 1989; Gottman and Notarius 2000, 2002; Gottman et al. 1998). If we are to know how to prevent and treat dissatisfaction, we must understand the characteristics of unsatisfied couples.

Gottman has identified several differences between satisfied and dissatisfied couples. First, satisfied couples manifest high rates of positive to negative behaviors in their exchanges, maintaining a ratio of 5 positive behaviors to 1 negative behavior, whereas dissatisfied couples manifest a ratio of about 0.8 to 1. Second, distressed and divorcing couples manifest high levels of what Gottman has called "The Four Horsemen": defensiveness, criticism, contempt, and stonewalling. Gottman has shown that these four characteristics, which manifest early in marriage and often display nonverbally, are the best predictors of later divorce and intractable marital distress (Gottman and Levenson 1992).

Gottman has also conducted research that indicates that most problems in marriages tend to be irreconcilable and stable over time, even in happy couples. Successful couples learn to problem-solve and navigate their differences through direct communication, whereas unsuccessful couples get stuck in a pattern of conflict. Similarly, Gottman has shown that, contrary to the general public's beliefs, satisfied couples do argue but that they resolve their differences successfully and avoid common traps such as too-rapid startup by the partner stating the issue (who often is the female spouse) and flooding on the part of the listener (who often tends to be the male spouse) (Gottman 1998).

Gottman (and numerous others) has also shown that not only our behaviors but also our cognitions contribute to the levels of satisfaction in marriage. Positive sentiment override, the sense of feeling positively about one's partner and viewing events and processes within the relationship in the context of that positive view, is crucial to couple satisfaction.

Other researchers have shown that many unhappy couples are engaged in sequences of demand/withdrawal (Bradbury et al. 2000; Roberts and Krokoff 1990). This type of interaction pattern is present when one partner tries to engage the other in communication, problem solving, or affection, and the other partner distances. More often than not, it is the male who withdraws and the female who pursues (Kluwer et al. 1997).

Yet another important line of research has shown that distressed couples are more likely to engage in violent behavior with each other than is typically thought (Fritz and O'Leary 2004).

This growing body of research about couple processes has informed newer treatments addressing marital distress. There is no universally accepted treatment for marital distress, but there is a set of universally shared process goals. These goals include providing a calm environment in which relationship difficulties can be communicated and negotiated,

increasing mutual acceptance, ameliorating crisis, improving communication, improving problem solving, building attachment, improving marital friendship, and improving sexuality (Lebow 1999, 2003). Varying approaches differ in the extent to which they accentuate these goals.

Assessment of Marital Distress: There are numerous foci for assessment in couples. The most common concerns stated in couples therapy are communication, problem solving, affective connection, sexuality, conflict resolution, violence, parenting, finances, and relationships with extended family. Looking beyond such surface manifestations, couples can be assessed along a number of systemic levels, including behavior, cognition, affect, and the internal dynamics.

A number of assessment tools are available for couples therapists to use in tracking the degree of marital distress. Many of these tools are self-report questionnaires that the couple may fill out prior to their initial session. These questionnaires include the Marital Satisfaction Inventory—Revised (Snyder and Aikman 1999), which is used to assess marital satisfaction; the Weiss-Cerreto Marital Status Inventory (Weiss and Cerreto 1980), which is used to assess partners' thoughts about ending the relationship; the Dyadic Adjustment Scale (Spanier 1976), which is used to assess relationship satisfaction; the Area of Change Questionnaire (Weiss and Heyman 1990), which is used to assess areas of concern; and the Conflict Tactics Scale (Straus et al. 1996), which is used to assess violent and controlling behaviors. More complex measures utilized in the laboratory focus on the observation of behavior. These include Gottman's Rapid Couples Interaction Scoring System (Krokoff et al. 1989) and the Marital Interaction Coding System (Sperry 2004; Weiss and Heyman 1990).

Treatment Approaches: Numerous couples's therapies have been developed. In the following sections, we summarize today's most prominent treatments, emphasizing those with the strongest evidence base.

Behavioral Couples Therapy: Behavioral couples therapy (BCT) is a treatment developed in various forms by Jacobson and Margolin, Stuart, and Weiss (Jacobson and Gurman 1995). Based in social exchange theory (Thibaut and Kelley 1959), BCT attempts, as its primary process goal, to increase the frequency of reciprocal positive behaviors demonstrated by each partner, with the understanding that each partner's behavior influences the other, creating a circular and reciprocal sequence of positive reinforcers. There are two main components to BCT (Jacobson and Christensen 1996): behavior exchange and communication/problem-

solving training. The goal of behavioral exchange techniques is to increase positive behaviors and/or decrease negative behaviors in the couple's daily life. The therapist assigns behavioral exchange techniques as homework that the couple is asked to complete between therapy sessions. For example, the therapist may assign a couple to have a "love day," wherein each partner decides to enact specific behaviors, that will make the other person feel good. Communication or problem-solving training is administered in addition to behavioral exchange techniques to teach the couple skills that will enable them to solve future problems on their own. Therapists often teach a skill called reflective listening, whereby one partner expresses a feeling, thought, or emotion, and the other partner summarizes and restates what the other has just conveyed before responding.

Cognitive-Behavioral Couples Therapy: Cognitive-behavioral couples therapy (CBCT) was developed in accordance with the belief that relationship dysfunction occurs in part because people process information inappropriately or because they evaluate their relationship and their partners according to unreasonable standards. CBCT adds a cognitive emphasis to BCT. The assumption is that once people's distorted appraisals of events are altered, positive changes in behavior and emotion will ensue. CBCT therapists refer to two different types of stress in a relationship: primary distress and secondary distress. Primary distress results from the unmet fundamental needs of one partner (e.g., needs for intimacy, affiliation, achievement, autonomy). Secondary distress is the result of people using maladaptive strategies to address the conflict over primary distress (e.g., ignoring each other, verbally or physically attacking each other) (Epstein and Baucom 2002).

Typically CBCT is delivered within 8–25 sessions of weekly therapy (Baucom et al. 2002). The first 2–3 sessions are devoted to assessment and are followed by a feedback session, during which the couple and therapist work together to define treatment goals. Behavioral interventions may include behavioral exchange techniques and communication/problem-solving skills. Cognitive interventions may include Socratic questioning and guided discovery. Socratic questioning involves asking the client a series of questions that help him or her to reevaluate the logic or line of thinking that led the client to establish certain beliefs. This technique is often helpful in illuminating underlying issues affecting cognitive functioning that would not otherwise surface (Baucom et al. 2002). Guided discovery can include various techniques (such as role-playing or exploring the pros and cons of conducting the relationship according to each partner's standards) that will create

experiences that lead one or both partners to develop a different perspective on the relationship.

Integrative Behavioral Couples Therapy: Recognizing the limits of BCT and CBCT in achieving lasting change, Jacobson and Christensen (1996) developed integrative behavioral couples therapy (IBCT), a treatment that adds the concept of emotional acceptance to the framework of BCT. IBCT integrates behavioral interventions to effect change along with strategies to promote mutual acceptance and increase positive sentiment. Jacobson and Christensen theorize that in the early stages of a relationship, couples appreciate the differences in personality and functioning between them as the source of their attraction to each other. However, as time goes on, these differences can become sources of concern, even of discontent, and distressed couples may respond with mutual coercion, vilification, and polarization (Dimidjian et al. 2002). Designed to help couples effectively navigate their differences and conflicts, IBCT focuses not only on the agent of behavior but also on the recipient of behavior, with the understanding that increased acceptance both reduces conflict and, paradoxically, serves as a catalyst for change. Change techniques are directed toward the perpetrator to alter some behavior or lack of behavior. Acceptance techniques are aimed at the recipient of the behavior to help soften the adversarial stance that partners often take toward each other (Doss et al. 2002). This acceptance work is based on Gottman's findings that some problems simply cannot be solved (Gottman 1998, 1999). Instead of aiming to resolve the conflict, IBCT "attempts to turn areas of conflict into sources of intimacy and closeness" (Jacobson 1992, p. 497).

