

COUNSELLING SKILLS I BPS109

SUBJECT GUIDE

Course Aim

To develop your knowledge of the basic skills used in counselling, and how these skills are applied to the counselling process.

Course Contents

There are eight lessons in this module as follows:

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 - Learning micro-skills
2. Listening & Bonding:
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 - Listening with intent
3. Reflection:
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Assignment Submission Details

- When you feel confident that you are ready to submit your assessment please do.
- ALL assignments in this booklet are to be submitted in one go once you have reached the end of the booklet.
- Assignment tasks should be submitted to:
assessments@InternationalCareerInstitute.com
- Should you at any time need the assistance of a tutor please send an email to:
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- Make sure that you have included your personal details such as address name, course level, assignment number etc...
- Type all assignments in a clear and legible font

Lesson 1

LEARNING SPECIFIC SKILLS

Aim

To be aware of various methods of learning, and identify essential micro-skills.

A Reminder – What is Counselling

Many people go through times when they find their lives overwhelming or distressing. This may be due to bereavement, illness, family crisis, relationship breakdown and so on. They may find it hard to cope or not have the resources to deal with the problem. Counselling can help them to retain their self-sufficiency, build better relationships and help them to make and act on their choices. Before moving on to specific skills, it is important to just repeat what counselling is.

Counselling means different things to different people. It is not a get well quick option, offering quick answers, but is asking the person to engage in a process and an exploration. There are many definitions of counselling. A simple version is that counselling is a working relationship where the client is helped to manage what is happening in their life and to explore their life. It is a form of psychological or talking therapy that offers people the ability to change how they live and feel. The aim of counselling is to provide the client with a more satisfying experience of life. Everyone has different needs, so counselling can be concerned with many different aspects of a person's life.

Activity

Briefly make a list of all the different areas where you think a person might require counselling.

You may have listed things such as :

Resolving and addressing specific problems
Personal development issues
Decision making
Coping with a crisis
Developing personal insight and knowledge
Working through an inner conflict
Improving relationships with others.
And so on.....

The role of the counsellor is to facilitate the person's resolution of these issues, whilst respect their values, personal resources, culture and capacity for choice. Counselling can provide people with a regular time and space to talk about their problems and explore difficult feelings in a confidential and dependable environment.

Counsellors do not usually offer advice, but instead give insight into the client's feelings and behaviour and help the client change their behaviour if necessary. They do this by listening to what the client has to say and commenting on it from a professional perspective. Counselling covers a wide spectrum from the highly trained counsellor to some one who uses counselling skills as part of their role, for example, a nurse or teacher.

Many people use counselling skills in their daily lives. However, sometimes it may be inappropriate for people to use their usual methods of support. They may not want to discuss their problems with a friend or family member. They may feel that the person is too close, that they don't want them to know their confidential problems or the person they would usually

confide in might be part of the problem. Counsellors are trained to be effective helpers in difficult or sensitive situations. They should be independent, neutral and professional, as well as respecting our privacy. Counselling can help people to clarify their problems, identify changes they would like to make, get a fresh perspective, consider other options and look at the impact that life events have made on their emotional wellbeing.

Counselling can help people to come to terms with specific issues. It works best if the client enters counselling of their own free will. Counselling is a specific arrangement between the counsellor and the client. It is not about making judgements.

There are five elements that must be in place for counselling to work. These include:

- A contract between the counsellor and client.
- A warm and trusting, professional relationship.
- The focus is on the client.
- A space where the client feels safe.
- A place where the client is able to share difficult feelings in an accepting atmosphere.

Counselling

Counsellors provide guidance for clients and a support system, rather than working with the deeper levels of the psyche. However, there are other therapists who work with people with difficulties. A *psychoanalyst* is someone who has been trained in the theory and techniques of psychoanalysis. Initially they would be trained as a physician, psychiatric social worker or psychologist. Their training will involve personal analysis. Psychoanalysis is the term used for Freud's set of theories about human behaviour and the form of treatment of mental disorders he devised. Although psychoanalysis has developed more since Freud's time.

A *psychotherapist* is a practitioner of psychotherapy. S/he is usually a psychiatrist, a clinical psychologist or a psychiatric social worker. Psychotherapy is the use of psychological techniques to treat psychological disturbances. The four main forms of psychotherapy are behavioural, cognitive, humanistic and psychoanalysis. There are many variations of the four approaches.

A *clinical psychologist* is a practitioner of clinical psychology. They may *also* be psychotherapists, but this is not essential. They may work in hospitals or clinics or may have a private practice. Clinical psychology is the branch of psychology concerned with the application of psychological theory and research to the treatment and diagnosis of mental, emotional and behavioural problems.

A *Psychiatrist* is a person who specialises in psychiatry. Psychiatry is the branch of medicine that covers mental illness. The subject matter of psychiatry overlaps to a great extent with clinical psychology, the main difference being in the training of the psychiatrist and the clinical psychologist. A psychiatrist has no training in psychology, other than psychopathology and uses the medical model to deal with mental disorders. The clinical psychologist is not medically trained, cannot prescribe drugs and tends to view normal and abnormal behaviour as on the same continuum.

SOME THEORIES OF COUNSELLING

Empathy

Empathy is the ability to understand someone else's point of view and to share their emotions, almost "to stand in their shoes". Empathy is a centrally important ingredient of any therapeutic situation. Without empathy, the client is unlikely to trust the therapist, and without trust, will be unlikely to explore deeper levels of problems and effect changes.

To practice empathy, a therapist must continually be in touch with the client's feelings and values, without intruding their own set of values. The therapist must in a sense imagine being in the "client's shoes".

Part of empathy is the practice of **reflection**.

The therapist becomes like a mirror, constantly reflecting the client's attitudes back to him/her; for example:

Client:	<i>He makes me mad. I just want to lash out at him.</i>
Therapist:	<i>You feel angry and frustrated.</i>
Client:	<i>Yes, and I don't know what to do -how to end it</i>
Therapist:	<i>It's confusing for you and you don't know how to end the frustration.</i>

One might ask why reflection can help a person -the therapist doesn't appear to be adding anything to the clients understanding. The client however, in this way learns to accept their feelings. They then find it easier to express their feelings. They are making sense of a confused world through verbal articulation. All of these factors form a basis for problem solving.

Transference

Although the concept of transference originated in psychoanalysis, it has been proved to be of profound relevance to any therapeutic situation.

Transference involves the **projection** of feelings towards people in your life, onto the therapist. If the client perceives her husband of being a cold aloof person, she brings this attitude into the therapeutic situation, and projects it onto the therapist. Thus she perceives the therapist as being cold and aloof. In this way the therapist acts as a sounding board for the clients feelings. Since people's problems are often about loved ones, clients often experience feelings of love and attachment toward their therapists. A good therapist will not encourage OR suppress such feelings. Instead they will work with them during the therapy session to broaden the clients self awareness. He/she will help the client realise that these feelings come from other relationships, for example:

Client:	<i>I don't know what's wrong with you today. You're not listening to my silly problems. You're not even listening.</i>
Therapist:	<i>You're mistaken about that. I'm listening very closely. I begin to feel that someone at home perhaps, hasn't been listening to you. Is that so?</i>

Transference can be a positive key to finding out what the client's central hidden problems are. A client cannot openly admit anger to her husband, who perhaps doesn't even know that she is angry; but she might project those feelings onto the therapist.

DIRECTIVENESS/NON-DIRECTIVENESS

The use of empathy or reflection might be referred to as a non directive approach.

Here the therapist is not actively leading the client to a solution.

This is a necessary part of therapy as it guides the client to learn to express his/her hidden feelings.

Once the client's world is opened to the therapist willingly, and the client has trust in the therapist, then a more directive technique can be used.

Directive techniques include:

1. Introducing the client to open ended questions which require a greater level of trust & honesty. E.g. Why do you stay with your husband when he hurts you so much?
2. Introducing a level of interpretation
Instead of merely reflecting the client's feelings, an element of interpretation is added. This is not to say that you will take wild guesses. Your interpretation of the client's verbalisation must be grounded in your knowledge of their feelings and attitudes.
3. Greater Intervention as regards the direction of discussion.
Often when the client has revealed a greater part of his/her experiences in therapy, a new level of defensiveness sets in, and the client might experience mental blocks.

BEHAVIOUR THERAPIES

The basic assumption of behavioural therapy is that maladaptive behaviour is a learned way of coping with stress, and that these learned behaviours can be unlearned and replaced with more efficient forms of behaviour. According to the behaviourists, it is not enough to simply change a person's attitude in therapy, for even if one develops healthier mental attitudes, one's behaviour does not necessarily change. I might develop the attitude that violence and aggression are abhorrent and counter productive ways of dealing with stress, yet as soon as I am stressed I might still automatically have violent outbursts.

The behaviourist's main aim therefore is to modify behaviour through therapy.

The therapist's technique of modifying the client's behaviour is largely based on learning theory, such as classical and operant conditioning

SYSTEMATIC DESENSITISATION

This is a method used to eliminate fears and phobias. The individual is taught that they cannot be anxious and relaxed at the same time.

Relaxation training is provided and then used by the client whenever they encounter stress. Smaller fears are eliminated before greater fears are tackled.

Since one cannot be anxious and assertive at the same time, the person is also taught how to assert themselves. The individual learns how to act assertively in situations which usually produce passivity and timidity in the client. For instance, a depressive might be trained to overcome learned helplessness

Both relaxation and assertive training are practiced in a therapeutic situation, and then the client is encouraged to employ the learned methods on his/her own, in real life situations.

Role modelling is a particularly important therapeutic tool in this respect (e.g. If a client is having problems with the boss at work; the therapist may pretend to be the boss in a work situation and ask the client to act out the situation in his own role as if he were at work.

POSITIVE REINFORCEMENT & EXTINCTION

These are other methods of behaviour modification used by behaviourists.

Healthy behaviour is positively reinforced by the therapist or the client's own self. The client might develop a self awareness system e.g. "For every three times I speak out at a meeting, I can buy myself a little gift"

Any therapist should always provide positive reinforcement in response to any psychological growth in a client: e.g. "You have made excellent progress in regards to stating your needs to others".

Extinction involves the elimination of negative patterns of behaviour through withholding positive reinforcement

Behavioural therapy is largely geared towards helping individuals to regulate their own behaviour outside of the therapeutic situation. This is called *self regulation*.

One way of doing this is to note the kinds of stimuli that produce negative and positive behaviour, thus avoiding situations that lead to negative responses and favouring situations that produce positive attitudes.

Goals of the Psychoanalytical Approach

Psychoanalysis seeks to make the unconscious conscious. It strives to probe into the deeper part of the psyche and get to those issues that were not resolved during cognitive development. It does not aim simply to uncover these issues, but rather to understand and experience them so that a change in character can occur.

This is based on the idea that psychological maladjustment is the result of unconscious conflicts. The individual uses defence mechanisms to keep these conflicts at bay. Sometimes the individual's maladjustment concerns an over reliance on defence mechanisms, leading to an alienation from their own emotions. We will discuss defence mechanisms shortly. At other times, stress is so great that all defences break down leading to irrational and disorganised behavioural patterns. The psychoanalyst's primary aim is to bring these conflicts into the individual's conscious awareness.

The therapist will typically not engage in much self-disclosure and will therefore consider that most of what the client discloses will be related to significant others from the past.

The relationship relies on transference and the client making projections onto the counsellor. They also seek to enable the client to deal with impulsive and irrational behaviour and to cope with anxiety, thus leading to a greater sense of self-awareness and hopefully more successful relationships.

The therapist also tunes in to the client's resistances and interprets dreams and free-associations to get an overall picture of what the client's problems may be. It is hoped that increasing the client's awareness will encourage them to change, though it is up to the client to want to change. The therapist's interpretation can therefore be seen as being not as important as the client's willingness to change.

Typically this form of therapy will last between 3 and 5 years, and the client will see the therapist several times a week. It is important that the therapist does not rush to interpret the information supplied by the client.

DEFENCE MECHANISMS

The most common ways of dealing with stress are by using *defence mechanisms*, such as those described by Freud. Freud claimed that we have an *id*, *ego* and *superego*. The *id* is our unconscious self, motivated by pleasure. The *ego* is our day to day self, responding to situations, our conscious self. Whilst the *superego* is our moral self, almost our controller.

Repression

Memories that cause anxiety are kept out of our conscious awareness as a means of protecting ourselves. This is also called motivated forgetting. This involves repressing the chaotic desires of the *id* into the unconscious realm. Often these repressed desires will still find expression in dreams, slips of the tongue or psychopathological symptoms.

Displacement

This involves displacement of a disturbing emotion such as anger, from one person to another. Displacement reduces anxiety produced by the unacceptable wish, but at the same time it partially gratifies that wish. The basic emotion of irrational anger toward a parent (for example)

cannot be removed. The individual will instead direct this anger toward another less important, less threatening person.

Rationalisation

This is when we pretend to have a socially acceptable reason for a form of behaviour that is actually rooted in irrational feelings.

Example: A person is angry with their mother and wants to avoid her. They then give a false reason for not going to visit her (e.g. It is too far away).

Projection

This is a particular form of rationalisation. It involves projecting our own undesirable characteristics onto someone else.

Example: You feel an irrational hatred toward someone else, and then you go around telling people that the person concerned hates you.

Reaction-Formulation

This involves unconsciously covering up what you really feel by behaving in the opposite manner, without realising it.

Example: A woman, who could not obtain an abortion, might harbour a lot of hatred towards her child, and unconsciously still want to get rid of it. Instead she behaves lovingly and over protective to the child, to an excessive degree.

Intellectualisation

This involves detaching ones self from deep emotions about an issue, by dealing with it in abstract and intellectual terms.

Denial

This involves simply denying that a situation or emotion is real (simple but extreme!)

This is a defence most frequently employed by a person who has lost a loved one -they go through a period of refusing to believe that it is true.

Sublimation

This involves establishing a secondary socially acceptable goal that can be satisfied; instead of satisfying the primary (original) goal.

Example: An excessively aggressive person might satisfy their desire to kill by joining the army where it can be socially acceptable to kill.

Defence mechanisms all play the role of distorting reality to a greater or lesser degree, in order to get rid of anxiety producing feelings. Nevertheless, they are necessary to keep our psyches from being overloaded with the *id's* irrational feelings. They can however be over used by certain individuals so that reality becomes distorted to an unhealthy degree.

The use of defence mechanisms is inevitable and necessary; however an individual can rely on them too much; resulting in personality problems.

Use of Psychoanalytic Psychotherapy

Modern psychoanalytic psychotherapy differs from traditional psychoanalysis in several ways:

- There is less of a focus on dream and fantasy material, and more of a focus on practical elements of the client's life
- They tend not to use the traditional therapist's couch
- There are a lesser number of sessions
- The therapist is more active in terms of self-disclosure and the use of minimal responses
- There is less of an accent on restructuring personality and more of a focus on finite objectives

Psychoanalytic Techniques

The main techniques used by the psychoanalyst are "free association", "dream analysis" and "transference". There are a number of principles of this form of therapy as outlined below:

Analytic Framework

This refers to the maintenance of a set procedure in terms of the regularity of the meetings, the timing of the meetings, and trying to disrupt the parameters of the therapeutic process as little as possible. This includes such things as, minimizing vacations and avoiding changes to life conditions such as divorce.