IBCT therapists identify one central theme for each couple they treat. The theme is a summary of the central issue the couple is facing. From the IBCT viewpoint, as couples make efforts to change each other, a polarization process occurs that serves to exacerbate the conflict between partners. IBCT therapists call the result the mutual trap, the hopelessness and frustration the couples experience as a result of the defeat they face upon trying to change one another.

Doss et al. (2002) describe four broad methods for increasing emotional acceptance: 1) empathic joining around a problem (creating intimacy by examining the problem together), 2) unified detachment in examining a problem ("taking a step back" to examine the problem as objectively as possible), 3) increasing tolerance of an aversive problem (for example, by presenting the positive aspects of a negative behavior), and 4) increasing self-care until the problem is ameliorated or alleviated (this can include encouraging the distressed partner to

call a friend, get a professional massage, engage in physical exercise, express negative emotions through journaling, etc).

Emotionally Focused Couples Therapy: Emotionally focused couples therapy (EFT), an experiential approach developed by Susan Johnson, focuses on couple emotion and attachment (Johnson 2004; Johnson and Denton 2002). The treatment focuses not on understanding and excavating the past but on recreating bonds in couples by "restructuring and expanding their emotional responses to each other" (Johnson and Denton 2002). The new secure bond enables couples to better cope with crises and life transitions and to experience a more satisfying cycle of interaction. Couples are also encouraged to explore their vulnerabilities together in order to increase attachment to one another and provide opportunities for mutual soothing.

Johnson and Denton (2002) outline three main tasks to be accomplished by the EFT therapist: "first, to create a safe, collaborative alliance; second, to access and expand the emotional responses that guide the couple's interactions; and third, to restructure those interactions in the direction of accessibility and responsiveness" (p. 222). The therapist uses techniques based on humanistic/experiential therapies (Greenberg et al. 1998; Rogers 1951) that focus on acceptance, empathy, and authenticity.

The therapist creates a secure base for the therapy by refocusing the couple to see the negative interaction cycle as the common enemy—instead of seeing each other as the enemy. A variety of intervention techniques are used to achieve the goal of exploring and reformulating emotions within the couple. The therapist may use heightening techniques, such as repetition, images, or metaphors, to help the couple engage in a constructive emotional experience. Johnson and Denton (2002) offer the following examples of heightening techniques: "So could you say that again, directly to her, that you do shut her out?" "It seems like this is so difficult for you, like climbing a cliff, so scary." Couples are also encouraged to engage in the process of softening, in which "hard" emotions like anger are explored deeper and transformed into "softer" emotions like fear, sadness, and shame. In these ways, partners are encouraged to be open and vulnerable, and helped to experience secure attachment with one another.

Object Relations Couples Therapy: Object relations couples therapy (Scharff and de Varela 2005) is an offshoot of individual object relations–based treatments. Object relations theory views the infant as primarily driven by the desire to have a relationship with a nurturing

figure (Scharff and Bagnini 2002). As the infant bonds, attachment develops. However, the attachment experience is inherently unsatisfying because the infant's needs cannot be met before they cause discomfort.

In turn, the infant self is split into three distinct parts:
1) The central self, whose needs are satisfied and met by the mother;
2) The craving self, who is attached longingly and unsatisfying to an unavailable figure; and
3) The rejecting self, who is angrily attached to the rejecting figure.

Object relations theory holds that couples seek lost parts of themselves in their spouses, and "that through marriage unacceptable parts of the self can be expressed vicariously" (Scharff & Bagnini 2002). The success of the marriage depends on the spouses' ability to receive and return these projections to each other as well as contain and modify each other's views of the self and the other (the object). Object relations couples therapy provides a safe holding environment in which the couple is enabled to better understand their own defenses and anxieties, and ultimately free themselves from the confining pattern of projection and identification. Interpretation of the mutual transferences that emerge between the couple is a major agent of change. Object relations couples therapy is typically delivered as long as necessary, with an ideal average duration of 2 years. Sessions are longer, up to 90 minutes in length, and may occur once or twice weekly (Scharff & Bagnini, 2002).

Affective Reconstruction: Affective reconstruction is a pluralistic, developmental approach whose theory is derived from the main assertion that couple difficulties often stem from injuries sustained in previous relationships that cause partners to develop defensive strategies that interfere with intimacy (Snyder & Schneider, 2002). As defined by Snyder and Schneider (2002), affective reconstruction is "the interpretation of persistent maladaptive relationship patterns as having their source in previous developmental experiences". This process is a hierarchical, pluralistic model that incorporates structural, behavioral, and cognitive interventions to address six fundamental tasks:

1) Developing a collaborative alliance,
2) Containing disabling relationship crises,
3) Strengthening the marital dyad,
4) Promoting relevant relationship skills,
5) Challenging the cognitive components of relationship distress, and
6) Examining developmental sources of relationship distress.

Affective reconstruction affords the therapist flexibility to move in a nonlinear fashion among these six tasks according to the couple's needs and level of functioning. Treatment length is 25 sessions, each 50 minutes in duration, although many couples require fewer sessions and some require more (Snyder & Schneider, 2002). An earlier form of this treatment (then called insight-oriented couples therapy) proved not only effective but also highly durable in its effects, with most couples maintaining change at a 5-year follow-up (Snyder & Wills, 1989).

Brief Integrative Marital Therapy

Brief integrative marital therapy (BIMT), developed by Alan Gurman at the University of Wisconsin, generally is focused on the present. It tends to be pragmatic, brief (as the name suggests) in duration, and problem focused in nature. Strongly influenced by both behavior therapy and object relations therapy, much of its theory rests on the foundation created by attachment theory and general family systems theory (Gurman 2002). BIMT operates according to the belief that both our interpersonal and intrapersonal worlds need attending to, that neither can exist meaningfully without the other, and that problems cannot be solved without addressing both factors.

The three central therapist goals in BIMT are to teach relationship skills, to challenge dysfunctional relationship rules, and to inculcate systemic thinking. This final goal involves helping clients become "more sensitive to the recurrent circular processes in their relationship that maintain their primary problems, including intrapsychic events and cues" (Gurman 2002, p. 200). This can often be achieved by asking pertinent questions that require the couple to observe and reflect on their own functioning. The BIMT therapist is equipped to intervene in a variety of ways to achieve these goals.

BIMT therapists believe that it is essential to modify the overt behaviors about which couples complain, as do behavior therapists. But BIMT therapists, much like object relations therapists, also believe it is essential to modify the patterns of collusion, or mutual projective identification, in a relationship. Collusion, as already described, is the process by which each partner projects the undesired parts of his or her own self onto the other partner, who thereby accepts the projection and behaves in accordance with it. Gurman (2002) has described the "implicit agreement, or 'collusion,' not to talk about or challenge the agreement": "The collusion is a joint, shared avoidance that involves both intrapsychic and interpersonal defenses against various fears (e.g., merger, attack, abandonment, etc.). Collusion is a

bilateral process in which partners seek to maintain a consistent, if maladaptive, sense of self".

Blocking interventions are designed to interrupt collusive processes as they transpire during a session. Cognitive restructuring is one such blocking intervention that is derived from CBCT whose goal is to target the automatic thoughts generated about a partner, especially negative overgeneralizations about the partner's character or behavior. Alternatively, the therapist may choose to "shift affective gears," much like in EFT, in which the therapist refocuses one partner's "hard" feelings (e.g., anger) about the other partner's behavior to his or her "soft" feelings (e.g., sadness). The therapist may also use self-control coaching as a blocking strategy, in which the therapist trains the partner to alter his or her response to the other partner's undesired behavior using behavioral techniques. Another technique utilized is anticollusive questioning. During this process, the therapist asks specific but often rhetorical questions that illuminate the collusive processes taking place within the session and encourage the couple to reflect on them and address the roles they play in the relationship. BIMT sessions are typically 50–60 minutes long, with the average treatment lasting 12–15 sessions (Gurman 2002).

Narrative Couples Therapy

Narrative couples therapy, like BIMT, is grounded in the belief that change happens when couples modify their views of themselves and others, but the approach is dramatically different from these other approaches. Based on the postmodern view that we define ourselves and each other through the stories we tell ourselves concerning our lives, narrative couples therapy seeks to help couples create stories that better reflect the lives they want to live and the relationship they want to experience (Freedman & Combs 2002). Narrative couples therapists are not typically interested in the assessment of problems in a relationship, nor do they see people as having stable characteristics (Freedman & Combs 2002). Instead, they are interested in helping people generate new stories about themselves and their relationships, with the hope that these new stories invite the possibility for change and growth. Problems in a relationship are thought of as plots, and the problems are tackled by developing what narrative therapists call projects, which serve as counterplots. Couples may identify joint projects involving both partners, individual projects to be addressed by one person, or both. Treatment length in narrative couples therapy is not specified; some couples find that a story may be reworked and redefined in only a few sessions; other couples may take years to flesh out and reauthor the stories that define themselves. The time, duration, and

date of the therapy session are not fixed. Rather, they are decided on by the couple in treatment on the basis of their perceived needs at the end of each session (Freedman & Combs 2002).

Integrative Problem-Centered Therapy: Integrative problem-centered therapy (IPCT), as conceptualized and formulated by Pins of (1983, 1995), is a psychotherapeutic framework that approaches problem solving in therapy by integrating individual, family, and biological therapies. Developed with the belief that each psychotherapeutic approach has its domain of expertise, and that no single psychotherapeutic approach is sufficient to treat all presenting problems, IPCT is a hierarchical approach to therapy in which specific psychotherapeutic techniques are employed sequentially so that one picks up where the previous one failed. Therapy begins with the simplest, most direct, and least expensive form of treatment and progresses to more complex, indirect, and extensive strategies only if the previous methods have failed (Pins of, 2002).

One of the key concepts of IPCT is the problem maintenance structure. All of the people who are involved in maintaining or resolving a patient's presenting problem are collectively known as the patient system. All of the factors within the patient system that prevent a problem from being solved are known as the problem maintenance structure. Each of the factors that make up the problem maintenance structure can be assigned to one of six categories: social organization constraints, biological constraints, meaning constraints, family-of-origin constraints, object relations constraints, and self-psychological constraints. Social organization constraints are addressed in therapy first, primarily through behavioral interventions. For example, if marital dissatisfaction is a result of a social constraint, such as not enough time spent together without the children present, the therapist intervenes behaviorally, helping the couple to modify their schedule to make it more conducive to the needs of the relationship. If this method of treatment fails, the therapist progresses to the other levels of intervention in turn, as needed.

IPCT is a process in which therapy progresses from the simplest to the complex, from outside in, and from the present (behavioral modification) to the past (analysis of childhood events and attachments). Movement from one orientation to the next is a result of the failure of the previous intervention to solve the problem. The progression is not always strictly linear; instead, the therapist may move back and forth as the problem maintenance structure reveals itself during therapy.

Feminist Couples Therapy: Feminist couples therapy has brought into focus issues of gender in marital therapy. As Rampage (2002) notes, "Although there is no monolithic feminist method of couples therapy, all feminist-informed approaches carefully attend to the ways in which power differences are manifested in the couple relationship". Feminist couples therapists believe that intimacy cannot be achieved without equality. Therefore, in the feminist approach, the therapist must evaluate the distribution of power in a relationship and work with the couple to balance it.

15.8 CONJOINT THERAPY

Conjoint therapy is an approach to treatment where two or more clients are seen together in a therapy session. This type of therapy may be used in marriage counseling or to deal with issues between a parent and a child. Clients dealing with Post-Traumatic Stress Disorder (PTSD) following military service or another traumatic event who are having trouble in their personal relationships may also benefit from conjoint therapy.

During the sessions, the couple or family members can get help to improve their communication and coping skills. The sessions are a safe place for clients and their families to bring up issues which may be awkward, uncomfortable, or too "loaded" to discuss outside of the office.

Under the direction of the therapist, clients can reduce blaming and negativity in their relationship. Part of the therapy process involves setting goals for improving the relationship and determining the specific steps required to achieve them. With conjoint therapy, each step in this process is completed with the help of a therapist. The client and his or her family don't have to go it alone or feel that they are getting stuck or bogged down in the process.

This type of treatment has the advantage of being highly flexible and its focus can be adjusted according to the needs and goals of the clients involved. Conjoint therapy can also be used in conjunction with individual therapy sessions in situations where a client wants or needs to do some individual work before feeling ready to bring others into the process.

To begin with, the conjoint therapy offers unique diagnostic advantages. One sees the family in operation, instead of having to construct an image or model from the different accounts of each individual (though one gets these as well). If the interaction is allowed to develop and is skillfully facilitated at the right moments, the problem actually begins to happen in the here and now of the interview, moving from its first locus in the referred

patient towards a disturbance of function in the family as a whole. It may quickly be apparent, to take one example, that a scapegoated child is excluded from the family and becomes a problem each time the discussion comes near criticism of the mother. The advantages of this for diagnosis are overwhelming, even if one chooses to halt the process at this point and offers treatment on an individual basis. Further, the balance of motivation for or against change, in the family as a whole, is often apparent too in the family diagnostic session. Many of the "interminable" treatments we encounter when only a part of the family is worked with are avoided at the beginning, therapist or family deciding against further interviews for the time being.

Another asset is the way responsibility for solving the problem is kept with the family. No procedure using interviews with separate individuals can match this, for then the therapist is the only person who has access to all the information provided (which he cannot divulge without a fear of breaking confidence) and it is not unreasonable for the family to look to him to put it all together and tell them what to do, or at least tell them what is wrong. In family therapy, on the other hand, the therapist automatically avoids receiving secrets. He can infer and guess as much as he likes, and will indeed be less inhibited in giving his impressions since no-one can misconstrue these as based on a private communication. Responsibility is shared, the therapist having a definite but clearly limited expertise in problems of communication generally, the members of the family being aware of the limited and distorted nature of the knowledge they have given him about their own functioning, which they always know better than he does. Economy of time and effort is another factor. Therapy of the artificially constituted group does offer some economies, but in my experience these are more limited than they appear. However, the intensity and rapidity with which family therapy produces its effects, where it is indicated, does make its value outstanding where resources are limited. Not only are major changes in family functioning effected in a few interviews, often indeed in one, but the interviews can be spaced widely without losing this intensive therapeutic character. Partly this is because of the homework the family does between sessions, at discussions often lasting far into the night, so that a meeting once in three weeks is felt as just about right. The enlistment of the overtly healthy members, as well as the more obviously sick one, also increases the therapeutic potential. Time and again it is the non-referred siblings who provide the key information, break a family collusion and generally save the day.

There is also the possibility, to a greater extent than in other forms of treatment, of a widely variable degree of intervention, from one session to a long series. Each intervention is in some way complete in itself, perhaps because transference phenomena, including dependency problems, are in general kept within the family itself while the therapist remains a more real individual, and also because, if movement occurs, everyone changes and a new equilibrium is reached. All these points, and the suitability of this method to long term but intermittent contact, may make it especially suitable for the general practitioner and others in a permanent relationship with many family members.

For diagnostic purposes there are hardly any contraindications to this family approach at some point. People without experience of this method often fear explosive or damaging interactions, but John Bowlby wrote in his early paper on this technique that he had "no longer come to be alarmed by the hideous scenes which may occasionally ensue"; and John Elderkin Bell, remarks that "there are occasions when the intensity of feeling within a family rises to flood proportions, but in all cases where this has happened, the family itself has been able to control the feelings".

The main limitation of family therapy is that change is naturally restricted to what is acceptable to the family as a whole, rather than adapted to the needs of any one individual. Individual therapy or inclusion in separate groups may be indicated for those who need and want a greater degree of self-knowledge than the more resistant members of the family can accept for themselves.