Free Associations

This involves encouraging the client to speak freely and honestly about any thoughts that come to mind, without editing or censoring, or even trying to make sense of what is said. It is essential that the therapist conveys a sincere attitude of attentive listening and unconditional acceptance; to ensure that even the most irrational thoughts are not suppressed. Only after the client finishes speaking does the therapist intervene and encourage more free association. Thought and feelings that emerge during this process provide raw material for analysis and interpretation. The client can experience a great relief in being able to express old and disturbing emotions in a safe, non-judgmental environment.

During this process the client reels off whatever they think of, no matter how disconnected, outrageous, silly, trivial or otherwise they feel about it. In so doing the therapist is able to tap into the client's repressed fantasies, past conflicts, wishes, desires and so on.

If the client experiences psychological blocks in revealing information, then this can be viewed as a cue that they are dealing with anxiety-provoking material. What is not said is as significant as that which is vocalized.

Whilst the therapist offers interpretations of this material, the client needs to determine their own meanings.

Interpretation

This involves identification, clarification and translation of the client's information that arises during the therapeutic relationship.

This should only be offered with regard to material that is close to consciousness and with material that the client is going to be comfortable facing. It is acknowledged that in the case of repressed material which the client is resisting or defending, that the resistance should be drawn to the client's awareness before any revelations over what it is concealing are drawn to the client's attention.

Dream Analysis

Freud saw dreams as an expression of unconscious fears, needs and desires. Some of these motivations are seen as being too intolerable to the individual, and therefore are expressed in symbolic form.

Latent content is viewed as the symbolic unconscious component.

Manifest content is the way in which the latent content is disguised into a more acceptable form to the dreamer. It is therefore the actual dream as it is experienced.

Dream interpretations also shed light on the client's current life situation as well as past experiences and unresolved conflicts.

Freud regarded the dream as the "royal road to the unconscious". Psychoanalysts can often use dream analysis as a way of gaining a deeper awareness of unconscious conflicts that might not emerge during conscious speech.

Dreams have both a manifest & latent content. The manifest content is the set of images and events which the person experiences while dreaming. The latent content is made up of unconscious impulses and repressed memories upon which the dream is based. Not all repressed material is expressed in dream imagery. Much of it is censored and distorted before it is translated into the manifest dream images. The client and the therapist work together in order to unravel these distortions, in order to arrive at the latent content, which tells the story of major conflicts in the unconscious. Usually the client focuses on each particular dream image, and makes free associations about that image to aide access to the latent content.

E.g. A house fails to resemble a place that is familiar to the dreamer.

After free associating on particular images of furniture for instance, the dreamer might realise that the house is an amalgamation of several different places where they have felt alienated or unloved.

Resistance

This is any action, thought, feeling or whatever that impedes the therapeutic process and hinders change. It is considered to be unconscious and a method of avoiding anxiety-provoking thoughts and feelings. By drawing resistance to a client's awareness it is hoped that they will then be able to deal the cause of the resistance.

Transference

Through awareness of transference the client can re-experience those issues that have been discarded into their unconscious and in so doing, hopefully alter their behaviour. Transference is the key in the relationship between the therapist and the client. Transference involves the **projection** of feelings towards people in your life, onto the therapist. This concept originated in Freudian theory, but has been useful for therapists of various orientations.

During the relationship the client uses transference to project their feelings and emotions toward significant others from their past onto the therapist. The therapist therefore acts as a replacement for these significant others and their client may project a whole range of feelings onto the therapist ranging from love to hate.

In order for the client to change they need to work through the unconscious material and defences that come to light during the therapy. In order for the client to achieve independence they need to free themselves from motivations that arose in their childhood.

Even during long-term therapy, not all childhood needs and traumas will be eradicated. Counter-transference also occurs whereby the therapist becomes aware of their own unresolved conflicts. It also occurs when a therapist's reactions within the relationship interferes with the therapeutic process, disrupting the therapist's objectivity. Counter-transference can be incorporated into the process and be used as another means of helping the client.

HUMANISTIC THERAPY

Humanistic therapy is based upon an interactive explanation of behaviour (unlike behavioural therapy or psychoanalysis which are based on a developmental approach to behaviour).

A *developmental explanation* of behaviour emphasises influencers from the past or present behaviour, for example, genetic history, past environmental influences, past psychological traumas.

An *interactive explanation* of behaviour focuses on present trends in the individual's life, which together exert influences on their behaviour; for example, present fears and goals, present environmental conditions.

Both explanations of behaviour are valid and necessary. Depending upon the individual's predicament, one approach may be more appropriate than another.

Example: If we are counselling a newly divorced woman, we may probably tend to explain her behaviour in terms of present influences such as social isolation and lack of self esteem.

On the other hand: imagine if a friend suffers from a nervous breakdown "out of the blue", so to speak. During the last five years, we have known her, and her life appeared to run smoothly. It may be appropriate then to investigate her past history, to determine any causes of anxiety or tension.

The most popular branch of humanistic therapy is "client centred therapy", as formulated by Carl Rogers. We will come on to this again later. The basic assumptions of client centred therapy are:

1. That the client is the best equipped person for understanding and solving their own problems.
2. That behaviour is less a product of external stimuli than a product of subjective reality.
3. That psychological conflict is the result of a conflict between the individual's self concept and actual experience.

The aim of the client centred therapist is to provide the client with a relationship and therapeutic atmosphere which facilitates growth, understanding and self acceptance. This helps the client overcome the incongruity between self concept and actual experience. One's self concept is usually based on a defined set of values. If the individual has an experience which contradicts this set of values, stress and anxiety are experienced.

Client centred therapists are not as directive as behaviourists or psychoanalysts in their techniques. They do not aim to modify or interpret the client's behaviour. Instead, they play the role of facilitator. This therapist provides conditions such as warmth, empathy, genuineness and unconditional positive regard.

Eclectic Approach

Most contemporary psychologists don't adhere strictly to only one particular theoretical orientation. Instead, they take what is useful from the different approaches and use them according to the situation they find themselves in. This is called the eclectic approach.

Evaluating the Effectiveness of Therapies and Counsellors

There is clear evidence that counselling and psychotherapy are effective, but it can be difficult to pin down exactly why. Subjective client reports and objective measures indicate counselling and psychotherapy are effective, in the short and long term. For some kinds of psychological distress, such as depression, there is evidence that counselling can have a positive interaction with medications such as anti-depressants. So counselling and medication together can offer better results than counselling or medication alone. Different types of conditions have also been found to respond better to certain approaches. For example, people with panic disorders seem to respond well to cognitive behaviour therapy.

No one type of therapy stands out alone as having overall effectiveness, but individual counsellors obviously do. Within certain approaches, research has shown significant variation between individual counsellors. There is evidence that the abilities of individual therapists can be a significant factor in determining the outcome of the counselling. So there are better and worse therapists!

Research has not yet been able to determine any particular accreditation or training which will definitely show a better or worse counsellor. But to become an effective counsellor, it is important to pick up effective counselling skills and continue to learn and develop throughout your career.

Case Study – Examples Of Different Types Of Therapy In The Treatment Of Ptsd

Treatment of PTSD - A National Center for PTSD Fact Sheet

(This leaflet is reproduced with the kind permission of the National Center for PTSD Website www.ncptsd.va.gov.)

This fact sheet describes elements common to many treatment modalities for PTSD, including education, exposure, exploration of feelings and beliefs, and coping-skills training. Additionally, the most common treatment modalities are discussed, including cognitive-behavioural therapy, pharmacotherapy, EMDR, group treatment, and psychodynamic treatment.

Common Components of PTSD Treatment

Treatment for PTSD typically begins with a detailed evaluation and the development of a treatment plan that meets the unique needs of the survivor. Generally, PTSD-specific treatment is begun only after the survivor has been safely removed from a crisis situation. If a survivor is still being exposed to trauma (such as ongoing domestic or community violence, abuse, or homelessness), is severely depressed or suicidal, is experiencing extreme panic or disorganized thinking, or is in need of drug or alcohol detoxification, it is important to address these crisis problems as a part of the first phase of treatment.

- It is important that the first phase of treatment include educating trauma survivors and their families about how persons get PTSD, how PTSD affects survivors and their loved ones, and other problems that commonly come along with PTSD symptoms. Understanding that PTSD is a medically recognized anxiety disorder that occurs in normal individuals under extremely stressful conditions is essential for effective treatment.
- Exposure to the event via imagery allows the survivor to re-experience the event in a safe, controlled environment, while also carefully examining his or her reactions and beliefs in relation to that event.
- One aspect of the first treatment phase is to have the survivor examine and resolve strong feelings such as anger, shame, or guilt, which are common among survivors of trauma.
- Another step in the first phase is to teach the survivor to cope with posttraumatic memories, reminders, reactions, and feelings without becoming overwhelmed or emotionally numb. Trauma memories usually do not go away entirely as a result of therapy but become manageable with the mastery of new coping skills.

Therapeutic Approaches Commonly Used to Treat PTSD:

Cognitive-behavioural therapy (CBT) involves working with cognitions to change emotions, thoughts, and behaviours. *Exposure therapy* is one form of CBT that is unique to trauma treatment. It uses careful, repeated, detailed imagining of the trauma (exposure) in a safe, controlled context to help the survivor face and gain control of the fear and distress that was overwhelming during the trauma. In some cases, trauma memories or reminders can be confronted all at once ("flooding"). For other individuals or traumas, it is preferable to work up to the most severe trauma gradually by using relaxation techniques and by starting with less upsetting life stresses or by taking the trauma one piece at a time ("desensitization").

Along with exposure, CBT for trauma includes:

- learning skills for coping with anxiety (such as breathing retraining or biofeedback) and negative thoughts ("cognitive restructuring"),
- managing anger,
- preparing for stress reactions ("stress inoculation"),
- handling future trauma symptoms,
- addressing urges to use alcohol or drugs when trauma symptoms occur ("relapse prevention"), and
- communicating and relating effectively with people (social skills or marital therapy).

Pharmacotherapy (medication) can reduce the anxiety, depression, and insomnia often experienced with PTSD, and in some cases, it may help relieve the distress and emotional numbness caused by trauma memories. Several kinds of antidepressant drugs have contributed to patient improvement in most (but not all) clinical trials, and some other classes of drugs have shown promise.

At this time, no particular drug has emerged as a definitive treatment for PTSD. However, medication is clearly useful for symptom relief, which makes it possible for survivors to participate in psychotherapy.

Eye Movement Desensitization and Reprocessing (EMDR) is a relatively new treatment for traumatic memories that involves elements of exposure therapy and cognitive-behavioural therapy combined with techniques (eye movements, hand taps, sounds) that create an alternation of attention back and forth across the person's midline. While the theory and research are still evolving for this form of treatment, there is some evidence that the therapeutic element unique to EMDR, attentional alternation, may facilitate the accessing and processing of traumatic material.

Group treatment is often an ideal therapeutic setting because trauma survivors are able to share traumatic material within the safety, cohesion, and empathy provided by other survivors. As group members achieve greater understanding and resolution of their trauma, they often feel more confident and able to trust. As they discuss and share how they cope with trauma-related shame, guilt, rage, fear, doubt, and self-condemnation, they prepare themselves to focus on the present rather than the past. Telling one's story (the "trauma narrative") and directly facing the grief, anxiety, and guilt related to trauma enables many survivors to cope with their symptoms, memories, and other aspects of their lives.

Brief psychodynamic psychotherapy focuses on the emotional conflicts caused by the traumatic event, particularly as they relate to early life experiences. Through the retelling of the traumatic event to a calm, empathic, compassionate, and non-judgemental therapist, the survivor achieves a greater sense of self-esteem, develops effective ways of thinking and coping, and learns to deal more successfully with intense emotions. The therapist helps the survivor identify current life situations that set off traumatic memories and worsen PTSD symptoms.

Psychiatric Disorders That Commonly Co-occur With PTSD

Psychiatric disorders that commonly co-occur with PTSD include depression, alcohol/substance abuse, panic disorder, and other anxiety disorders. Although crises that threaten the safety of the survivor or others must be addressed first, the best treatment results are achieved when both PTSD and the other disorder(s) are treated together rather than one after the other. This is especially true for PTSD and alcohol/substance abuse.

Complex PTSD

Complex PTSD (sometimes called "Disorder of Extreme Stress") is found among individuals who have been exposed to prolonged traumatic circumstances, especially during childhood, such as childhood sexual abuse. Developmental research is revealing that many brain and hormonal changes may occur as a result of early, prolonged trauma, and these changes contribute to difficulties with memory, learning, and regulating impulses and emotions. Combined with a disruptive, abusive home environment that does not foster healthy interaction, these brain and hormonal changes may contribute to severe behavioural difficulties (such as impulsivity, aggression, sexual acting out, eating disorders, alcohol/drug abuse, and self-destructive actions), emotional regulation difficulties (such as intense rage, depression, or panic), and mental difficulties (such as extremely scattered thoughts, dissociation, and amnesia). As adults, these individuals often are diagnosed with depressive disorders, personality disorders, or dissociative disorders. Treatment often takes much longer than with regular PTSD, may progress at a much slower rate, and requires a sensitive and structured treatment program delivered by a trauma specialist.

SO WHAT ARE COUNSELLING SKILLS

Counselling skills are the skills many of us use in our daily lives. They are the same as the counsellor will use as part of their job. But obviously the role of the counsellor is a bit more complicated than that, but counselling skills are very important to assisting them in that role.

Activity

Make a list of skills you consider are counselling skills. Consider the skills you use when communicating with others.

You've probably come up with a list similar to this –

Counselling Skills
Listening
Giving the speaker your full attention
Clarifying statements that are ambiguous or general
Creating a relationship with a person, so that they feel accepted, that is a warm relationship, creating a "rapport."
Problem solving
Planning actions to be taken and how to go about them
Summarising important themes and trying to get the person to see things from another point of view
Putting statements into your own words so the person you are speaking to knows that you have really understood what they are trying to say

Communication skills enhance almost every caring role. Counselling skills focus on helping people to express their feelings, as well as having an ethical basis to emphasise counselling values. Counselling skills are used to support the client's healing or decision making process, without the counsellor imposing his/her personal opinion on the client.

A central aim of counselling is that the person will have the inner resources that they need to help them decide what is best for them. The counsellor's role is therefore to help them find the resources they need and start to use them. When a person has explored what they think they can and cannot do, they are more likely to implement any changes and stick to their plan.

Many different jobs include helping people to change and supporting them to put that plan of change into action.

Activity

Make a list of professions where you consider they may use counselling skills to help people change and to implement their plans to change.

You may have come up with –

Teacher

Nurse

Social worker

Dentist

Doctor

Youth worker

Alcohol and addiction worker

Dietician

Manager and so on.....

Activity

Make a list of the difference between using counselling skills and listening as a friend.

You may have come up with a range of different answers. The main difference is that by using counselling skills, we are using specific techniques to establish a relationship and encourage a person to talk. Also, we should not be giving our opinion or trying to influence the person, we should be encouraging the person to come to their own conclusions. When listening as a friend, we may want to interrupt, to say what we want to say, give our opinion and so on.... Not always the same thing as the person we are listening to wants.

Methods of Learning

With more than 450 psychological and counselling theories on offer today, the main theories that have been tried and tested and have received consistent positive outcomes, are the one's

which are being used the most by practitioners. These theories have not only been tested for their reliability but for the validity as well.