But even in individual work the family as a whole will try to impose limits on change which will be effective if the child is still at a dependent stage. In adolescence the natural termination of family sessions occurs when strivings for independence normal to this stage are being expressed and accepted and here further therapy apart from the family, by individual or group methods, can have its greatest value.

Other disadvantages seem to involve the therapist rather than the patients. Family therapy is noisy, confusing and very demanding of one's capacity for attention. It is often a good deal more difficult to keep one's emotional equilibrium than in individual therapy, though less taxing than other types of group work. There is no history to cling to when one feels at sea, not even the obsessional routine of history-taking to fall back on. Nevertheless, it is this exposure of oneself to the family problem, whereby one lives it with them and shares the struggle towards an understanding of what is really happening that partly accounts for its

efficacy. It is fair to add that it can also be very rewarding and enjoyable. Little has so far been written about the syndromes best treated by family group methods, but there seems to be agreement, as one might expect, that it is particularly useful where the children are acting out impulses, or expressing feelings, which cannot be admitted and coped with in the parents' inner psychology or acknowledged within the family as a whole. Such families need a scapegoat, or a sick child, or a delinquent, or a helpless baby, or an ambitious, successful wonder boy, to function at all, and the joint family sessions are ideally suited to help them include and integrate the child and the problem he represents.

Marital problems often provide the key to such family syndromes, and it is sometimes possible to trace the disturbance from the symptoms in the referred child to the parents' sexual incompatibility, in one session. Problems of authority and control frequently have their origin in an envious rivalry between the father and mother over each other's sexual roles. Many writers have commented on the phenomenon of the "activation of the passive father"; which so often occurs in family group work when this conflict is dealt with. The method seems to be especially suited to the treatment of ego-syntonic, acting-out character disorders, and it is worth remarking that the technique seems equally effective at all social levels, from the most intelligent and sophisticated to the most inadequate and primitive.

Contra-indications have been even less well documented, though they include families where there is one particularly sick and resistant member, families where the main gratifications come from thinly-veiled sadistic and destructive maneuvers, with little positive feelings left to provide motivation to face the true state of affairs, and families where there is too little capacity to share. At Woodberry Down Clinic where all the staff participate, separately or in combination, in work with family groups, we have been discussing this question over the past two years, and though we cannot formulate definite conclusions the evidence is very suggestive. It appears that families are suitable for, and indeed often only suitable for, family group therapy when they are functioning at a basically paranoid-schizoid level, with part object relationships, lack of ego boundaries and extensive use of denial, splitting and projection. In such families' different psychological functions-impulse, controls etc.-are located in different individuals and may move from one to another. The functioning unit is not the individual but the family, in that only the family as a whole contains the necessary psychological structures by which a mature individual operates, and the individuals are lost without each other, in treatment as in other activities. The family group is not a group, since true individuals do not yet exist.

The technique of family group therapy described seems to engender such feelings of separateness without providing a sufficiently personal relationship to "hold"; the individuals and provide sufficient security for them to tolerate and work through the painful affect. We have found that a period of individual psychotherapy is necessary at this stage with at least one family member, though it is still possible to make productive use of family interviews if key members have their own therapists' present, main training a personal relationship with them as is done in four way interviews with couples.

Later, when individuals can bear some degree of psychological separation, and can face a situation involving three and the loss inherent in this, the group becomes possible again. But now it is no longer a fragmented unity-the split-up mother of the primitive levels-but begins to be an assembly of individuals with separate identities, a true group situation.

For families functioning at this third level it seems that therapy by individual, artificial group and family methods are all available, and the most appropriate choice will be determined more by the severity of the problem, the time available, the degree of intervention and involvement desired, the extent to which the individual problem is personal or conditioned by family reactions, and so on.

Where an individual has encountered an identity crisis, and the overt disturbance is related more to the need to master a real stage in development, some family interviews may release constraints to development imposed by family attitudes, but individual therapy may be desirable to help him understand and integrate an essentially personal experience. Again, where family interviews have released straight-forward adolescent strivings for autonomy, therapy based on the peer-group is in accord with normal development.

15.9 SUMMARY

The present unit explains about the family therapy, when it is required and not necessary. Various approaches have been briefly explained such as Bowens approach, family systems approach, structural approach and similar such models have been briefly explained. One of the trending and important therapies through means of online platforms has been mentioned with a specific explanation of development of social behavior and network therapy. The various components of marital therapy gives a better understanding on how to understand the various processes involved. The importance and limitations of conjoint therapy has been explained, highlighting the indications and contra-indications of the therapy.

15.10 KEY WORDS

Family Therapy: Family therapy is a type of psychological counseling (psychotherapy) that can help family members improve communication and resolve conflicts. Family therapy is usually provided by a psychologist, clinical social worker or licensed therapist.

Social network therapy: An individual's social network is the sum of those human relationships that have a significant effect on his or her life. Members of an individual's network may represent both affective (i.e. psychosocial support and supplies, such as personal interest and emotional support) and instrumental (i.e. money, housing, etc.) resources, and include relatives, friends, neighbors, associates, employers and so on.

Marital Therapy: It is a psychotherapeutic treatment for married couples, who are seen by a therapist both individually and jointly to assist them in resolving various problems related to their marriage.

Conjoint therapy: It is a process in which the partners in a relationship or members of a family are treated together in joint sessions by one or more therapists, instead of being treated separately. Also referred to as conjoint counseling

15.11 CHECK YOUR PROGRESS

1. What is psychotherapy? Give a detailed note on when it is required and when it is not required.
2. Explain briefly the Bowen's model of family therapy? Describe the eight concepts to elucidate family development and functioning
3. Describe the various Family systems and structural approaches
4. What is social network therapy and mention their goals and applications
5. Explain in brief the marital and conjoint therapies.

15.12 ANSWERS TO CHECK YOUR PROGRESS

1. 15.1 2. 15.2 3. 15.3 & 15.4 4. 15.5 5.15.6 & 15.7

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UNIT : 16 - SPECIALIZED GROUP THERPIES

STRUCTURE:

16.1 OBJECTIVES

After reading this unit, you should be able to:

- Understand nature of specialized group therapies and types
- Master the techniques and stages of Inspirational group therapy
- Get a fair knowledge various types of online therapies
- Understand the 12 steps programme and sensitivity training
- Understand philosophical and religious approaches to educational group therapy

16.2 INTRODUCTION

Specialized group therapies are designed to assist anyone seeking to process/heal from their history of violence and abuse. The program/group involves individual counseling, family work, couples work, and groups. In this, group therapeutic sessions will address a wide range of emotional, behavioral, lifestyle management and personal development issues. The clients can relate to each other and have the benefit of a therapist facilitating healing, learning, and growth.

Usually specialized group therapies involve evidence based treatment, education and support, sometimes delivered in a group format. This form of treatment provides an opportunity for a deeper understanding of self and others. Patients suffering from specific disorders, can all work together to overcome their fears and anxiety and to learn the healing, therapeutic value of group work.

Few of the specialized group therapies are listed below

1. ***Group fitness therapy:*** The clients are allowed to experience the physical and psychological benefits of exercise. We offer many options to patients once medically stable and at a healthy weight including: Fitness training, regular walks, yoga, and strength training with a personal trainer. Additionally, fun and unique fitness outings off campus take place weekly where patients participate in various forms of physical activity.
2. ***Group dance and movement therapy*** *:*Dance therapy helps patients reconnect with their feelings and communicate on another level. Movement encourages individuals to step outside of their mind and reclaim their bodies, giving them courage to find beauty and freedom in their own rhythms.