An integrated or eclectic approach that is client centred and client driven will usually bring the best results. Being able to integrate the most effective communication skills, coupled with the most effective counselling theory(ies) takes time and persistence and patience.

The main learning techniques are:

- Experience
- Reading texts
- Practical counselling courses
- Counselling supervision
- Discussions with other counsellors

Counsellors who join professional associations (or other peak bodies) and who undergo ongoing supervision throughout their career will more readily be at the forefront of new techniques and theories, so that they can constantly upgrade and improve their skills. Hence, it is highly recommended that upon completing any course or book or work experience, a trainee counsellor continue to learn and upskill.

Most trainee counsellors will find a combination of practical consistent experience and ongoing reading to be most beneficial learning tools.

Counsellor training can be seen as being threefold:

- Reading about techniques in order to establish the general framework from which you are going to operate.
- Practicing those techniques in a professional setting
- Undergoing supervised training sessions to further develop and work on these techniques.

Many of us have 'natural counselling abilities'. We use them when we offer a shoulder to cry on or when we help our neighbour in distress or even just listen to the local shop assistant! Obviously some people are more talented than others in this respect. The goal of counselling training is to build on these natural abilities so that they become effective skills that can guide a person to consider the many possible solutions available to their problem, while validating their emotional perspective about the situation.

In order to be an effective counsellor, a person must learn to be client centred (based on the work of Carl Rogers). Counsellors must have a genuine/authentic and friendly warm manner with all people, regardless of their background, culture, race etc.. Possessing a non-judgemental attitude is essential for creating and building an accepting rapport. Remember too that counsellors do not need to be 'perfect'. In fact hiding behind a mask or pretending that you don't suffer from any of the regular everyday problems many people do, will actually alienate you from your clients. Being able to meet people where they are at and relate to them on their 'level' will help ensure that a warm trusting relationship is developed that will encourage clients to openly share and express their concerns. Finding your own personal style and balance in creating this professional environment comes with experience.

Micro Skills

The techniques available to the counsellor to improve the effectiveness of the counselling process are known as micro skills. These skills are usually learnt individually and applied to the counselling process. They become mastered (like second nature) through practice. Before we begin to cover these skills, let's take a look at what we might need to help practice them.

Triads

Triads are a valuable method of learning new counselling techniques for students. Within the triad, each person takes on once of the following roles:

- Counsellor
- Client
- Observer

For face-to-face practice, chairs should be arranged so that the counsellor and client face each other and the observer looks on (the importance of this will be addressed further on). For telephone counselling the counsellor and client should face away from one another while the observer looks on. The observer can then relay back information to the other two with regard to their body language, facial expressions, tone of voice and so on.

In counselling training, the students may be expected to meet weekly to practice. Each member of the triad should expect to receive feedback on their skills at each session. Therefore, each student must play each part of counsellor, client and observer each week. Videotaping of practice sessions is useful. The supervisor/trainer will also meet with the triad to observe the students' abilities to demonstrate the skills practiced and give written or verbal feedback.

When the student takes on the role of the client, the triad experience is more meaningful if the student is able to role play a realistic situation. The situation can be taken from people you know, your own past situations which you have resolved, or situations you make up. The more real the role plays, the easier it is for the counsellor in the triad to use appropriate counselling skills.

Problems with Triads

It is important not to use triads as a way to get counselling for your own problems. Therefore, it is important for students to only reveal information about themselves that they are willing for others to know about them. In other words, it is important to have clear limits on what you are willing to discuss in the triad. Whilst there is a need to set limits on the personal information revealed, but students should be willing to honestly evaluate their counselling skills development. A student's openness and flexibility to consider their strengths and weaknesses is important. It is also important for the student to seek out feedback as to their performance.

Trainee counsellors or triad participants may be reluctant to reveal problems due to:

- Lack of trust in others
- A belief that they will be rejected as counsellors
- A belief that they will become distressed
- A belief that they will not receive adequate support from the trainee counsellor

It is possible to role-play imagined problems or other people's problems, however it may be difficult to simulate problems and solutions to problems that you yourself are not experiencing. In such instances role-play may be a challenge and issues that are real life ones should be used instead.

Case Study

Alan is a member of a counselling triad playing the counsellor. Richard plays the role of client, Jeremy the role of observer. Richard pretends to have a history of depression. He is finding it hard to cope with his life as a full time worker, father and have a social life. Alan believes that this is truly how Richard feels and pushes for more and more information, using personal information he has of Richard's life to delve further. Richard, who is playing a role, starts to feel that this is intrusive and becomes reluctant to answer. Jeremy tries to encourage Alan to use this as a role playing exercise. Alan becomes more belligerent and argumentative with Richard, before finally storming out of the session. Consider the difficulties with this for Alan.

Past and current life experiences can affect a person's ability or inability to demonstrate helping skills within a class situation. Some helpers will try to take over more responsibility for the

client's problems. If this was the case, a tutor or supervisor would have to intervene to discuss this with the student. There is also the issue that students must follow the correct ethical standards, such as those of the Australian Psychological Society, British Psychological Society and so on.

Theory Into Practice

When applying micro skills it is important to use one at a time, and to build upon each one when you feel a certain level of mastery has been attained of the current skill being learnt. Even learning just one or two micro skills can produce an effective counselling session.

The observer should literally observe without making any judgements or interpretations (they can write details down so that it can more easily be revisited after). The information gathered can include everything from tone of voice to movement of the hands. The observations are fed back to the counsellor and client at the end of the triad session for evaluation. Comments need not be evaluative, merely observational facts without any personal interpretation.

Modelling

This is a valuable tool for observing the necessary skills required of a counsellor and may take different forms, i.e.:

- video
- demonstration
- observation of counsellors in real-life situations
- role-play

Note that throughout a counsellor's training they will be exposed to influences from other counsellors, supervisors and lecturers. Each counsellor needs to adapt their own unique qualities to the counselling setting, to develop their own genuine style.

Modelling can be highly useful however it can also have its pitfalls if the trainee counsellor is unaware they are having poor practice exemplified to them.

While some people may pick up on this instinctively, others may find it difficult to observe and therefore may make the same mistakes in their own practice.

Counselling individuals is a highly responsible position. A counsellor can, if not fully prepared and respectful of the process with a client, can cause more harm than good.

Be Prepared

Counsellors must begin each session by obtaining a clear and full background understanding of the client's situation. Completing a comprehensive yet concise history on the client will help collect the vital information required to proceed in the best possible way.

Example: Sarah was a new trainee counsellor who had learnt the skills necessary to conduct a professional counselling session. Within the first few months of practicing Sarah had a client who the intake officer at her place of work experience had told her was depressed. With only this brief information, Sarah proceeded to counsel the client believing that the client may respond to Rational Emotive Behaviour Therapy (REBT). What Sarah did not know was that the client had been diagnosed with bi-polar disorder and had taken herself off medication, and not advised Sarah. Because Sarah never asked, she had no idea of this vital background! Counselling sessions became more 'stuck' and Sarah eventually felt a failure when the client's symptoms gradually worsened.

The new counsellor should also be aware that there are vast differences between individual counsellor's average success rates, their case outcomes, and indeed that these differences can be attributable to the individual counsellor. Sometimes, a personality clash can obstruct the very best counselling technique and skills, and prevent effective counselling from taking place. If this occurs, the counsellor must always remember that it is never a sign of weakness or failure to refer a client on to another professional. In fact, to recognise this process and to act constructively to produce a better outcome for the client is a sign of a true professional.

Each counsellor should pay careful attention to the results of their labours, and continuously strive to improve their skills and outcomes.

Each counsellor needs to be aware of:

- The complexities of individual counselling processes
- The need to monitor client outcomes (short and long term if possible, as this gives useful feedback regarding the strengths and weaknesses of the counsellor)
- Being cautious and not to become complacent about their influential role
- Maintaining the aspirations to improve their counselling on a continuous basis
- Recognising that helping can be detrimental and to know the difference between a manageable client case and one that is way out of their capability.

It is advisable for counsellors to never show shock or alarm at certain factors that clients may disclose. This can have the effect of upsetting the client, or of creating fear for the client that the counsellor can not cope with the information being shared, breaking the trusting relationship.

Online and Telephone Counselling

Before going further, it is important to clarify the differences in online and telephone counselling. Telephone and online/email counselling are not done face-to-face so will have some similar and some different aspects to face to face counselling.

Telephone and email support may be appropriate for situations when a client wants to –

- Discuss ways of solving a problem.
- Find the energy to address a problem.
- Understand the psychological aspects of a situation better.
- Discuss ways to modify the client's behaviour.
- Discuss ways to modify the behaviour of others in certain situations.
- Generate new ideas or gain fresh perspectives.
- Access specialist knowledge and guidance.
- Build on progress already made in face to face sessions with a counsellor.

There are some situations that are not suitable for telephone or online counselling where the counsellor may suggest the client seeks an alternative form of assistance.

Activity

Can you think of situations where this might be the case?

The most obvious one is if the client finds telephone or email counselling unhelpful. It may be that they need the face-to-face situation.

Other situations where it might not be helpful are if –

- it is an emergency
- the client is suicidal
- there is a risk of violence
- the client is homicidal
- the client would value a face-to-face assessment of the situation
- there is evidence the client may have a mental illness
- a response from family or friends may be more effective
- there is a clinical indicator that telephone or email support may not be in the client's best interests.

Telephone counselling can be as productive and supportive as face-to-face counselling. The main difference being that body language is not a factor when working on the phone. This should not detract from the process can prove supportive, as distractions are kept to a minimum, which can help increase concentration and focus. Therefore, telephone counselling can work faster than traditional therapeutic encounters. Also, working with a telephone counsellor can enable some clients to express themselves more freely, as they have a sense of anonymity.

There are many different telephone counselling services available. For example, The Samaritans, Child Line and so on. Phone lines may specialise in certain problems, such as bereavement, domestic violence, addictions, mental health problems, rape, and victim support. They offer anonymity and can be a good source for information about other services that can help the client. Calls may be one-off or regular sessions. Some people find telephone counselling safer than seeing a counsellor face-to-face.

E-mail/online counselling Email counselling can prove as effective as face-to-face and telephone counselling, but it is again different. It relies on the written word and there is a delay in response times. The counsellor may ask more questions than usual to support their understanding of the client's issues. The client may not wish to answer all these questions, but the process relies on the client giving enough appropriate information to enable productive work to take place. The counsellor will also support the client on issues between sessions by giving them tasks and exercises.

Using email counselling may mean that the client will do a lot of work for themselves, guided and supported by the counsellor.

Case Study - An Example Of The Use Of Telephone and Online Counselling

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National Center for Post-Traumatic Stress Disorder, Department of Veterans Affairs
PTSD and Telemental Health - A National Center for PTSD Fact Sheet

By Leslie Morland, Psy.D., Carolyn Greene, Ph.D., Josef Ruzek, Ph.D., & Linda Godleski, MD

Many individuals in need of specialized PTSD services live in geographically remote regions, such as on tribal reservations or in rural areas. Because people with PTSD often use self-isolation to reduce stimulation, hyperarousal, and interpersonal conflict, people with PTSD are more likely to settle in remote areas with low population densities. Mental health care in these remote areas is generally only available on a limited basis - especially mental health care for PTSD. Traditionally, the individuals that need treatment do not get the services they need.

Sometimes an individual will travel a great distance to a larger city, or the clinicians based in the larger medical centres will travel a great distance to visit rural communities. As a result, providing PTSD care to these individuals can impose a tremendous financial, travel, or

personnel burden. Telemental health technology is increasingly easing these burdens by making PTSD clinical and educational services available in remote areas.

What is Telemental Health?

Telemedicine, also known as telehealth, uses electronic communications and information technology to provide and support healthcare when distance separates the participants (Field, 1996). Telemedicine uses various communication methods to connect clinicians and patients - in lieu of them meeting in person. The term *telemental health services* typically refers to behavioural health services that are provided using communication technology. These services include clinical assessment, individual and group psychotherapy, psycho-educational interventions, cognitive testing, and general psychiatry. The term *telemental health* describes the overall situation in which a clinician uses various technologies to deliver mental health care to a patient who is miles away. The major benefit of telemental health is that it eliminates travel that may be disruptive or costly. In addition, telemental health is a useful tool in situations, such as in correctional and forensic settings, where it is difficult to transport the patient to a clinician. Telemental health also allows mental health providers to consult with or provide supervision to one another.

Telemental Health Technology and Services

Although telemental health may utilize a variety of technologies, it is closely associated with video conferencing (VTC) technology. In VTC, a patient (or group of patients) in one location and a clinician in a different location each look at a computer monitor or television screen in order to see and hear each other in real time. Although many *psychiatrists* are employing telemental health technology, it is still considered an untapped opportunity for many psychologists, social workers, and counsellors (Maheu, Whitten, & Allen 2001).

In addition to VTC, telemental health also utilizes other technologies. Telemental health can make use of electronic mail (e-mail), electronic administration of psychological tests, online self-help groups, chat rooms, blogs, and websites. Mental health information on websites such as www.ncptsd.va.gov is available to anyone with Internet access. Some applications of telemental health, such as psychotherapy through e-mail, have been quite controversial and have not undergone scientific evaluation. In response to such controversies, professional organizations for both psychology and psychiatry have established committees to develop guidelines for behavioural telehealth (i.e., American Psychological Association Ethics Committee in 1997; American Psychiatric Association Ethics Committee, 1997). Plain old telephone service (POTS) is often not included in discussions of telehealth. However, telephones may be very useful; they provide a way for clinicians and patients to conduct simple program evaluations and the necessary aftercare. Most recently, virtual reality has been used to augment treatment for a variety of anxiety disorders and pain-management conditions. Virtual reality is a revolutionary new computer technology that enables clinicians to immerse their patients in a highly interactive, three-dimensional, computer-generated world.

This technology has already demonstrated clinical effectiveness for a variety of psychotherapeutic purposes including the treatment of PTSD (Rothbaum, Hodges, Ready, Graap, & Alarcon, 2001).

Telemental Health Applications for PTSD

While preliminary research has clearly established that a variety of telemental health modalities are feasible, reliable, and satisfactory for general clinical assessments and care (Frueh et al., 2000; Hilty, Marks, Urness, Yellowlees, & Nesbitt, 2004), much less is known about the clinical application and general effectiveness of telemental health modalities employed in the assessment or treatment of PTSD.

For individuals with a history of trauma exposure, the first step in getting the necessary treatment is to have an accurate assessment of psychiatric or psychological symptoms, related problems, and factors influencing functioning. The accuracy of a PTSD diagnosis is important for both treatment implications and benefit claims. Only one study has systematically evaluated a situation where VTC technology was used to conduct comprehensive PTSD assessments with veterans (Miyahira, Morland, Pierce, & Wong).

Only a few randomized clinical trials (RCTs) have been completed that assess the telemental health treatment of PTSD. Although formal outcome data have not been collected at these sites, anecdotal reports suggest strong support among veterans, local providers, and remote clinicians.

Researchers at sites such as the VA Pacific Island Healthcare System and the South Carolina VA Medical Centre are examining the efficacy of VTC group treatment for veterans with PTSD. Findings from pilot data suggest that the veterans, the clinic staff, and the remote clinician all viewed the VTC treatment as helpful. A comparison of the VTC group to an in-person control group revealed no significant difference between the two groups on measures of satisfaction and information retention (Morland, Pierce, & Wong).

In addition, the VA Pacific Island Healthcare System's Traumatic Stress Recovery Program has successfully provided a variety of telemental health PTSD clinical therapy groups to the neighbouring Hawaiian island Community Based Outpatient Clinics (CBOCS). These groups have included a 12-session anger management group (Green & Morland, 2004), a sleep hygiene group, and a PTSD coping-skills group.

Therapy provided over the Internet has been among the most controversial applications of telemental health services. However, Alfred Lange, et al. (2003), recently published the results of a controlled trial in which they provided psychoeducation, screening, and a protocol-driven treatment via the Internet for people suffering from PTSD and grief. More than 50 percent of the treated participants in this study showed reliable change and clinically significant improvement. The largest changes were seen in measures of depression and avoidance. Although it is too early to recommend web-based delivery of services, it is likely that the Internet will be increasingly used to supplement face-to-face care.

Most would agree that telemental health presents a more convenient and economical way to provide or supplement specialty care services to patients living remotely. However, research is still needed to determine the quality and clinical effectiveness of these services. There is still a great deal we need to know about how, when, and with what patient populations we can effectively apply this new technology. Based on early pilot studies, telemental health appears to be a promising way to offer skills-training and assessment from a distance to individuals with PTSD.

Clinical Considerations

Using telemental health for clinical work requires planning and preparation. It is important to consider logistics, such as preparation of the room and equipment, and to be sure there is technological and clinical backup support. It is also important to consider the patient's convenience and privacy. In the case of VTC services, the quality of the video images can be optimized by providing appropriate lighting and using stationary chairs. One essential key to working with PTSD patients is to establish a sense of safety, comfort, and trust. This can be challenging when the clinician is not physically in the room; however, there are tools and techniques that can be used to achieve these goals.

It is recommended that trauma-focused interventions, such as exposure therapy, *not* be provided using a telemental health technology such as VTC. There is a great possibility that the client will experience intense emotional distress with this type of treatment, and it may be very difficult to manage the discussion and contain the situation when providing remote services. Since telemental health is offered (in most cases) because there is not adequate or specialized

services at the patient's site, it is imprudent to open up an individual's traumatic experiences without having the necessary clinical backup available. However, telemental health can be used to successfully provide clinically significant interventions such as basic PTSD education, symptom management, coping-skills training, and stress management. Trauma-focused telemental-health interventions may be recommended in the future, following closer clinical and empirical evaluation.

Pros and Cons of Telemental Health For Patients With PTSD

Before deciding to provide a clinical intervention utilizing telemental health, it is important to carefully consider the patient's clinical needs and the potential benefits and costs. As with other remote services, it is important to consider what clinical support is available at the patient's site, and what availability there may be for follow-up care. A thorough evaluation of needs at a particular site is the first step. For more information on evaluating the need for telemental health at your site, you can link to the VA Toolkit (<http://www.va.gov/telehealth/toolkits.asp>).

Using telemental health to provide PTSD treatment can significantly reduce the costs, both in time and money, of having patients or clinicians travel to in-person sessions.

Telemental health allows a small community clinic to offer access to specialized interventions and specialists in PTSD, which the clinic would normally not be able to provide. Home-based telemental health has become a way for housebound patients to get the help that they need.

However, telemental health is not without its drawbacks. The equipment, maintenance, and fees for VTC, for example, can be costly. The quality of the equipment ranges widely, with lower-end equipment being quite unreliable. Clinicians need to be properly trained so that they can maximize the benefits of the technology and minimize technical malfunctions. Some technical malfunctions will inevitably occur, so it is recommended that the clinician have a backup technician available. There are significant clinical challenges when using telemental health for PTSD. Perhaps the biggest clinical challenge is that the clinician is not physically present to address crises such as suicidal thoughts and aggression, which are commonly associated with chronic PTSD. Having a backup clinician on-site with the patient is strongly suggested.

Although quality VTC equipment and connections can render extremely clear images, clinicians may find it somewhat challenging to pick up on nonverbal cues such as psychomotor agitation or poor hygiene. There is also a risk that the patient will not pick up on the clinician's warmth and empathy and will perceive the interaction as impersonal.

Because telemental health is still a relatively new phenomenon, it has not been thoroughly empirically validated. Ethical, clinical, and insurance-reimbursement guidelines are still in development. Clinicians must also be careful to follow interstate licensing rules when applicable.

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Copied from - http://www.ncptsd.va.gov/facts/treatment/fs_telemental_health.html

SET TASK

Get 2 people (e.g. friends, relatives, colleagues) to join you in a mock 'triad' counselling training session. Take on the role of 'observer'. Spend approximately 10 minutes on the session getting the 'client' to discuss a real or simulated problem with the 'counsellor'. Take notes and discuss your observations with the others.

Now get the other two to swap roles, and once again take notes.

ASSIGNMENT

1. What are the learning methods available to the trainee counsellor? Explain in your own words what difficulties might arise when first learning and applying micro-skills. Submit approx 200 – 300 words.
2. Give reasons why trainee counsellors might be unwilling to disclose their personal problems for use during trainee triad sessions. What risks can arise for those who are unwilling to do this? Submit approx 150 words.
3. Discuss different approaches to modelling as a form of counselling training, and their relative effectiveness. Submit approx 1 ½ - 2 pages.
4. Report on your set task. What did your observations tell you about natural counselling ability? Limit your answer to approx 1 page.

LISTENING & BONDING

Aim

To introduce the student to the skills of commencing the counselling process, helping their client to unwind, and making use of the skills of listening and bonding.

Listening and bonding are inseparable processes that are best discussed together. The relationship between a counsellor and client is unique and designed to encourage the client to talk about their deepest fears and feelings, sometimes even feelings they didn't know they had. The counsellor wants to make the client feel safe to express these feelings and emotions, such as anger, grief, pain and fear. These feelings may not be acceptable to other people that the client mixes with personally, so they are not able to express these feelings. Also, they will only express the feelings with the counsellor if they feel that they are able to do so and that the counsellor is dependable. A counsellor is effective, not just from having good intentions and liking people, but also from making a full commitment to undertake the counselling process and serving the client's best interests.

The unique relationship built up between the counsellor and the client has several important features that are important for a good outcome to the counselling process.

The counsellor should be reliable, punctual and there when sessions are booked.

The counsellor should not be judgemental. He/she should listen to things the client feels ashamed, scared, bad, guilty about and encourage the client to come to see them as unresolved feelings about their behaviour. Then use this as an opportunity to help them resolve these feelings.

The counsellor should not expect or require the client to consider their needs or values, as this should not affect their behaviour towards the client.

The counsellor should show warmth and interest in the client, giving them their full attention.

Other relationships may have some aspects of this relationship, for example, warmth, giving attention and so on. However, the main difference between a friendship, for example, and a counselling relationship is the reciprocity. The client speaks and the counsellor listens and offers support. The counsellor does not usually speak about their own life or experiences. An intimacy will develop, as often does when people share their life experiences, emotions and stories, but it will be different from taking turns in telling their stories.

Counsellors should be very good listeners and able to open up topics, rather than closing them down. Counsellors should not "explain away" things they are told, but encourage the client to respond and explain why they are upset and so on. For example, a client may come in and say they are upset because they are tired. The counsellor should not respond by saying something like "cheer up" or "you'll feel better soon", as this may not be the real reason they are upset, but the client may not want to reveal initially why they are upset. Think of it another way, have you ever done something silly, like dropped a bottle of milk and found yourself crying or extremely angry or irritated beyond what is rational for dropping a bottle of milk?

When this happens, do you often know that it is not due to the milk at all, but some other event(s) that have made you more sensitive or more angry or more upset, so when the milk bottle drops, it is like "the final straw"? So by responding in a "cheer up" way to someone feeling tired, the counsellor may not find out exactly why the person is really upset, as they have "shut them down" from discussing that conversation further. Or it will make the client work harder to bring this subject in to the conversation angry.

They should also take care not to divert attention to their own feelings. For example, “Yes, I know how it is, I’m tired out too, my baby kept me awake all night” or “Our neighbours had a loud party last night, so I’m shattered to”. Or if a client comes and says their partner has left them, “Oh no, I know exactly how you feel, that happened to me too and.....” and so on. The client has not come to hear about how tired the counsellor is or how the counsellor dealt with their relationship difficulties. They want to talk about their own. This may sound superficially selfish, but the client is coming to the counsellor for help with *their* problems. If they wanted to swap life stories and experiences, they could do this with a friend. Also, none of us *know* what another person is experiencing.

We may have exactly the same experience. Today you and I walk down the road and are both mugged at the same time by the same person.

Will we both feel exactly the same way? What if I was mugged yesterday or have been the victim of another serious assault. What if I had just been to the bank and had lots of money in my bag. What if a precious family heirloom was in the bag? What if you were an anxious person? And so on and so on.....We will all experience things in different ways because of our own personality and life experiences, so no one can say they know exactly how we feel. They can try to empathise (put themselves in our shoes) and think how we might feel, but no one knows. The only way they know how we feel is if WE tell them and tell them honestly. So the counsellor should avoid statements such as “I know how you feel because I went through that too.” They didn’t, no one has been through our life and our experiences in the same way as we have.

Also a counsellor should avoid any types of moral judgements, for example, “You shouldn’t have done that” or “Isn’t that illegal” or “that must have upset him”. Good listening does not mean that the counsellor is authoritarian, judgemental or directive, it means seeing the world from the client’s point of view and accepting their feelings, whilst helping them express their feelings, no matter how difficult or painful they may be.

Meeting and Greeting

In a face-to-face counselling session, the first impression the client receives from the counsellor is of utmost importance in shaping the early part of the relationship. Whilst bonding or building rapport generally does not occur in the first session, the client needs to feel comfortable with the counsellor in order for this to happen.

It is essential that the counsellor helps the client to feel at ease and able to relax. The counsellor should be neither superior nor inferior; but should be open, friendly and informal.

An awareness of cultural considerations is also important as different gestures can have different meanings across cultures.

You can also pick up a lot of information from observing the client’s body language, i.e. the sort of mood they are in, and perhaps how they see themselves.

Creating a Safe Environment

Activity

You walk into my building for our first counselling session. My receptionist tells you that I am running 20 minutes late. So you sit in reception and read a magazine. After 25 minutes, I call you in. I say hello and glance at my watch. I do not appear to remember who you are and start looking at some notes to remember, then start talking and asking how you are. The phone rings. I answer the phone without apologising and spend five minutes talking to the caller. At the end, I yawn and again look at my watch. After 15 minutes, I say that our time is up as I am late for another appointment. Write down what I did wrong and how it would have made you feel!

There’s probably a lot in here that would make you feel that the counsellor was disinterested and that you were in the way. Read through the notes now on creating a safe environment and

then come back to this activity and consider again how badly the counsellor behaved in this situation.

Meetings can go wrong because of poor management. The counsellor needs to be aware that sessions should be handled professionally and punctually to create a psychological connection and trust. Therefore, when counselling clients the counsellor should consider many different aspects of the situation to develop this relationship –

Location

The counsellor and client need a space to work together. This should be a quiet space without interruptions from phone calls, other people and so on. They should not answer the phone or expect anyone else to come into the session. The counsellor and client should not be overseen, distracted or overheard.

The room should be big enough to work in, but not too big to be impersonal. It should also not be too small to be uncomfortable. The counsellor and client should be able to hear everything that the other one is saying, without straining to hear.

Also, the counsellor and client need to be close enough so the counsellor can pick up the client's physical movements and non-verbal language. The counsellor also needs to be able to see the client clearly, to read their facial expressions, feelings and maintain eye contact to reassure the client that they have heard what they said.

The counsellor should not sit too close as this can appear threatening to the client. Ideally chairs should be moveable, so the counsellor can move away from, or nearer to, the client depending on whether they appear uncomfortable with the distance away from them. The chairs should also be of equal height so neither counsellor nor client is sitting above the other.

Lighting should also be considered. It should be bright enough for those with a hearing impairment to lip read. Physical barriers to communication should also be reduced, for example, there should be no desk between them, also the chairs should be a comfortable height, not too low to make the client uncomfortable. Tissues should be easily available in case the client wishes to use one, so that they can do so without embarrassment.

Duration and Time of Sessions

The counsellor should be responsible for suggesting how long the sessions last and their time. The client will depend on the counsellor's reliability. If the counsellor were late or forgot a session, the client may feel they are unimportant or let down. Counselling sessions will usually last 50 minutes to one hour. Sessions for children may be shorter or longer for couples/families. At the beginning, it should be made totally clear to the client how long the session will last, so the client knows this too. They should also be aware that at the end of this time the session will finish. Many counsellors will remind the client five minutes before the end of the session, so the client does not feel that the session has been abruptly terminated. A little flexibility is important, but it may not be good for the client to have longer sessions, as they could end up not using the time well.

Telephone and Online Counselling – Privacy

Activity

You phone a telephone helpline and are assured that the call is totally private. You begin to tell the counsellor something that is deeply disturbing you. Suddenly in the background, someone shouts, "Do you want a cup of tea, Bill?" You are then aware that the counsellor is not in the room alone and other people might be listening to what the counsellor is saying. How do you think you would feel?

Some telephone help lines will state that they are recording calls for training purposes, or there may be more than one counsellor in a room due to the issue of space. However, the client would not want to hear other people talking.

However, it is important that –

- All counselling calls are taken in private
- Closed doors are respected
- There will be no flippant talking, loud talking or laughing in the office when a call is being taken
- Eavesdropping should not be allowed
- Extension phones should not be left plugged in, to avoid interruptions to the call.

The counsellor also needs to be aware that the client's privacy may be disturbed. For example, if the client changes the way they are talking, becomes silent or hesitant, it may indicate that someone else has come into the room and the client doesn't want to talk in front of them. If this is the case, the counsellor could ask "yes/no" questions. For example, "Has someone come into the room?" "Would you prefer to phone back later when you are alone?" etc.

The Contract

When a counsellor meets a client for the first time, it is a good idea for them to spell out the details of times, duration and so on. It should be said briefly and put in printed form, so the client can take it away and read it. The counsellor will usually agree "ground rules" with the client, such as confidentiality, supervision, times and so on.

Helping the Client Unwind

During a pre-counselling meeting or intake, it is good policy to talk little to allow the client to inform us of those issues they wish to discuss during subsequent sessions.

During the first session, we may chat a little more to help put the client at ease. If, however, it is obvious that the client is on the brink of releasing emotional material it is better to remain relatively silent, and to assure them that it is OK to cry.

Clients vary in their willingness to talk. You may have to initiate their talking by asking them leading questions such as, 'what brought you here today?', or 'can you tell me about some of the main issues that are concerning you right now?'

It is also important to emphasise to clients who might want to rush through things that they can take their time.

Once a nervous client has started to talk it is necessary to encourage them by demonstrating that you are listening and attending to what they are telling you.

An important strategy is to get onto the same wavelength as the client to establish a harmonious relationship. This is called 'meeting the client where they are at'. We must also be careful to give out the right messages in our response to the client speaking.

Showing Warmth on the Phone

We have already mentioned that a counsellor needs to be able to show warmth. This can be harder on the telephone, but the counsellor should not try to hide their feelings as they are on the phone. There are two conditions to non-judgemental warmth – absence of judgement and communication of warmth. The telephone counsellor needs to be able to show they are not being judgemental and are genuine. Clients will be as least as sensitive to non-verbal cues as the counsellor is. They may be more sensitive, if they feel they are being judged or feel personal judgement from the counsellor. Most of the cues that show warmth rely on voice quality, so it is important to concentrate on the warmth in our voices, especially when working with clients on the telephone.