3. ***Group Art therapy :*** Art therapy allows patients to express themselves creatively, providing another window into each individual and a different way to promote understanding and communication. Art therapy asks participants to explore their inner experience- their feelings, perceptions, and imagination.
4. ***Meal therapy****:* Meal therapy, nutrition, and post-meal groups are led by therapists and dietitians. Therapists with clients plan, eat and review meals as a group. Clients begin to face and overcome their fear of eating with supportive feedback and encouragement before, during and after each meal. Self-portioning, restaurant outings, and cooking classes are offered to help patients build confidence in eating away from treatment.
5. ***Cooking class****:* Clients will be accompanied by dietitians and along with chefs, assist patients in grocery shopping prior to providing hands on cooking instruction. Clients will then eat their creations with assistance and support from the Dietitian.
6. ***Animal assisted therapy:***This involves pets, also called as pet assisted therapy, helps clients to connect, play, and relax after a week of intensive individual and group work.
7. ***Male only group****:* In an effort to make sure each patient's individual needs are met, we offer a male only group that is led by a male therapist. This allows for more open conversation about the unique struggles and challenges that males face when suffering from an eating disorder. Treatment explores male-specific medical/endocrine and body image issues as well as how social roles factor into their daily lives.

16.3 INSPIRATIONAL GROUP THERAPY

Inspirational group therapy is a systematic intervention approach for evoking change and is a combination of humanistic treatment and enhanced cognitive-behavioral strategies, designed to treat substance abuse. It is based on principles of inspirational psychology and is designed to produce rapid, internally inspired change. This treatment does not attempt to guide and train the client, step-by-step, through recovery, but instead employs inspirational strategies to mobilize the client's own change resources. Inspirational group therapy consists of four carefully planned and individualized treatment sessions. The first two focus on structured feedback from the initial assessment, future plans, and motivation for change. The final two sessions, at the

midpoint and end of treatment, provide opportunities for the therapist to reinforce progress, encourage reassessment, and provide an objective perspective on the process of change.

The focus of Inspirational group therapies is to encourage a patient to develop a negative view of their abuse (contemplation), along with a desire to change their behavior (determination to change). An Inspirational group therapist does not explicitly advocate change and tends to avoid directly contradicting their patient, but instead expresses empathy, rolls with resistance, and supports self-efficacy. Relapses in addictive behaviors are part of the treatment and is not considered a step back or a failure to advance in treatment.

Often, a methadone or similar program is used in conjunction with inspirational group therapies.

Some suggest that the success of Inspirational group therapies is highly dependent on the quality of the therapist involved and, like all therapies, has no guaranteed result. Others explain the frequent successes of Inspirational group therapies by noting that the patient is the ultimate source of change, choosing to reduce their dependency on drugs.

Inspirational group therapies are focused specifically on a person's needs, or on what their problems may be. Sessions are usually short the first time you see a patient, but time can vary the next few sessions. During these times there are different methods and techniques used by the therapist.

Techniques consist of:

- Brief Solution Focused Therapy
- Cognitive Behavioral Therapy
- Schema Focused Therapy
- Interpersonal Therapy
- Compassion Focused Therapy
- Compassionate Mind Training
- Hypnosis

Inspirational group therapy is grounded in the trans-theoretical model of how people change addictive behaviors, with or without a formal treatment. In this model,

individuals move through a series of stages of change as they progress in modifying problem behaviors. Each stage requires certain tasks to be accomplished, and certain processes to be used in order to achieve change. The stages are:

- ***Precontemplation*****-** people not considering changing their problem behavior;
- ***Contemplation***- entails the individuals beginning to consider both that they have a problem and the feasibility and costs of changing that behavior;
- ***Determination***- the decision is made to take action and change;
- ***Action*****-** the individual begins to modify the problem behavior; this stage normally continues for 3-6 months;
- ***Maintenance***- sustained change;

If these efforts fail, a *relapse* occurs, after which the individual begins another cycle.

The models, along with the techniques formulated by Rollnick and Miller have helped create a client-driven form of therapy that has been known to help clients with substance abuse and different caliber athletes in achieving success. Inspirational group therapy was designed to be less confrontational than other therapies that encourage clients to realize that they have a problem that they need to confront in order to change. Inspirational group therapy is different from those therapies that:

- Argue that the person has a problem and needs to change
- Offer direct advice or prescribes solutions to the problem without the person's permission or without actively encouraging the person to make his or her own choices
- Use an authoritative/expert stance leaving the client in a passive role
- Do most of the talking, or functions as a unidirectional information delivery system
- Impose a diagnostic label
- Behave in a punitive or coercive manner

The aforementioned therapy techniques are known to violate the essential spirit of Inspirational group therapy and is designed to be an interpersonal style of therapy that is not restricted to formal counseling settings. It focuses on the understanding of what initiates change while utilizing a guiding philosophy, and fosters a balance of components that are both directed and client-centered.

The Inspirational group therapy approach addresses where a client currently is in the cycle of change, and assists the person in moving through the stages toward successful sustained change. The counselor seeks to develop a discrepancy in the client's perceptions between current behavior and significant personal goal; emphasis is placed on eliciting from clients self-inspirational statements of desire for and commitment to change. The working assumption is that intrinsic motivation is a necessary and often sufficient factor in instigating change.

Inspirational group therapy requires fewer therapist-directed sessions than some alternatives. It may, therefore, be particularly useful in situations where contact with problem drinkers is limited to few or infrequent sessions (e.g. in general medical proactive or in employee assistance programs).

Intervention

Inspirational intervention is described as a directive, patient-centered counseling style that enhances motivation and inspiration for change by helping patients clarify and resolve ambivalence about behavior change. This type of therapy helps patients refocus on their goals in life and restructure the important things in their life.

Inspirational problems are increasing in addiction treatment settings, as more patients are identified by early interventions, and are court-ordered, ambivalent, and unmotivated. The earlier the intervention occurs, the less the inspiration.

Early intervention allows people to set realistic goals for their recovery. Recovery can take a while, so it is ideal that the patients receive the therapy as soon as possible. The sooner the better because it allows the patients to have confidence in the recovery process and the help that they are receiving

Differences from other therapies

Although very often used in similar contexts, inspirational therapy, inspirational interviewing and inspirational enhancement theory/therapy have their differences.

Inspirational interviewing is similar to inspirational therapy in the sense that it attempts not to create change within an individual but give foundation and support to the change the individual finds within him or herself. As a treatment for individuals with all types of substance abuse disorders, inspirational interview therapists focus on trying to

erase any type of ambivalence the individual may have towards their abuse. Similar to Inspirational group therapy, inspirational interviewing finds 'change talk' very important and the clinician interacts with the patient through open-ended questions, affirmations, reflections and end-of-session summaries. There are three key elements that build the foundation of inspirational interviewing; collaboration, evocation and autonomy. Evocation is expressed through the clinician's responsibility to "draw out" the opinions and commitment to change of the client, rather than suggesting or imposing ideas. The client and the therapist, through collaboration, work together to build a trusting relationship, as opposed to the therapist taking the expert or higher role between the two.

While Inspirational group therapy is a method to treat substance abuse, Inspirational group therapy is also a very common way to treat alcoholism or alcohol abuse. Inspirational group therapy is very focused on the individual or patient taking responsibility for their abuse and speaking about the actions needed to evoke change in their life. Through this therapy, patients learn alternative routes to deal with such a huge change in their lifestyle. Similar to Inspirational therapy, therapists attempt throughout Inspirational group therapy to evoke a feeling of optimism within patients, but unlike Inspirational group therapy, therapists are very clear on their advice and suggestions for change. Without taking the back seat and just listening to their patients' thoughts, therapists of Inspirational group therapy are more vocal in their feedback towards patient improvement. Like Inspirational therapy, there are five stages which set the stage for successful Inspirational group therapy (in order, from beginning to end): Pre-contemplation, contemplation, determination, action, maintenance. If not permanently successful, there becomes a sixth stage to work through – relapse.

16.4 ONLINE THERAPIES

Online therapy, also known as e-therapy, e-counseling, teletherapy, or cyber-counseling, involves providing mental health services and support over the internet. E-therapy is a term that has been coined to describe the process of interacting with a therapist online in an ongoing series of conversations over time. E-therapists are very different from one-question "advice" or "information" services. This can occur through email, text messaging, video conferencing, online chat, messaging, or internet phone. Online therapy can occur in real-time, such as in phone conversations and text messaging, or in a time-delayed format, such as through email messages. This type of therapy has limitations, but it is quickly becoming an important resource for a growing

number of consumers. There are a number of reasons why a person might choose an online therapy option, including the convenience and accessibility that this delivery method provides.