Activity

Why not record your voice over the telephone to see how you sound? Do you think you convey warmth? Play the tape to another person. What do they think? If you don't have a tape recorder, why not phone someone up who has an answer machine (with their permission) and just talk into the tape for a couple of minutes.

If you don't think your voice conveys warmth, how do you think you can change it? Do you know someone else who has a voice that you admire or you would like to emulate – the quality and tone rather than accent? Listen and observe how they talk.

Listening with Intent (Active Listening)

The primary task of the counsellor is to really 'listen to the client' and guide them towards finding their own solutions. Some clients may not be used to people "really" listening to them, so unless the counsellor gives their full attention to the client, they may be repeating previous cycles to the client. Trust must be earned before a client will speak of painful feelings to the counsellor.

The counsellor should try to encourage the client to talk about the things that are bothering them without interrupting unnecessarily. It is important to allow the client to talk as freely as possible.

The counsellor needs to attend to everything the client says, and to remember as much as possible. Remembering such things as family names and times in the client's history when certain events occurred will give the client confidence in the counsellor.

Listening with intent must be done so that the client feels valued and understood.

The 5 key elements of listening with intent are as follows:

- **Minimal Responses**

These can be a simple nod of the head, one word such as 'uh-huh', 'ok' etc., or several words. Timing is important; they should not be too frequent or too infrequent. The client should feel that the counsellor is paying attention to what they are saying but that they are not being interrupted.

It is also important to remain impartial to what the client is saying. It is the counsellor's role to be empathic, but not to agree or disagree.

- **Brief Invitations to Continue**

Once a client has finished talking it may be necessary to invite them to continue.

- **Non-verbal Behaviour**

Non-verbal behaviour may confirm or repeat what is being said during the counselling process. Studies show that between 65% - 95% of a message can be shown non-verbally. It can also be used by the counsellor to caringly challenge what the client is saying e.g. "you say that what they did, was not a bother to you, however I noticed that you clenched your hands together and sounded slightly upset when you said it". Body language may also emphasise what is being said, add intensity to what is being said or be used to control or regulate what is being said. There is little agreement on where the boundary between verbal and non-verbal communication can be drawn. This is especially so for non-word utterances such as clearing our throat.

As with other cultural factors, non-verbal communication can be interpreted by the recipient of the message. The interpretation and recognition of non-verbal messages can be subconscious and misleading in intercultural situations.

Whenever trying to understand non-verbal cues, the counsellor must exercise caution. The context in which it takes place provides a key to understanding. Matching a client's body language (mirroring them) is a great way to build rapport with a client.

This may include:

- o Matching non-verbal behaviour (however, if the client adopts a defensive posture, such as folding their arms and crossing their legs, then the counsellor may not wish to adopt this stance, but rather maintain a more open posture that signifies openness toward the client)
- o Physical proximity (leaning forward towards one another represents involvement, whereas slouching back represents disinterest or boredom)
- o Use of movement
- o Facial expression
- o Eye contact
- o Posture
- o Physiological responses (e.g. crying, sweating, trembling. A calm, accepting stance should be taken by the counsellor when physiological responses are expressed)

Non-verbal information can be used by the counsellor to get in tune with the client.

There are two main types of non-verbal communication –

Active behaviour – consciously controlled.

Passive behaviour – unconsciously displayed.

There are eight further main categories of non-verbal communication, these include:

Kinesics is nonverbal behaviour related to movement of part or the whole body. It is the most obvious form of nonverbal communication, but it can be the most confusing as it can have various meanings. Kinesics can be subdivided into five categories –

Regulators	These are non-verbal signs that regulate and maintain the flow of speech in a conversation, such as nodding your head, eye movements and so on. They give feedback that the person has understood a message, but may be confusing.
Emblems	Nonverbal messages that have a verbal counterpart. For example, in Britain putting the forefinger and middle finger erect can mean victory if your hand is one way round, or an insult if the hand is another way round. In America, it may just mean the number 2. In Australia, it may be seen as insulting.
Adapters	These include posture changes, movements at a low level of awareness to make us feel more comfortable.
Illustrators	These are less linked to specific words, but consciously illustrate what is being said. For example, holding your hands wide apart shows that something is big. However, use of illustrators depends on cultures. Some cultures will use more illustrators than others.
Affective Displays	These are body or facial movements that display a certain emotion. For example, showing anger. They can be subconscious, so this can be bewildering across different cultures.

Occulesics – This is the way the eyes are used during communication. This can be maintaining or avoiding eye contact. Occulesic movements are also associated with kinesic movements. For example, raising your eyebrow when looking at another person. Use of occulesics will again depend on culture. Lowering a gaze in some cultures may convey respect, but in others may be insulting. Length of eye contact is also different across cultures. In some cultures extended eye contact may be thought rude.

Haptics is touching behaviour. Touching can occur in different circumstances during a conversation. Some cultures touch a lot, whilst in other cultures, it may make people feel uncomfortable. Haptics can be hostile (hitting, kicking) or show the degree of intimacy. Such as whether a relationship is professional, polite, warm, loving or sexual. In a counselling situation,

it will be important for the counsellor to maintain a physical distance to avoid any misunderstandings in relation to physical contact.

Proxemics is our personal space and how it is structured. Personal space is the distance away from other persons and is a powerful non-verbal tool. The further an angry person is away from us, the less threatening we may perceive them to be, for example. If an angry person gets closer, the expression of anger may seem more threatening.

- Use of Voice

When we speak it is not just what we say that conveys a message, but also how we say it.

When seeking to create an empathic relationship it is important to bear in mind the effects of:

- Tone of voice (this can convey happiness, sadness, anxiety and so on)
- Clarity and volume (clients may speak less clearly and more quietly about issues of concern, and loudly when expressing anger and so on)
- Speed (some clients may rush through topics that are distressing to them)
- Word spacing, pauses and emphases also offer valuable clues as to what is of importance to the client
- It is perhaps most important in the creation of an empathic relationship to try to match the response of the client. That is, if the client talks fast, the counsellor talks slightly faster. Going against the client may only serve to upset them and make them feel that you are against them, rather than on their side. By doing this you can eventually dictate the pace by convincing the client that you are there for them.

- Starting a Counselling Relationship on the Telephone

When we sit in the same room as another person, we take body language and eye contact for granted. We rely on visual contact to see we are “there” with someone. However, on the telephone we are not so sure. We have to make psychological contact without the benefit of our vision. This means we have to use our ears and voice more than we would normally. For example, we may want to ask ourselves questions, such as –

- o How do I know the caller is a client?
- o How can I establish a good quality contact with them?

Also, if the person goes silent –

- o How do we know they are still there?
- o How do we know the client still wants to talk?
- o Does the client feel comfortable?
- o Does the client know the counsellor is still there?
- o Does the client know the counsellor is interested in what they have to say?

It has been suggested that telephone counsellors will use sound gestures. These are sounds and changes in our speech that we use to show more than what we are saying – communicating beyond words. For example, tutting, breathing, smacking our lips, talking faster, talking slower, speaking loudly, speaking softly, being silent and so on.

- Use of Silence

It is an equally important part of counselling to be able to read moments when silence may be appropriate. If a client is unused to being listened to or not sure how to begin, sometimes the best way is for the counsellor to stay quiet, until the client is comfortable saying what they want to.

This could be straight after a particularly emotional outpouring when the client may need time to assess what they have just said. Silence is most effective when the client is engaging in self-analysis.

Eye contact should normally be maintained so that the client realizes that the counsellor is still highly interested in what they have been saying or are thinking. The counsellor may choose to nod, or use other non-verbal responses to acknowledge the client. There may be other times when the counsellor should break eye contact in order to allow the client some space.

The counsellor may also use silence to ‘challenge’ the client to come up with a response that emerges from the silence. Challenging will be discussed later in this course.

Case Study – Use Of Counselling Skills In Disaster Counselling

DISASTER COUNSELING SKILLS

Disaster counselling involves both listening and guiding. Survivors typically benefit from both talking about their disaster experiences and being assisted with problem-solving and referral to resources. The following section provides "nuts-and-bolts" suggestions for workers.

ESTABLISHING RAPPORT

Survivors respond when workers offer caring eye contact, a calm presence, and are able to listen with their hearts. Rapport refers to the feelings of interest and understanding that develop when genuine concern is shown. Conveying respect and being non-judgemental are necessary ingredients for building rapport.

ACTIVE LISTENING

Workers listen most effectively when they take in information through their ears, eyes, and "extrasensory radar" to better understand the survivor's situation and needs. Some tips for listening are:

Allow silence - Silence gives the survivor time to reflect and become aware of feelings. Silence can prompt the survivor to elaborate. Simply "being with" the survivor and their experience is supportive.

Attend nonverbally - Eye contact, head nodding, caring facial expressions, and occasional "uh-huhs" let the survivor know that the worker is in tune with them.

Paraphrase - When the worker repeats portions of what the survivor has said, understanding, interest, and empathy are conveyed. Paraphrasing also checks for accuracy, clarifies misunderstandings, and lets the survivor know that he or she is being heard. Good lead-ins are: "So you are saying that . . ." or "I have heard you say that . . ."

Reflect feelings - The worker may notice that the survivor's tone of voice or nonverbal gestures suggests anger, sadness, or fear. Possible responses are, "You sound angry, scared etc., does that fit for you?" This helps the survivor identify and articulate his or her emotions.

Allow expression of emotions - Expressing intense emotions through tears or angry venting is an important part of healing; it often helps the survivor work through feelings so that he or she can better engage in constructive problem-solving. Workers should stay relaxed, breathe, and let the survivor know that it is OK to feel.

SOME DO'S AND DON'T'S

Do say:

These are normal reactions to a disaster.

It is understandable that you feel this way.

You are not going crazy.

It wasn't your fault, you did the best you could.

Things may never be the same, but they will get better, and you will feel better.

Don't say:

It could have been worse.

You can always get another pet/car/house.

It's best if you just stay busy.

I know just how you feel.

You need to get on with your life.

The human desire to try to fix the survivor's painful situation or make the survivor feel better often underlies the preceding "Don't say" list. However, as a result of receiving comments such as these, the survivor may feel discounted, not understood, or more alone. It is best when workers allow survivors their own experiences, feelings, and perspectives.

KEN-01-0096

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Activity

You will remember that you did an activity above. Just to remind you –

You walk into my building for our first counselling session. My receptionist tells you that I am running 20 minutes late. So you sit in reception and read a magazine. After 25 minutes, I call you in. I say hello and glance at my watch. I do not appear to remember who you are and start looking at some notes to remember, then start talking and asking how you are. The phone rings. I answer the phone without apologising and spend five minutes talking to the caller. At the end, I yawn and again look at my watch. After 15 minutes, I say that our time is up as I am late for another appointment. Write down what I did wrong and how it would have made you feel!

Using the notes you've just read through, reconsider your list. Is there anything you've missed or have thought of that the counsellor could have improved upon?

Dealing With Silent Telephone Calls

Some clients may phone and be silent. There are three main types of "silences" –

There are pauses in the conversation, of varying length, where the client does not speak.

The call begins with silence and continues until you or the client ends the call.

There has been a call where the client has spoken, but he/she suddenly goes silent and you or they end the call.

These silences can last for minutes or in some cases hours. This will depend on the policy of the agency that the counsellor works for, as they may often set a time limit for how long a silent call should be listened to.

In face to face counselling, the counsellor will make use of silences to encourage the person to speak. However, on the telephone this is slightly different. Counsellors aim to establish and maintain contact. When they are denied visual contact, the only way to do this is verbally. This means that on the phone, the counsellor has to talk to the client, even though they may remain silent. If a person stops speaking, the counsellor has to determine whether the client is still there, why they are not speaking, how they are feeling, is their silence trying to communicate something, can you hear anything?

At the same time, it is important to establish for the client that YOU are still there. They cannot see you either. So the counsellor needs to make statements to ensure the client knows this.

For example –

“I’m still here”

“I’m listening”

“It sounds as though you are crying”.

“If you don’t want to talk at the moment, please tap the phone so I know you’re still there.”

“It’s ok to say nothing, I’ll just wait until you are ready to talk.”

“If someone has come into the room and you don’t want to talk, that’s fine. I’ll wait or you can call me back.”

If the counsellor gets no response, then saying something every 15 – 45 seconds is helpful. This may feel awkward at first, but will help establish to the client that you are still listening.

Silences mean different things to different people, so the counsellor should not try to interpret the silences – for example “that’s an angry silence”, “that’s a sad silence” etc. etc. You don’t KNOW as you can’t see the person. Methods of terminating silent phone calls are dealt with in lesson 8.

Absence of Face-To-Face Cues In Online Counselling

The absence of face-to-face cues can have a large impact on the counselling relationship as we cannot see their faces AND we cannot hear them speak. So even the subtle cues from voices we may experience on the telephone are lost. People who converse in written form frequently can develop a sophisticated, expressive way of communicating with others. But this may not be the case for the client.

The lack of face-to-face cues can create an ambiguity in the message. Without seeing their body language, we may not be sure what a person means. This can stir our imagination or force us to project our own ideas or wishes onto the person.

As you spend more and more time writing to a particular person, you may develop some mental image of the person and what they are like. We may not be aware that we have done this. However, if we then meet or speak to the person, we may find that they are very different to what we expected them to be like. This is a unconscious transference reaction, which can cause counsellors to get lead astray into what they think the client wants, rather than what the client actually does want.

In online therapy, the client and the counsellor can have misconceptions. The counsellor and client can see those words and make judgements that are not effective. The counsellor will need to help the client to explore what and how they are saying things and encourage them to become more effective in their written communication.

Activity

The lack of face to face cues will have different effects on different people. Think about how it might affect you!

You may have come up with some of the following reasons –

It may reduce the sense of intimacy, trust and commitment in the counselling relationship.

Typed text can feel impersonal, lacking intimacy, lacking empathy and so on.

Some people need face to face cues.

They may feel less able to be honest and close.

Some people may like the ability to be distant from the counsellor, but consider whether this will lead to an effective counselling process.

However, online counselling can lead to disinhibition, where the person feels more able to open up about themselves and say things they would not in a face to face situation. They may reveal secret emotions and fears. The counsellor may feel more able to make important interventions than perhaps they would be face to face. Online disinhibition can make the person lose the psychological barriers that normally cause us to block the release of our innermost emotions and fears. There are two factors that come into play. The client may be experiencing one or both of these factors –

Invisibility The counsellor cannot see the client. Invisibility gives the person the courage to do things they wouldn't otherwise perhaps. The counsellor may know a great deal about them through the online environment, but cannot see or hear them. So the person does not have to worry about how they look or sound or present themselves. They can look bored, indifferent, shake their head and so on.

Whereas in a face to face situation, they may not feel able to do this, they may feel they need to be polite to the counsellor, rather than show boredom for example. It is also easy for the person to avoid eye contact, so they have an opportunity to build up a counselling relationship without this important counselling tool.

Anonymity The counsellor does not know the client. They may give a false name or give no name at all. They can then separate their lives and actions from their real world and real identity. They may feel less vulnerable about opening up to the counsellor. The person can take actions and say things they wouldn't usually, then say that "that wasn't me", "I wouldn't really do that" etc. This is called disassociation.

The client may also start to find some other factors that cause disinhibition with online counselling. For example –

Delayed reactions The online counsellor may not respond immediately, so not having someone's immediate reaction can cause disinhibition. They can say what they like and the other person has to listen, but then they don't get the other person's opinion back straight away. The person may also feel they can say something online that they would not usually say and there is no consequence to that. They do not have to speak to the counsellor again if they do not want to.

Solipsistic introjection – This means basically, "it's all in my head". Online, the person may sometimes feel that their mind has merged with the mind of another person. They might find reading the other person's message almost as if it is in their head. They may assign a voice to the person. They may also assign a visual image to the person. The online person becomes an individual to us and can become "real" in our minds. As already mentioned though, the person we *think* they are, may not be the actual person. The person can then begin to weave fantasies and imaginations about the person they are speaking to, which can lead to disinhibition.

Status Neutralisation – This is the idea that we are equals. We do not see the counsellor, their clothes, their office, the certificates, so assume we are equal. We start on a level playing field, so this may reduce our feelings of authority and perhaps the respect towards the counsellor. People may be more willing to speak out because they feel they are the equal of the counsellor in this situation.

Online disinhibition is not the only factor that affects how people open up with online counselling. Our personality, defence mechanisms, emotions, compulsions and so on can affect the relationship.

SET TASK

Observe an interview on the TV, or listen to one on the radio (if you do not have either, observe a conversation between 2 people perhaps at a restaurant, on a bus etc.). Pay particular attention to the use of minimal responses, verbal and non-verbal. Make notes of your observations.

ASSIGNMENT

1. What is the counsellors' primary role? What are the benefits of a counsellor talking less and acting as a guide towards solutions? Submit approx 200 words.
2. Minimal responses are an important means of listening with intent. How can they be used to pass on messages to clients? What are the dangers of expressing too much through minimal responses? Submit approx ½ page (200 words).
3. List different types of non-verbal response. How are they important in the counselling procedure?
Submit approx 1 page.
4. Report on your set task. How frequent was the use of minimal responses? In your opinion were they used effectively? Submit 200 – 300 words.

REFLECTION

Aim

To convey to the counsellor an understanding of the notion of reflection of content, feeling, and both content and feeling, and its appropriateness to the counselling process.

There are different ways that the counsellor can reflect what the client is saying in order to bring about clarity of important details that the client is disclosing and so help the client make more sense of them.

Okun (1997) describes reflection as:

"communicating to the helpee our understanding of his or her concerns and perspectives. We can reflect stated or implied feelings, what we have observed non-verbally, what we feel has been omitted or emphasized, and specific content." \$

Another Example of A Counselling Theory - Non-Directive Counselling

Many counsellors use a number of techniques with their clients. Carl Rogers developed this technique to allow individuals in emotional turmoil to talk about their problems and difficulties with the minimum direction from the counsellor. Rogers believes that everyone has the motivation and ability to change to become a "better" or self-actualised person. To achieve this state, the counsellor acts almost as a sounding board, observing, listening and responding within certain guidelines, whilst the client explores the problem, analyses it and comes to their own personal solution. The counsellor should always be non-punitive and accepting, so the client feels comfortable to express their feelings and therefore facilitate positive change.

There are five basic responses used in non directive counselling.

Reflection – this is the restating of a client's comment, using the same terminology to reflect you are listening.

A leading statement or question – to encourage the student to elaborate on a topic or devise a solution to a specific problem.

Clarification – this involves stating the implied feelings behind a statement. "You seem unhappy", "you seem angry about...." This can help the client to identify their feelings.

Summarization – this is a summary or review of the counselling session so far, where the counsellor and client can reflect on what has occurred and continue.

Questioning – there are two main types, closed questions – yielding specific information, and open questions – designed to encourage a client to talk at greater length.

We will cover some of the counselling techniques used within non-directive counselling throughout the rest of the course. Counsellors using other theories will also use some or all of these techniques.

Paraphrasing

The most usual and possibly most effective method of dealing with this is 'paraphrasing'. By using this skill the counsellor reflects back to the client what they have said. When using paraphrasing the counsellor re-words what the client has said and picks out the most important bits for emphasis.

By doing this the counsellor is able to reflect back to the client the most important parts of what they have told the counsellor. Paraphrasing can be seen as a response to the client's experiences, thoughts, and/or behaviour.

It is possible for the counsellor to complete a successful counselling session just using paraphrasing and minimal responses, provided they are skilled at accurately and clearly reflecting the content of what the client has said.

A paraphrase –

- Does not contain most of the words or phrases of the original.
- Is not a summary.

- Includes all minor details from the original sentence.
- Once paraphrased, the meaning of the sentence should be clearer.
- It is usually shorter than the original.

Activity

Try out some paraphrasing. Ask a friend or family member to say some sentences. Practice paraphrasing them back. Or if no one is available, use text from a book or magazine, or watch the television for examples.

A few examples to help you –

“I’m so fed up this morning, I got up late, the car kept juddering and juddering, and I couldn’t get it to go. Then I missed the bus, so I was really annoyed by the time I got into work.”

Paraphrase –

“You’re not happy this morning as you had a lot of practical problems with your car and the bus, which made you late for work”... or similar.

You may find paraphrasing hard at first. It is a skill, like any other, which takes time and practice.

Paraphrasing can be one way of developing empathy with a client. It can seem unnecessary to paraphrase what a person has already said, but if we communicate it with a general desire to understand, it can be reassuring to the client. A client may not have spoken about their issues before, so by rephrasing what they say, we may provide them with the opportunity to reflect on it objectively or modify our paraphrase to help us get a better picture of what they have said.

Responding Inappropriately

Every counsellor is prone to make inappropriate responses on occasion. This should not be viewed as a disaster, but rather as another tool to work with. The subsequent interaction between client and counsellor can be used to explore the client-counsellor relationship further.

Parroting

This is literally repeating word for word what the client has said. It can be used to add weight to the last few words a client has uttered, or to assist the client to finish an unfinished sentence. It should not be used to replace paraphrasing, which is a far more effective tool for making the client feel valued and understood.

Feelings

Facts gain importance by the amount of emotion and feelings we attach to them. Counsellors work with facts and feelings too. By changing the way a client feels about facts, they can begin to make new choices about who they are and what to do next.

Early experiences or life events can leave us with habits, self-destructive behaviours and so on, which can lead to unsatisfactory relationships, difficulties expressing emotion and so on. Traumatic events can lead to strong bodily reactions or emotional responses, panic, phobias and reminders of the original events. Unless a client is able to talk about their emotional response to an event, they are less likely to be able to talk about its meaning for them in the past and present. Some people may find the feeling confusing, for example, they have heard a family story many times where everyone else is happy, but they remember feeling scared. Why? What meaning did that story have for them? It could be that at the time, no one listened to the client’s fears, so they have affected the way they dealt with similar situations and viewed that situation in the future.

Counselling therefore enables clients to reassess the “facts” about their lives, come to terms with their life stories, consider any misunderstandings and so on. Understanding how memory works is essential for counsellors. You may have heard in the past about false memory syndrome where adults came to believe that they were abused as children, when the adult denied this happened.

Some adults came to believe they were abused and this caused their problems, when in fact the abuse was a “false memory.” This is not to say that people do not “forget” abuse by repressing their feelings and memories, then this abuse can come to the surface later in their lives, perhaps in counselling. But these are two separate things – a resurfacing of a memory they had repressed of earlier abuse or a false memory “created” during the counselling process.

How Do Clients Show Their Feelings

Clients can show their feelings through actions and words. Actions include body language such as nodding, smiling, blushing, going pale and so on. Learning body language can take time and experience. The less experienced counsellor may find client's reactions bewildering and irrational, coping with these reactions takes practice, training and supervision.

Reflection of Feelings

This is similar to and yet different from paraphrasing.

The similarity lies in the fact that information is reflected back to the client. The difference lies in the fact that this information relates to feelings rather than information and thoughts. It is considered as being synonymous to empathizing and involves the counsellor imagining themselves in the client's position and trying to see things from the client's perspective. Even if the counsellor has not experienced the same feelings that the client has had by making it clear that they desire to understand the client's feelings.

It is often the case that clients avoid their feelings because they don't want to deal with them. By avoiding them, they tend to achieve little and just go around in circles. It is important for all of us to get in touch with our feelings so that we can move on and feel better emotionally.

It is an important role of the counsellor to encourage clients to experience their feelings and engage in their emotional release, through crying, laughing, shouting or whatever. This process is known as ‘**catharsis**’.

Example

Mary experienced a bad traffic accident in her 20s. At the time, her friends thought that she coped very well. She sorted out her insurance, recovered from her injuries and continued with her life as if nothing had happened. In her thirties, Mary became depressed and withdrawn. There was no particular event that had caused this. Mary went to see a counsellor. She kept going back to the crash in her twenties. The counsellor asked if she still felt upset by this. Mary broke down in tears and cried and cried. She had not cried at the time and had therefore not released the emotions that the accident had evoked in her. Ten years later, these pent up feelings were causing her upset, and lead to her depression. By crying and discussing the accident with the counsellor, she was able to experience catharsis.

Activity

Think of examples of when you have experienced catharsis. They do not have to be within the counselling situation. It can be simple, such as shouting at a friend who had annoyed you for years, crying when someone upset you and so on. Whatever the situation is, the feeling after you have released your emotions should be one of release or relief. If you shout or cry, but did not feel that release or relief, this is not catharsis. For example, if you shouted at a friend, then felt guilty and bad for doing it, it would not release your emotions, but cause other emotions of guilt etc.

However, in the minority of cases, there are people who are continuously in touch with their emotions and who would benefit more from a more cognitive behavioural approach.

Egan (1994) draws a distinction between empathy and advanced empathy. The latter comprises of observing a connection, a theme, and playing a hunch.

Playing a hunch is where the counsellor follows his/her intuitive sense of what might be going on within the client. This can only occur once a trusting relationship has been established and involves the counsellor presenting new information to the client so that they can think over this new information and then later the counsellor may ask them to reflect on this new information.

Hunches should be delivered tentatively as they represent a challenge, and are therefore of a confrontational nature.

Thoughts v Feelings

It is necessary to distinguish between thoughts and feelings. A good method is to consider that feelings can usually be described by one word, e.g. 'I feel *angry*', 'I feel *sad*.'

Thoughts usually require a series of words to describe them, e.g. 'I feel that if my partner continues to prevent me from being able to express myself I will be angry'.

Even though the sentence begins, 'I feel', it does not in fact relate to feelings, but thoughts instead.

You may find that some clients will focus more on "thoughts", whilst others will focus more on "feelings".

Activity

Think of these sentences –

"I feel so stupid all the time, I just can't work out how to do these accounts. There must be something wrong with me."

"I don't think I can do these accounts".

Reflect on the sentences briefly, consider what they say to you. The first sentence may suggest to you that the person has low self-esteem, can't do the accounts because THEY are stupid. Whilst the second sentence, again suggests the person can't do the accounts, but they THINK they can't. They do not mention being stupid or anything else. It is a statement of their thoughts.

People can become confused with what are thoughts and what are feelings. Our feelings are our emotions and how we feel about events. Our thoughts are basically statements that we think are correct. If a client is continually referring to their emotions, you may find that much of their life focuses around their emotions –

"I couldn't go out today, I was so upset."

"I get so anxious at the thought of it."

"I really fed up today". Etc. etc.

However, we must be wary of clients who express everything they say as if it were a rational thought.

"I didn't go out today. It was raining, so I thought it was best to stay in."

"I wasn't that keen on going to the party, so I decided to miss it."

"I had a quiet day today."

The client may be trying to rationalise or intellectualise their feelings. They may not have gone out, because they were anxious at the thought of leaving the house, they may not have gone to the party, because they have a social phobia, for example. But because they rationalise their feelings, it may appear that they do not have any difficulties. The counsellor needs to be aware that people will express themselves in different ways, sometimes as a defence mechanism.

You may find it useful to re-read the section on defence mechanisms in lesson 1.

Reflection in counselling

Counsellors need to be able to identify a client's feelings so as to be able to reflect them back to the client. It would not necessarily have to contain the words 'feel', but could simply be something like 'you're angry'.

Words that describe a client's feelings can be arranged in terms of strong / medium and mild feelings along a continuum.

For example the same feeling could be 'tired' (mild), 'weak' (medium), and 'powerless' (strong).

Client Responses to Reflection of Feelings

Crying

If a client wishes to cry or begins to cry, then the counsellor ought to allow them to do so uninterrupted, so that they do not interfere with their internal processes.

It is important for the counsellor to be prepared for the client response. If you sense that the client will break down in tears, then you must prepare yourself for how you are going to deal with that too.

Anger

Clients may respond to anger in a variety of ways. If a counsellor reflects back anger the client may deny it or may project their anger onto the counsellor. A good counsellor will feel comfortable with this because they have still enabled the client to release anger and they may feel better for it.

Abusive calls and silent calls are issues that telephone counsellors may have to deal with. We have already discussed silent calls earlier. Angry clients can pose a threat and we will discuss this in more detail in Counselling Skills II.

Case Studies

Consider the following and write some notes on how you would respond to them as a counsellor.

Case Study 1 – Mary is a very attractive, 24 year old, single woman. She tells you she is having an affair with a married man who is 40. She starts to cry uncontrollably.

Case Study 2 – Angela is 40. She has just found out that her mother is dying of cancer. She only has weeks to live. Angela says she is glad.

Case Study 1

This may raise a number of issues for a counsellor about the counsellor's values and how a counsellor can react to tears. The counsellor will need to find out what the tears mean and what the cause of her distress is. It may not be as simple as you think. If someone cries uncontrollably, it is useful not to interrupt or distract them, so they can cry for as long as they need to (as long as it does not go beyond the length of the counselling session). When they stop, ask them what is troubling them. It may not be the person's age or marital status that is bothering Mary, it may be something else, so the counsellor does not have the right to say whether or not she should be having this relationship or to assume that this is what is wrong with her. However, counsellors are human too. If the counsellor has recently had a marital breakdown because their partner had an affair, they may not feel able to support Mary effectively. Also, some counsellors working in pastoral services may wish to uphold a certain position based on their religious faith. If the counsellor is too concerned with the wife's feelings or how Mary will maintain the relationship in the future, he/she may not be focussing fully on what Mary needs from the counselling sessions.

The gender and sexual orientation of the counsellor may make a difference also. Mary is an attractive woman. Counsellors are prohibited from having relationships with their clients and ex-clients, but the counsellor may find the client attractive or Mary may come to find the counsellor attractive. Therefore, he/she must be careful not to overstep the boundaries by making any inappropriate comments or behaviour.

Case Study 2

Angela has revealed unexpected emotions that may shock you. The counsellor's own experience is relevant here also as they may have suffered a recent loss or lost someone to cancer, so may find it harder to give their full, unbiased attention to the client. The counsellor will want to explore the feelings the client has. Angela may have a mixture of different feelings. Losing a parent is a significant loss, but Angela obviously has some difficult emotions about her relationship with her mother. Dealing with bereavement in this sort of situation can be very difficult for the person, as they may find it hard to grieve. The client may be glad that her mother is dying, because she is in pain and she wants to see an end to her suffering. Or she

may hate her mother and want her to suffer more. The counsellor will need to determine what support Angela wants – she may want support to explore her hatred of her mother. The counsellor should not make comments such as “you don’t mean that”, “you don’t really hate her” etc. etc. as this is not helpful to the client. The counsellor may also provide Angela with information on local support groups for people with relatives dying of cancer.