E-therapy is about forming a relationship with someone who is trained to help. It can cover anything from simple befriending, to a much more intense and directed way of interacting. It means deciding to explore deep thoughts and feelings, and share them with someone who cares and who will listen and try to help. This process doesnt happen in one e-mail exchange. It takes time, while the therapist gets to know about the client, and the client has a chance to tell his/her story in some depth. This e-therapy process is closer to what might happen if the client met with a psychotherapist in an office.

Primary tools for communicating in online therapy include:

- Email
- Text messaging
- Real-time chat
- Internet phone
- Videoconferencing
- Mobile device apps

Such services may be accessed via a desktop computer or laptop, but mobile apps are also becoming an increasingly popular option.

Distance communication between a therapist and client is not a new concept. Sigmund Freud utilized letters extensively to communicate with his clients. Self-help groups began emerging on the internet as early as 1982. Today, there are numerous sites offering mental health information as well as private e-therapy clinics. The growth in online counseling and mental health services has led to the foundation of the International Society for Mental Health Online. This dramatic rise in the availability of online health care has led to a need for information and guidelines for customers interested in receiving mental health services via the internet. In recent years, online sites and apps devoted to mental health services have become increasingly popular.

While online therapy presents some challenges, it has received support from many patients who have utilized online mental health treatments. In a review of studies published in the journal *World Journal of Psychiatry*, patients receiving mental health treatment through video conferencing reported "high levels of satisfaction. Research also suggests that online

therapy may be effective in the treatment of a number of health issues. This is good news for many people, particularly those who live in rural areas where access to mental health services may be limited.

Types of online therapies:

Online therapy options have become an effective and convenient alternative to in-person treatment. New types of online counseling are emerging each day. Teletherapy, text-based chats, videoconferencing and other forms of virtual therapy are changing the way people receive mental health services. Because treatments in this field are constantly evolving, people may not be aware of the available online options for treating addiction and co-occurring mental health conditions.

Common Types of Online Therapies: Mental health and drug addiction therapy may involve one or many types of therapeutic approaches. Numerous styles of therapy and therapeutic orientations can help a person explore their motivations, adjust their behaviors and improve their feelings. When a person engages in online counseling or telehealth, they may encounter mental health therapy options like cognitive behavioral therapy, dialectical behavior therapy, family therapy and EMDR therapy.

Cognitive Behavioral Therapy: Cognitive behavioral therapy (CBT) is one of the most frequently used styles of mental health treatment, so there is a high likelihood someone could engage in cognitive behavioral therapy online. Like face-to-face sessions, online CBT therapy will address: The connection between thoughts, feelings and behaviors/Distorted beliefs and the negative impact they have on mood

More beneficial behavior patterns that improve symptoms. CBT is effective for numerous mental health issues, including depression, anxiety, addictions, behavior compulsions and many others.

Dialectical Behavior Therapy: A specific version of CBT, dialectical behavioral therapy (DBT) can be an effective treatment style for a variety of symptoms and conditions like: Suicidal thoughts, Self-injury, Borderline personality disorder, Eating disorders like anorexia and bulimia, Post-traumatic stress disorder. Online DBT helps build new skills related to regulating emotions, tolerating stress and improving relationships. Often, DBT involves both individual and group therapy sessions to help create the desired change.

Family Therapy: People may think online therapy only offers one-on-one phone calls or video chats with a professional. In reality, online family therapy is a helpful approach that includes an identified client and one or more loved ones. Online family counseling services are based on the notion that the family system affects and is affected by each person. Ideally, online counseling will improve communication skills and routines to create a more peaceful and rewarding family setting.

EMDR Therapy: Eye movement desensitization and reprocessing (EMDR) is a helpful treatment that minimizes the unwanted impacts of past traumatic events, depression, anxiety and addictions. A therapist can accomplish EMDR online with a few modifications to fit the virtual space. An online EMDR therapy session may help achieve desired results from the comfort of the person's home.

Advantages and disadvantages of online therapy

Advantages

- Therapy can reach remote areas
- Accessibility for people with physical limitations
- Convenience and affordability
- Treatment is more accessible

Disadvantages

- Insurance companies may not cover it
- Some governments may not permit out-of-state providers
- Confidentiality, privacy, and unreliable technology issues
- Lack of response to crisis situations
- Not appropriate for serious psychiatric illnesses
- Failure to understand the body language of the client
- Ethical and legal issues

16.5 THE 12 STEPS PROGRAMME

12-step programs consist of a set of uniform steps that attempt to support individuals who wish to address a variety of addictions and behavioral concerns. Developed in 1935 by Bill Wilson and Dr. Bob Smith, the program was originally intended for those who were experiencing alcohol addiction, but it is now widely utilized in the United States to treat a huge array of addictions, including smoking, drug addiction, compulsive overeating, compulsive gambling, and compulsive shopping.

People who are close to someone who is experiencing an addiction can also attend 12-step programs. The steps in these programs are slightly different; as they are tailored to help friends and family, who may be described as codependent, break the destructive patterns the addiction has caused in their lives.

THE 12 STEPS

Each program varies the 12 steps slightly to accommodate the particular addiction it treats. Participants work the steps in order and attend meetings to receive support in completing the steps. Many of those who are recovering from addiction continue to attend meetings even after completing all 12 steps. A desire to help other people who are experiencing addiction is a significant component of a 12-step program. While many of the steps make explicit mention of God, participants need not be religious: They are encouraged to define God however they see fit and to locate a "higher power" upon whom they can rely. However, because many groups also use prayers and Christian doctrine, 12-step programs have been criticized for being overly religious.

The 12 Steps of Alcoholics Anonymous

Because recovery is a lifelong process, there's no wrong way to approach the 12 Steps as the participant tries to figure out what works best for their individual needs. In fact, most participants find that as they grow in their recovery they will need to revisit some steps or even tackle more than one step at a time. Steps 1, 2, and 3 are considered the foundation of a 12-Step program and are recommended to practice daily.

Here are the 12 Steps as defined by Alcoholics Anonymous:

1) We admitted we were powerless over alcohol–that our lives had become unmanageable.
2) Came to believe that a Power greater than ourselves could restore us to sanity.
3) Made a decision to turn our will and our lives over to the care of God as we understood Him.
4) Made a searching and fearless moral inventory of ourselves.
5) Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6) Were entirely ready to have God remove all these defects of character
7) Humbly asked Him to remove our shortcomings

8) Made a list of persons we had harmed, and became willing to make amends to them all.
9) Made direct amends to such people wherever possible, except when to do so would injure them or others.
10) Continued to take personal inventory and when we were wrong promptly admitted it.
11) Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12) Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

The 12 Traditions: The 12 Traditions speak to the members of Alcoholics Anonymous as a group, unlike the 12 Steps, which are focused on the individual. The traditions are defined in the Big Book, the main governing literature of Alcoholics Anonymous. Most 12-Step groups have also adapted the 12 traditions for their own recovery plans.

Here are the 12 traditions

1) Our common welfare should come first; personal recovery depends upon AA unity.
2) For our group purpose there is but one ultimate authority–a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3) The only requirement for AA membership is a desire to stop drinking.
4) Each group should be autonomous except in matters affecting other groups or AA as a whole.
5) Each group has but one primary purpose–to carry its message to the alcoholic who still suffers.
6) An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.
7) Every AA group ought to be fully self-supporting, declining outside contributions.
8) Alcoholics Anonymous should remain forever nonprofessional, but our service centers may employ special workers.
9) AA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.

10) Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.
11) Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.
12) Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities

Does the Model Work: Because of the anonymity of the program and lack of formal research available, it's hard to tell just how effective the 12 Step model is. However, the prominence of this type of treatment as well as success stories from recovering addicts suggest it is effective.

At the very least, the 12-Step model provides support, encouragement and accountability for people who genuinely want to overcome their addiction. The sponsorship model as well as regular meeting times encourage the kind of social support that has helped countless people stay clean.