Reflection of 'Content and Feeling'

All the skills mentioned to date in this course are collectively known as 'Rogerian Skills', as they were identified and used by Carl Rogers. See earlier in the lesson for a reminder of Non-directive counselling.

These skills stand alone as being the most important skills that a counsellor needs to master. Once they have been fully learned, other skills can be added to them.

Rogers also combined reflection of content and reflection of feeling to form a single response.

The secret is to keep these responses as short as possible once again so as not to intrude on the client's inner processes. You do not want to remove the client from their own world that they are trying to express and deal with, but rather you want to allow them to remain in that world.

What to Reflect

Obviously there are times when it is better to choose one type of reflection as opposed to another.

It is often the case that reflection of feeling alone is enough. This is particularly poignant when trying to get a client to experience feelings that they have been avoiding. You would not wish to attach a cognitive element to the reflection that may draw them away from what they are experiencing emotionally.

It is the role of the counsellor to encourage the client to express their feelings as much as possible, rather than deal with thoughts at a cognitive level.

Although this can be a painful experience it is also cathartic and therefore beneficial to the client.

There are those (minority) clients previously mentioned who find it hard to deal with high levels of emotions, and for whom a more cognitive approach is desirable.

Effective counsellors should try to see the world the way their client sees it. By empathizing with the client they are able to see the problems as the client sees them and then are better able to explore these problems.

Activity

Try to provide a reflection response to the following –

- "I was really embarrassed. I wanted to curl up and die."
- "Why are you looking at me like it's my fault? What about Mary?"
- "I'm stupid and a waste of time, I can't do anything right."

Remember to reflect the feelings not the words they have chosen.

SET TASK

The assignment questions in this lesson are going to be based upon your set task.

Get together with a friend, relative, colleague etc., and get them to talk about a problem that they are having, or have had in the past (nothing too serious, it can be anything that has / does bother, frustrate or annoy them).

Try to restrict your contribution to 1/ paraphrasing the information your 'client' supplies you with, 2/ using minimal responses and, 3/ reflecting their feelings.

You may need to record the conversation (with their permission) so that you can concentrate on the interview and not on trying to remember what is being said.

You may have to try a number of times or attempt the same procedure with several different people.

(If you still find that you are unable to use the micro-skills effectively, that's ok... we learn through our mistakes and through practice. You can still use your interview to work through the questions).

ASSIGNMENT

1. Submit a transcript of the discussion you had in your set task (or a sample of it if it was very long). Indicate an example of where you have paraphrased, used a minimal response and reflected feelings.
2. With regard to your example of paraphrasing:
Was it effective in enabling your 'client' to see things more clearly? Why?
(If not, how might you have paraphrased differently?) (Submit approx 200 words).
3. With regard to your example of reflection of feelings:
Do you think that your 'client' experienced catharsis? Why?
Can you site any examples of where either yourself, or your 'client', has confused thoughts and feelings. (If not, explain how sometimes they can be easily confused). (Submit approx 200 words).
4. Can you pinpoint an example of where you have reflected back both content (thought) and feeling in the same phrase? If not, can you see anywhere that you may have done so, or do you think that it would have been inappropriate? Submit 100 – 150 words.

QUESTIONING

Aim

To introduce the student to different questioning techniques and their usefulness in the counselling process.

Questioning is an important part of counselling, but should be kept to a minimum. The idea is that when seeking to deal with a client's emotional material, the counsellor should not need to ask too many questions. Rather, they will be able to glean most of the information they need by reflecting content and feeling and using the other skills mentioned so far.

Within the counselling process the counsellor should restrict themselves to asking questions that are of therapeutic value, i.e. questions that acknowledge, explore or challenge the client rather than just seeking factual information.

It is important not to ask too many questions, so as to avoid the client from feeling that they are being interrogated. If this happens, the clients are less likely to freely submit information. It is important to allow the client to go in the general direction that their feelings take them.

It is also possible that by asking too many questions, you do not permit the client to think for themselves so that they become reliant on being asked questions to proceed. Most clients will also be aware when the counsellor is asking questions as fillers, where the answer bears little or no relevance to the counselling process. Even experienced counsellors will occasionally find themselves asking these types of questions. The counsellor needs to avoid questions that are intrusive and which produce information of little value.

Therefore, asking questions is really only appropriate when it is necessary for the session to continue.

Open & Closed Questions

Closed Questions

These types of questions generally have a specific answer, e.g. yes or no. They are useful when the counsellor is after a specific piece of information.

There are, however, problems with this mode of questioning:

- The client may go ahead and expand on the question
- The client is restricted in the sort of response that they can give.
- It can also act as a leading question making the client think that they have to go into a particular direction in order to satisfy the counsellor.

Open Questions

These allow the client far more scope in terms of adding information, typically requiring several sentences to answer. The information supplied by the client could be unexpected by the counsellor and hence revelatory leading the counselling process into a new direction.

Open ended questions allow the client to express what is most significant to them with regard to a subject area or problem, rather than what is most important to the counsellor.

Other Types of Questions

Although it is suggested that questions be used sparingly, when used appropriately they can be extremely powerful in accessing information.

Linear Questions

These types of questions are used to probe for information that helps to assess the client's problems. For example, 'What are the things that are troubling you right now?'

Information-seeking Questions

Caution should be recognized when asking questions that attempt to seek information. It is only necessary to ask such questions when they are going to be of benefit to the counsellor's

knowledge. If they are not going to reveal anything that will help the counselling relationship, then they should not be asked. They should certainly not be asked in order to satisfy the counsellor's curiosity.

Strategic Questions

These are used to encourage a client to challenge their beliefs, values or behaviour.

Questioning for Clarification

This is useful when clients offer vague or ambiguous statements. It allows them to be more specific so that it becomes clear to both the counsellor and the client exactly what is being described.

Questions to Heighten Awareness

This type of questioning is most useful for helping a client to understand what is happening inside them, both mentally and emotionally. They are then able to deal with these feelings and associated thoughts.

Reflective Questions

These are used to assist the client to generate new possibilities and consider making changes to their lives.

Transitional Questions

This type of question is used to draw the conversation back to an earlier part of the discussion. They tend to begin with a statement about an earlier topic and then raise a question pertaining to this.

When using these questions the counsellor is steering the conversation into a direction that they wish to take it. It is important therefore to ensure that it is only introduced at a point where it is not going to prevent the client from imparting important emotional material.

Choice Questions

These are similar to reflective questions but have been used mostly when dealing with adolescents. They infer that the client has a choice about past / present and future actions, and enable them to consider what the different consequences of their behaviour are likely to be: e.g. 'In what other ways could you respond to that?'

Guru Questions

These types of questions invite clients to step outside of themselves and consider someone in their situation, and ask what advice they would give to this person.

Career Questions

These sorts of questions help the client to see that they have choices that they can make in their present lifestyles that could have a profound impact on their future.

They normally have an exaggerated or paradoxical content that helps the client to see beyond their present behaviour.

Care should be taken to only use these questions where the client can interpret the paradox, rather than take it literally as a suggestion.

Circular Questions

These can be useful for helping clients to understand their own feelings, thoughts, attitudes and behaviour. Instead of asking them directly about how they feel or what they think, the questions ask about how the client thinks someone else feels or thinks about something. This may be less threatening than asking the client directly how they feel about something.

Exploratory Questions

These are also circular in nature, but tend to focus on identifying patterns and connections in a client's behaviour, problems, thoughts and ways of coping.

For example the counsellor might ask;

'What type of situations make you feel really angry?'

Questions to Avoid

It is preferable in counselling to avoid 'why?' type questions. The reason being, that they tend to open up intellectual explanations rather than invite clients to disclose what is happening internally. 'What?', 'How?' and 'When?' questions are generally more productive as they focus more on feelings and emotions.

Goals of Questioning

It is important to restrict questioning during counselling sessions so that the client does not feel interrogated. Questioning should only be used as an addition to the main tool of reflection. Timing is also important. The counsellor needs to know when to and when not to ask a question. The counsellor can master timing by learning the therapeutic value of the question, and the likely response of the client.

Case Study

Ellen comes into the counselling room. She is obviously agitated.

C = counsellor E = Ellen

C "Hello, are you OK?"

E "No"

C "Is there something I can help you with?"

E "No".

C "Are you upset about anything in particular?"

E "No."

C "Is there something you want to talk about?"

E "No".

The counsellor is not encouraging Ellen to talk by asking these closed questions. Go through the questions again and think of ways that the counsellor could have used other questions for encourage Ellen to talk about what was bothering her.

These are not definite answers. You may have come up with different questions to these, but these are some suggestions.

C "Hello, are you OK?"

Perhaps – "you don't look very happy today ... followed by a pause to allow Ellen to talk" Or "you don't look very happy today, can you tell me why?"

C "Is there something I can help you with?"

"I think there is something the matter, so talk to me about it and we'll see if I can help".

C "Are you upset about anything in particular?"

"Tell me what you are upset about in particular" or "What in particular are you upset about?"

C "Is there something you want to talk about?"

"What is it you want to talk about?"

These new questions or statements encourage Ellen to make a response that is not a yes/no response. They encourage her to talk, even if only with one sentence. But this one sentence will also allow the counsellor to open up the conversation more.

Activity

As you go through your day, when you are talking to other people, look at your own use of open and closed questions and theirs. Are there times when you use closed questions to end a conversation? Or open questions to prolong a conversation? Try to make a conscious note to use more open questions when talking to people. The more counselling skills are practised within our daily lives, the more natural they become to us.

Example – Questioning in Crisis Counselling

The following article gives you some idea of how questions may be used in crisis counselling.

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ERIC Identifier: ED405535

Publication Date: 1995-00-00

Author: Stevens, Brenda A. - Ellerbrock, Lynette S.

Source: ERIC Clearinghouse on Counselling and Student Services Greensboro NC.

Crisis Intervention: An Opportunity To Change. ERIC Digest.

Crisis intervention is emergency first aid for mental health (Ehly, 1986). This digest provides a brief, conceptual overview of crisis intervention, and summarizes the steps a worker may use to identify, assess, and intervene with an individual experiencing crisis.

The Chinese language contains two characters which, taken together, connote the concept of crisis. The first character, "wei," indicates a critical or dangerous situation, while the second one, "ji," means an opportunity for change. Thus, these characters together indicate that crisis is a point in time that allows the opportunity to change.

Crisis intervention involves three components: 1) the crisis, the perception of an unmanageable situation; 2) the individual or group in crisis; and 3) the helper, or mental health worker who provides aid. Crisis intervention requires that the person experiencing crisis receive timely and skilful support to help cope with his/her situation before future physical or emotional deterioration occurs.

A crisis may occur when an individual is unable to deal effectively with stressful changes in the environment. A stressful event alone does not constitute a crisis; rather, crisis is determined by the individual's view of the event and response to it. If the individual sees the event as significant and threatening, has exhausted all his/her usual coping strategies without effect, and is unaware or unable to pursue other alternatives, then the precipitating event may push the individual toward psychological disequilibrium, a state of crisis (Caplan, 1964; Smead, 1988).

Psychological disequilibrium may be characterized by feelings of anxiety, helplessness, fear, inadequacy, confusion, agitation, and disorganization (Smead, 1988). At this point, the individual experiencing this disequilibrium may be most receptive to outside assistance, thus providing an opportunity for behavioural change and a return to balance. To summarize, a crisis results from a person's negative perception of a situation.

Psychologists, counsellors, social workers, mental health personnel, and therapists are trained to provide services to individuals in crisis. These workers can assist an individual or group in crisis by providing direct intervention, by identifying alternative coping skills, or by consulting with others. A helper's primary goals in a crisis are to identify, assess, and intervene; to return the individual to his/her prior level of functioning as quickly as possible; and to lessen any negative impact on future mental health. Sometimes during this process, new skills and coping mechanisms are acquired, resulting in change.

IDENTIFICATION

Identification recognizes that a problem exists and it focuses on 1) the event's significance in the person's environment, and 2) the person's current functioning. The event or crisis may be categorized as either developmental or situational (Smead, 1988). Developmental crises result from predictable change, and are due to normal growth or development, such as the onset of adolescence. Situational crises are either predictable, arising from certain events, such as divorce or failing a grade, or are unpredictable, such as an accidental death or natural disaster. Both types involve a change in circumstances, usually accompanied by a loss, which can precipitate a crisis reaction in an individual.

Therapists must promptly identify a person in crisis, as well as assess the degree to which his/her functioning is impaired. In addition to psychological disequilibrium, other signs and symptoms may indicate a problem for those experiencing a crisis. Physical symptoms such as changes in overall health, energy, or activity level, as well as in eating or sleeping patterns, may point to a problem. Emotional signs that may indicate a person in crisis include increased tension or fatigue, and changes in temperament, such as angry outbursts or depression.

Behavioural signs such as the inability to concentrate, being preoccupied with certain ideas, or social withdrawal may also indicate a person in crisis (Ehly, 1986; Greenstone & Leviton, 1993).

ASSESSMENT

After identifying a crisis situation and a person in crisis, workers assess the crisis's impact on the individual. This assessment usually takes the form of an interview, during which the worker strives to convey an atmosphere of acceptance, support, and calm confidence about the future. Communication with the person experiencing a crisis is vital; this involves establishing eye, and sometimes, physical contact. Questions addressed to the individual may include his/her perception of the problem, the frequency and sequence of events, his/her feelings, and a history of attempts to deal with the problem. Forced choice or open-ended questions may be used to assess the individual's ability to communicate, as he/she may experience difficulty in expressing him/herself, in making decisions, or in solving problems.

Assessment may include what the individual is saying as well as his/her nonverbal communication, i.e., facial expression, posture, body and eye movements, and mannerisms. An essential part of this assessment is an evaluation of the person's current safety as well as any risk to his/her own or someone else's life. Additionally, factors such as alcohol and drug use, current stress level, and emotional affect, such as hopelessness and helplessness, should be identified.

INTERVENTION

After identification and assessment of the crisis and the person involved, the intervention occurs. While specialists (Hoff, 1989; Greenstone & Leviton, 1993; Sandoval, 1988; Sandoval, 1991; Zins & Ponti, 1990) in this area may differ on the name and number of steps involved, they agree that certain points are integral to intervention and are basic to a best-practice, problem-solving approach. First, while supporting and empathizing with the individual in crisis, the worker should listen and avoid using the phrase "I understand" so as to allow the individual full and open expression of feelings and emotions. Second, the individual in crisis should answer the worker's questions so as to define and clarify the incident and acknowledge any social and cultural factors which may relate to the crisis. This second step places the problem in a framework. As Burak (1987, p. 1) states, "Understanding of and respect for the differences inherent in each culture are needed for rapid, effective, and sensitive treatment of emergency situations" (p. 1). Third, the worker develops an awareness of the significance of the crisis from the individual's point of view. These first three steps may have been partly completed during the identification and assessment stages of the crisis; it is important that they be finished before going on to the fourth step.