Twelve-step programs, designed as self-help groups, are conducted without a professional, but are worth mentioning here because of their well-known use in addiction recovery. Practitioners wishing to encourage participation in twelve-step programs as an adjunct to treatment can engage in twelve-step facilitation (TSF; Nowinski & Baker, 1992). TSF is a structured, time-limited treatment designed to encourage active involvement in twelve-step programs as a means of overcoming addiction. Practitioners choosing to use TSF should be prepared to discuss spirituality with their clients, as the program calls for several explicit discussions on the topic. Although designed for individual treatment, it has been suggested that TSF can be tailored for use in group treatment as well (Nowinski & Baker, 1992). The interventions outlined above were created for very specific purposes, but it is possible for group practitioners to incorporate elements of these interventions in their more general group work. In addition, clinicians could benefit from additional guidance on attending to spirituality and religion in group counseling. Thus, the following section outlines some initial guidelines for attending to spirituality and religion in group counseling. Although meant to help clinicians, these guidelines can also be seen as hypotheses to be tested in future research.

16.6 SENSITIVITY TRAINING

Sensitivity training is about making people understand about themselves and others reasonably, which is done by developing in them social sensitivity and behavioral flexibility. Social sensitivity in one word is empathy. It is ability of an individual to sense what others feel and think from their own point of view. Behavioral flexibility is ability to behave suitably in light of understanding. Sensitivity training refers to techniques to increase well-being, self-awareness of an individual's own prejudices and sensitivity to others. Members of different gender, culture and abilities are brought together in a free and open environment, in which participants discuss different issues in an interactive way.

In organizations, sensitivity training helps employees to be more sensitive and accepting of the existing diversity in the workplace. It enhances understanding between members of the organization and enables building good interpersonal relationships with other team members. Sensitivity training educates members about constructive behavior which will benefit everybody working in the organization through developing acceptable and correct behavioral and emotional actions

Goals of Sensitivity Training

While the emphases, styles and specific goals of the multitude of sensitivity training programs vary, there does seem to be some consensus as to general goals. These include:

1. Increased understanding, insight, and self-awareness about one's own behavior and its impact on others, including the ways in which others interpret one's behavior.
2. Increased understanding and sensitivity about the behavior of others, including better interpretation of both verbal and nonverbal clues, which increases awareness and understanding of what the other person is thinking and feeling.
3. Better understanding and awareness of group and inter-group processes, both those that facilitate and those that inhibit group functioning.
4. Increased diagnostic skills in interpersonal and inter-group situations. For the authors, the accomplishments of the first three objectives provide the basic tools for accomplishing the fourth objective.

5. Increased ability to transform learning into action, so that real life interventions will be more successful in increasing member effectiveness, satisfaction, output, or effectiveness.
6. Improvement in individuals' ability to analyze their own interpersonal behavior, as well as to learn how to help themselves and others with whom they come in contact to achieve more satisfying, rewarding, and effective interpersonal relationships.
Different sensitivity programs may emphasize one or more of these goals or may neglect some. However, they are goals that are common to most groups.

Sensitivity Training Program: Sensitivity Training Program requires three steps:

1. *Unfreezing the old values* -It requires that the trainees become aware of the inadequacy of the old values. This can be done when the trainee faces dilemma in which his old values is not able to provide proper guidance. The first step consists of a small procedure:

a) An unstructured group of 10-15 people is formed.
b) Unstructured group without any objective looks to the trainer for its guidance
c) But the trainer refuses to provide guidance and assume leadership
d) Soon, the trainees are motivated to resolve the uncertainty
e) Then, they try to form some hierarchy. Some try assume leadership role which may not be liked by other trainees
f) Then, they started realizing that what they desire to do and realize the alternative ways of dealing with the situation

2. ***Development of new values*** **-** With the trainer's support, trainees begin to examine their interpersonal behavior and giving each other feedback. The reasoning of the feedbacks are discussed which motivates trainees to experiment with range of new behaviors and values. This process constitutes the second step in the change process of the development of these values.

3. ***Refreezing the new ones*** **-** This step depends upon how much opportunity the trainees get to practice their new behaviors and values at their work place.

In one way sensitivity training is the process of developing emotional intelligence, which means "the mental ability an individual possesses enabling him or her to be sensitive and understanding to the emotions of others as well as being able to manage their own

emotions and impulses". Emotional intelligence enable employees to act according to the situation in the organization faced by him. It develops the ability to understand others feeling and their mental status and interact accordingly. Conflicts and misunderstandings are mostly raised because of lack of emotional intelligence possessed by the person which leads to breakup in perception and relationship they main since long time in organization and effects the productivity of the organization.

The advantages of sensitivity training are

- Helps to build good interpersonal relationships with their team members
- It helps employees be sensitive to the existing diversity in the workplace. It leads to better understanding between members of the organization
- Educates the members about constructive behavior which will benefit everybody working in the organization.
- Helps managers get an insight into their own behavior
- Helps to develop correct behavioral and emotional actions

The disadvantages of sensitivity training are

- Sometimes members of a group find these activities chaotic and disorganized especially at the onset
- As sensitivity training is an informal activity, there is no superior and subordinate relationship. Sometimes the informal talks can harm the relationship between both of them,
- It can tamper relationship between employees also
- Sometimes people are unable to give their true opinion as they are too aware of others and afraid of their reaction
- Sensitivity training is based on assumptions and not on facts
- Although sensitivity training is referred to as having a psychological impact, the meetings are unable to find a psychological reason for the behavior.
- Critics often have slammed sensitivity training as a method for brainwashing.

16.6 EDUCATIONAL GROUP THERAPY-PHILOSOPHICAL AND RELIGIOUS APPROACHES

Spirituality and religion have been increasingly viewed as important components of people's lives that can be successfully attended to in mental health treatment. The increasing interest and changing perceptions have stimulated a growth in research on spirituality and religion in counseling. However, much of this literature has focused on individual counseling.

Although knowledge continues to grow about the use of spirituality and religion in individual counseling, very little is known about how to best attend to spirituality and religion in group counseling.1 A growing number of group interventions include a spiritual or religious focus, but there is little general guidance for how to best approach the topic of spirituality and religion in group counseling. Group counseling is an effective means of treatment and can provide a viable, cost-effective alternative to individual counseling. In addition, the structure of group counseling can actually provide additional benefits not easily achieved in individual counseling (Corey, 2008; Yalom, 2005). Thus, it is important to consider the ways in which spirituality and religion can be most effectively attended to in group counseling.

Group Interventions with a Spiritual or Religious Focus: Despite the general lack of literature on attending to spirituality and religion in group counseling, a growing number of group counseling interventions have been developed that explicitly incorporate spirituality or religion as a treatment component. Most of these interventions were developed for very specific purposes, but practitioners could tailor elements of the interventions for their own groups. Many of these groups are psychoeducational; others are more psychotherapeutic in nature. Descriptions of these groups, as well as evidence of their effectiveness, are included below. In addition, twelve-step group programs are briefly discussed.

Psycho-educational Groups: Several psychoeducational group interventions have been developed that include a spiritual or religious focus. For example, Rye and colleagues have conducted two randomized clinical trials to examine the role of religion in facilitating forgiveness of romantic partners by female college students (Rye &Pargament, 2002) and ex-spouses by divorced men and women (Rye et al., 2005). In both studies, the intervention tailored to Christians loosely followed Worthington's (1998) REACH model of forgiveness. Leaders actively encouraged participants to utilize their religious resources to help them forgive, and prayer and scripture readings were utilized in session. The religious treatment was compared to a secular treatment (which had all the same components except that religion and spirituality were not explicitly addressed) and a control group. In both studies, participants in the active intervention groups improved significantly more on a variety of forgiveness and mental health measures than did those in the control group. There were no outcome differences between the religious and secular interventions. Interestingly, participants in the secular and religious interventions were equally likely to report that they drew upon religious or spiritual resources to promote forgiveness, which may explain the lack of outcome differences between the religious and secular interventions (Rye &Pargament,

2002; Rye et al., 2005). Some individuals, then, might benefit from spirituality and religion in the process of forgiveness.

A psychoeducational group with a religious focus has also been created for Mormon students struggling with perfectionism, the effects of which were tested in a pilot study (Richards, Owen, & Stein, 1993). A religious emphasis was incorporated in several ways. First, the relationship between religious beliefs and perfectionism was explored (e.g., many devout Mormons literally and rigidly interpret scriptural passages that call them to be perfect). Second, religious bibliotherapy was used, in which clients read material by Mormon leaders with themes of forgiveness, grace, and acceptance of oneself despite imperfections. Third, religious imagery was used in relaxation exercises. From pre- to posttreatment, perfectionism and depression significantly decreased and self-esteem and existential well-being (i.e., satisfaction with the direction of one's life) significantly increased. Religious wellbeing (i.e., perceived strength of relationship with God) did not change as a result of this intervention.

A group counseling intervention designed to enhance awareness of the sacred was examined as a treatment for social anxiety (McCorkle, Bohn, Hughes, & Kim, 2005). Each session in this intervention had a different focus, including the meaning of sacredness, sacred gifts given and received, and sacred sharing of suffering. Group members rated their anxiety and perceptions of sacredness before and after each session. In all but the final session (which was devoted to termination and celebration), perceptions of sacredness increased from pre- to post-session. In addition, anxiety ratings decreased during nine of ten sessions, with a falling trend line over the course of the intervention. Participants indicated that focusing on external, sacred elements took the focus off their internal reactions to anxiety-provoking stimuli.

A spiritual coping group was created for adults living with HIV/AIDS (Tarakeshwar, Pearce, & Sikkema, 2005). Different topics were covered in each session, including HIV and relationships, control versus active surrender, and the effects of spirituality on mental and physical health. Much of the intervention focused on coping methods; members shared their own experiences with coping, and facilitators provided information about healthier coping and the benefits of using spiritual coping strategies. From preto post-intervention, members reported an increase in self-rated religiosity and in positive spiritual coping (e.g., looking to a higher power for strength), as well as a decrease in negative spiritual coping (e.g., feeling angry at a higher power, feeling punished by a higher power) and depression. Post

intervention evaluations indicated that members found focusing on spirituality often helped them "let go" and find "peace" (p. 187) in the face of uncontrollable events.

Several psychoeducational groups have been developed for individuals with severe mental illness. Lindgren and Coursey (1995) developed a group with a focus on how spiritual themes can provide a sense of self-worth and support for those with severe mental illness. Group members explored spiritual versus societal values, the spiritual meanings they had given to their illnesses, self-forgiveness, and the impact their spiritual experiences had on their feelings and symptoms. After receiving the intervention, members showed an increase in perceived spiritual support. In addition, greater reductions in depression from pre- to postintervention were correlated with more frequent thoughts about God (r .42)

Another group intervention for individuals with severe mental illness was designed to provide members with new information about spirituality (Phillips et al., 2002). Topics covered in this group included spiritual resources, spiritual strivings, spiritual struggles, forgiveness of others, and hope. Ways in which their mental illness affected their spirituality were often discussed, along with suggestions to deal with or overcome the barriers associated with their illnesses. No formal evaluations were made of this group.

Structured Versus Unstructured Groups

Another way in which counseling groups differ is in the degree to which they are structured. Psychoeducational groups that teach a specific scripted curriculum are at one end of this continuum with psychotherapy groups whose leaders simply facilitate group process at the other. Although we do not believe the usefulness of the guidelines detailed above are seriously affected by the degree of structure in a group, the way in which those guidelines are applied very well may be. For example, the suggestion to approach religious or spiritual topics might take a more explicit form in structured groups. A clinician leading a structured psychoeducational group might include a short presentation about the role spirituality can play in the topic under consideration (e.g., spiritual meditation practices to cope with anxiety). In contrast, in an unstructured group, the therapist might follow up with clients who bring up spiritual issues or may direct the group's attention to the ways a specific topic relates to spirituality. For example, in a discussion of grief and loss, a leader might ask, "In what ways do your spiritual beliefs impact the way that you experience the death of loved ones?"

Another guideline that might differ based on the level of structure in a group is the suggestion to elicit feedback about and process discussions of spirituality and religion in

group. The classic practice of processing group interactions is a mainstay of less structured process groups (Yalom, 2005), making this suggestion easier to incorporate in unstructured, process-oriented groups. However, receiving feedback on how members accept and respond to spiritual or religious discussion can also be applied in structured groups. In such groups, therapists can set aside a particular time to elicit feedback from members. They might set this up as a "go-around" asking each member to respond to a specific question. Alternatively, therapists might have clients complete a homework assignment that encourages them to apply spirituality or religion to a particular problem or concern and write about their successes or struggles with this. Although most of the guidelines are applicable to either structured or unstructured groups, the way in which they are applied needs to be carefully considered and might very well differ based on the group, the counselor, or the specific situation.

Conclusion: The outcome of the group interventions may or may not be directly connected to the spiritual or religious factors at work in the group therapies presented, and it remains unclear whether these group therapies are separated from other types of group therapies without an integration of spirituality or religiosity. Despite the growing amount of literature on spirituality and religion in counseling, there is still a lack of guidance for attending to clients' spirituality and religion in the group counseling context. Group practitioners are encouraged to utilize the above suggestions, but additional research is still needed in order to identify appropriate and effective methods of assisting clients in exploring their spirituality and religion in group counseling.

16.8 SUMMARY

The current unit helps in understanding the role and function of various specialized group therapies, their specific importance and the types of clients suitable for such therapies. A brief explanation of the inspirational group therapy is given to help comprehend the dynamic role it can play for group therapies and help a large number of clients. The emerging branch of online therapies have been mentioned to help the students understand the role technology can play in reaching out to people far off and assist multiple clients at the same time. One of the most famous 12-step program has been elucidated to give an idea on how it can help addicted clients overcome their maladaptive behaviors followed by sensitivity training where the therapists can play a vital role in enhancing and bringing meaningful beliefs and values to the lives of the clients. A brief explanation of the educational group therapy highlighting on the philosophical and religious approaches has been given to show

their influence and use it to the advantage of assisting the clients in becoming better individuals.

16.9 KEY WORDS

***Specialized group therapies**:* Specialized group therapies are designed to assist anyone seeking to process/heal from their history of violence and abuse. The program/group involves individual counseling, family work, couples work, and groups. In this, group therapeutic sessions will address a wide range of emotional, behavioral, lifestyle management and personal development issues. The clients can relate to each other and have the benefit of a therapist facilitating healing, learning, and growth.

***Inspirational group therapy**:* Inspirational group therapy is a systematic intervention approach for evoking change and is a combination of humanistic treatment and enhanced cognitive-behavioral strategies, designed to treat substance abuse.

***Online therapy**:* Online therapy, also known as e-therapy, e-counseling, teletherapy, or cyber-counseling, involves providing mental health services and support over the internet. E-therapy is a term that has been coined to describe the process of interacting with a therapist online in an ongoing series of conversations over time. E-therapists are very different from one-question "advice" or "information" services.

***Sensitivity training**:* Sensitivity training is about making people understand about themselves and others reasonably, which is done by developing in them social sensitivity and behavioral flexibility. Social sensitivity in one word is empathy. It is ability of an individual to sense what others feel and think from their own point of view.

16.10 CHECK YOUR PROGRESS

1. What is specialized therapy? Give a detailed note on the types of specialized group therapies.
2. Explain briefly the inspirational group therapy, the intervention process and how they are different from other therapies.
3. Describe and explain the role of online therapies.
4. What is the 12 step program and elucidate the process of sensitivity training
5. Explain in brief the educational group therapy and the approach of religion and philosophy.

16.11 ANSWERS TO CHECK YOUR PROGRESS

1. 16.1 2. 16.2 3. 16.3 4. 16.4 &16.5 5.16.6

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