Fourth, mutual brainstorming of alternatives and discussion of available resources are jointly carried out by the individual in crisis and the worker. At this point, the worker may need to be more directive, by focusing on the current situation, proposing ideas and strategies for action, as well as suggesting other resources for support, instead of just listening and reflecting. (Sandoval, 1988). Fifth, the individual in crisis and the worker choose one or more specific, time-limited goals which take into account the person's significant others, social network, culture, and lifestyle. Complete planning, including recognition of all the steps involved, as well as consideration of any barriers to success, should be completed before the solution is attempted. Some brief education, modelling, role playing or rehearsal of potential situations may be done in this step to empower the individual further. Sixth, the worker and individual implement their plan and, if possible, evaluate its effectiveness. They then adjust the plan as necessary. Seventh, the worker provides for follow-up or refers the individual in crisis to a resource that can provide ongoing support. The worker then terminates the established crisis relationship.

SUMMARY

In summary, crisis intervention provides the opportunity and mechanisms for change to those who are experiencing psychological disequilibrium, who are feeling overwhelmed by their current situation, who have exhausted their skills for coping, and who are experiencing personal discomfort. Crisis intervention is a process by which a mental-health worker identifies, assesses, and intervenes with the individual in crisis so as to restore balance and reduce the effects of the crisis in his/her life. The individual is then connected with a resource network to reinforce the change. Thus, as the Chinese characters suggest, crisis truly holds the opportunity for change.

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SET TASK

You will need to repeat this set task several times asking different types of questions.

Get together with a friend, relative, or colleague, etc. Simulate a counselling situation. Ask them lots of closed questions about an emotional issue (but not something that is going to upset them, or that is going to stir up feelings that you cannot deal with) so as to try and get to the heart of a problem that they have. (If you find it easier you could always not disclose that you are researching your counselling techniques, until you have pursued with your questioning, though you should disclose this information to them afterwards)

Try to balance your questioning with reflection, and other techniques, so as not to upset your 'client' by bombarding them with too many questions. Make notes of their responses.

ASSIGNMENT

1. Report on your set task. How did your 'client' respond to your questioning? Did they become defensive or avoid talking about the main issues that were bothering them? Submit approx 200 words.
2. Repeat the task using **open questions** and comment on your findings. Submit 200 words.
3. Compare your use of open and closed questions in your set task, and the information that these 2 types of questions produced. Submit ½ to 1 page.
4. What do you see as being the main risks involved in asking too many questions? Why is it important to avoid questions beginning with 'why?' (If you asked any 'why' questions in your set task site them as an example in your explanation). Submit 200 – 300 words.

INTERVIEW TECHNIQUES

Aim

To describe and provide understanding of various micro-skills including: summarising, confrontation and reframing.

There are a number of techniques that can be used to streamline the counselling session.

Summarising

Every now and then it is important to review the counselling to date. This technique is something similar to paraphrasing, but rather than reflecting back what has been said in a single client sentence, it is reflecting back what has been said in a number of client sentences. The summary will reflect back the main points in terms of content, and may also reflect back the client's feelings.

Summarising helps bring together the thoughts and feelings that a client has just revealed and enables the client to focus more clearly on them.

The summary does not reflect back the entire content, but rather just the most important points. In doing so, the counsellor is able to present the information in such a way that the client can think over the information, and gain a clearer picture.

It invites the client to make their own resolutions.

Application

Summarising may be used a number of times throughout a counselling session. It is particularly useful towards the end of the session when it can be used to tie together thoughts, feelings and ideas that have been exposed during the session.

It also serves to move towards the session closure.

It is also very useful when a session appears to be heading nowhere. In such instances it can stop the client from going around in circles.

The use of a summary at the onset of a session prevents a client from going over the same ground that they have previously covered. In this way the client is encouraged to move on to new ground.

Another useful application is where a client appears to be in a rut. Once again it can help the client to move on and keeps the ball in the client's court.

Finally, it may be used to help the client see things from another point of view and focus on the wider picture.

Confrontation

Ivey (1994) describes confrontation as:

'...noting discrepancies in the client and feeding them back via attending skills.'

Leuver and Harvey (1997) suggest that:

'...counsellor-perceived discrepancy in client behaviour is a cue for counsellor intervention'

During the confrontation process, the person doing the confronting is feeling anxious and the person being confronted feels threatened. The counsellor will therefore need to consider the receptiveness of the client to confrontation and decide how tentatively any confrontation should be delivered.

In counselling, confrontation attempts to raise the awareness level of the client by presenting information to them in a way that helps them to identify things that they are overlooking, deliberately or otherwise. The purpose of confrontation is always to point out discrepancies.

It should be done in such a way that respects the client's feelings. The truth often hurts and so this is a subtle skill that needs to be mastered effectively before it can be used. It should never

be used until a trusting relationship has been established with the client. If not, the client may feel inclined to finish the counselling sessions without receiving the help that they need.

Confrontation is sometimes considered as a last resort, only to be used when the other micro-skills learnt to date have failed to enlighten the client. The counsellor will need to judge where usage is appropriate and of benefit to the client.

Observation of discrepancies

The counsellor may note discrepancies under a number of circumstances that include:

- a difference between what the client is saying and what they have said on a previous occasion
- what the client is saying and their behaviour outside the session
- what the client is saying that is not in accord with their behaviour
- a difference between what the client is or is not saying and the counsellor's perception of the client's behaviour.

Appropriate use of confrontation

The best times to use confrontation can be summarized as follows:

- the client is avoiding troublesome issues
- the client does not recognize their own self-destructive behaviour
- they fail to recognize the consequences of their behaviour
- they are making contradictory statements
- they talk about anything other than the present
- they are repeating themselves
- their non-verbal behaviour does not match what they say
- it is necessary to focus on the relationship between the client and counsellor. E.g. the client has become dependent on the counsellor, or is showing anger towards the counsellor.

Elements of confrontation

The following would be included in good confrontation:

- a reflection or brief summary of what the client has said
- a statement of the counsellor's feelings, or:
- a statement of what the counsellor has observed without interpretation

A useful method is to outline the two different components of what the client has said by saying things like:

'On the one hand...yet on the other...'

The client should feel enlightened, and NOT attacked or undermined.

Reframing

We all perceive things differently. A client's interpretation of events when they come to a counsellor is usually going to be perceived from a depressed or low self-esteem point of view. That is, the client tends to frame the picture of how they see things.

A skilled counsellor will sometimes be able to change this picture of the client's perceptions by a process of 'reframing'. It is not intended to alter the client's own perception, but to reframe this perception within a larger frame so that they are able to see an expanded view of the world, compared to the way that they currently see it. Reframing can thus be seen as the counsellor using the client information to provide an alternative explanation or interpretation of the client's way of seeing things.

Thus the client may, if they wish, see the world in a different way.

It is anticipated that by helping the client to see the world in a broader sense, they will be able to be less negative.

Reframing needs to be done sensitively, so that the client feels good about themselves rather than feeling like a failure. Indeed, due its confrontational nature, tentative delivery is once again necessary.

Reframes should also be offered in such a way that there is no compulsion on behalf of the client. They should feel that they can accept or reject them. By seeing that there are alternatives, the client has broadened their outlook, and this in itself is often enough for them to feel a reduction in hurt or pain.

For example, a woman asking her husband where he has been can be seen as negative and lacking in trust. This could be reframed positively, to show concern for his well-being.

Case Study – An Article Relating To Substance Abuse And Counselling

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ERIC Identifier: ED435893

Publication Date: 1999-00-00

Author: Sales, Amos

Source: ERIC Clearinghouse on Counselling and Student Services Greensboro NC.

Substance Abuse and Counselling: A Perspective. ERIC Digest.

Substance abuse is a critical problem in the United States across all segments of the population and impacts in some way all members of our society. It is the most prevalent mind disorder, the number one continuing health problem, and the number one prison problem in the United States (Inaba, Cohen, and Holstein, 1997). The significant number of the United States population having substance abuse problems is indicated by approximately 6% abusing illegal drugs, 12% having problems with drinking, 25% being addicted to nicotine and, conservatively, 10% addicted to prescription medications.

All counsellors no matter what their specialty or setting will encounter clients with presenting or related problems of substance abuse. However, counsellor education programs and their accrediting bodies do not require knowledge or skill development in this area. Thus, it is critical that we implement strategies to insure that all counsellors in practice and in counsellor preparation programs understand the process of substance abuse.

Substance abuse is defined as the categories classified in the Diagnostic and Statistical Manual IV (DSM-IV) (American Psychiatric Association, 1994) as Substance-Related Disorders and Substance-Induced Disorders. These disorders include the active use and/or dependency on any mood-altering substance. Substances include alcohol, sedatives, amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, caffeine, nicotine, and prescription drugs, as well as legal drugs. Similar addiction processes to those of substance abuse include experiences such as eating, gambling, sex, and work addiction. Addictive behaviour is characterized by preoccupation with the substance or the experience, withdrawal symptoms after not engaging in the substance or experience, increased tolerance for the substance or activity in order to achieve the same effect, and continued use despite negative consequences. While similarities of behaviour exist across all types of substance abuse, individuals cannot be categorized, defined, and treated in relation only to their substance abuse problem. An individual with a substance abuse problem is unique in his/her history, pattern of use and abuse, and counselling and related treatment needs.

While many models of causation of substance abuse have been proposed, no clear etiology has been identified. Models emphasize morality or individual conscious choice, biological or disease vulnerability, behavioural learning patterns, cultural-environmental concerns, or biopsychosocial impact. The biopsychosocial model views substance abuse as a complex interaction of all of the other models and endorses multiple strategies for counselling from these models as appropriate. Counsellors need to review these models to develop a conceptual position regarding causation upon which he/she can make consistent therapeutic assumptions and decisions to guide counselling practice.

Counselling

Conclusions regarding effective counselling strategies for counselling individuals with substance abuse are limited in that this counselling specialty area has been driven more by experience and clinical intuition than by research. As a result, most traditional substance abuse treatment programs (e.g., Alcoholics Anonymous, alcoholism education, half-way houses and therapeutic communities utilizing confrontation, group therapy, individual counselling, and use of medication) have not demonstrated their efficacy. Some successful treatment outcomes have been linked to short-term interventions, aversion therapy, stress management, solution-focused brief therapy, and social skills training, yet seldom are these methods utilized in traditional substance abuse treatment programs in the United States. Given this, conclusions regarding counselling and substance abuse have to come from general counselling research data.

Counsellors, regardless of their settings, impact as change agents within the context of therapeutic relationships with individuals. Successful relationships are facilitated by a skilled counsellor who helps the client become more invested in the process and who utilizes therapeutic techniques appropriate to the client. A thorough review of counselling outcome research (Sexton, Whiston, Bleuer, and Walz, 1997 pp. 58-62, pp. 87-93) concludes the following:

1. Counselling is a process beneficial to most clients of skilled counsellors. However, it is not always so. A significant number of clients get worse.
2. Counselling models (e.g., cognitive, experiential, behavioural, dynamic) are effective and, when compared, seem equivalent in their effect on counselling outcome.
3. Successful counselling has process factors which are common across the various counselling models. These factors include the counsellor's establishing an open, trusting, collaborative relationship, facilitating client cognitive learning through reframing, feedback, and insight, and assisting the client in behaviour changes through behavioural regulation, reality testing, and successful experiences.
4. Successful counselling outcome is dependent on counsellor therapeutic skills such as focusing conversations on life problems, addressing presenting problems directly, and providing structure for counsellor-client intervention.
5. Successful counselling progresses through various process stages, wherein different types of counsellor-client interactions are reflected by different counselling techniques.

PERSPECTIVE

The above research conclusions support the following perspective regarding counselling clients with substance abuse problems. Counsellors, to be effective, first must have the ability to develop an open, collaborative relationship with clients wherein clients perceive trust and commitment. Carl Rogers identifies, and research supports, this ability as related to the counsellor's skill in conveying, in interaction with clients, unconditional positive regard and empathic understanding (Austin, 1999). Within this relationship, the counsellor must provide focus for the process by addressing the client's presenting problems directly and identifying client need for change. Counsellors of clients with substance abuse problems often find this process difficult because of the chronic nature of interrelated destructive attitudes and coexisting disorders these clients often bring to counselling. Once problem identification and client need for change are identified, the counsellor must be able to articulate and implement counselling intervention strategies perceived by both the counsellor and the client as appropriate to the client's need to change.

These process considerations in counselling clients with substance abuse problems hold to be true for specialists in this area and for counsellors working in school, rehabilitation, mental health, and social work settings. The counsellor emphasis is on the person not the substance abuse problem. Additional knowledge and skill on the part of the counsellor relates to being

able to assess the extent and impact of a client's substance abuse problem and the client's need to change. Familiarity with and ability to utilize standardized assessment instruments specific to substance abuse will help the counsellor in this assessment process. Familial and social environment assessment also is required to identify the extent of and to utilize the client's support systems. The counsellor's ability to identify the needs of the client and the quality of counselling and related treatment intervention strategies obviously linked to his/her assessment and diagnostic skills.

Counsellors should be thoroughly familiar with the facilities and services in his/her community to insure proper referral for clients with substance abuse problems. Referral options are determined by client need and are collaboratively agreed upon as appropriate by the counsellor and client. These include short-term, inpatient care lasting three to seven days for withdrawal from substance abuse, or intensive, outpatient programs lasting eight to twelve weeks wherein clients maintain vocational and family responsibilities while participating in treatment. Another option, the half-way house, provides moderately structured and supportive residential treatment lasting for three to six months, wherein successful living within the environment becomes part of the treatment plan.

Other options include therapeutic communities, structured, highly intensive, residential treatment program such as Synanon, where clients may remain up to two years, and out-patient alcoholism treatment programs of two kinds, drug-free clinics with services lasting four to six months, and methadone or opiate clinics that a client may attend by medical referral for two to five years. Within these settings, group treatment is the predominant mode of therapy with individual counselling viewed as an adjunct.

SUMMARY

Substance abuse is a major social problem and concern for counsellors. It is the most prevalent mind disorder, encompassing some 40 percent of the diagnoses in the DSM-IV (American Psychiatric Association [APA], 1994), the number one continuing health problem, and the number one prison problem in the United States (Inaba, Cohen, & Holstein, 1997). Yet, school, rehabilitation, and mental health counsellor education programs do not require expertise in this area as a prerequisite to receiving a degree. Given this, a need exists to implement strategies to insure that all counsellors have expertise in this area.

This digest focuses on identification of counselling outcome research implications for counselling individuals with substance abuse problems. The following conclusions regarding counselling individuals with substance abuse problems have been highlighted.

1. All counsellors, no matter what work setting or clientele, will counsel individuals with presenting or related problems of substance abuse.
2. Counsellors counsel and empower individuals with substance abuse problems versus treat the substance abuse problem.
3. Counsellors must be able to establish the same open, collaborative, therapeutic relationship in counselling individuals with substance abuse problems as they do with other client populations. This ability is viewed as a prerequisite to successful outcome in any counselling setting.
4. Counsellors must focus the counselling relationship on addressing the client's presenting problems directly and identifying client need for change.
5. Counsellors must be able to articulate and implement counselling intervention strategies perceived as appropriate by both the counsellor and the client.
6. Counsellors must know community resources and procedures for referral to be able to insure access to effective and appropriate support services for clients.

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SET TASK

Either

Look for a newspaper article(s), (or extracts from novels etc.) that demonstrate 2 of the following:

- summarising
- confrontation
- reframing

(Note that these articles do not have to be related to counselling, but could be in regard to any subject)

Or

Get together with a friend, relative, colleague etc., and discuss an issue or minor problem that they have.

Attempt to use the skills of summarizing and reframing during the course of your discussion.

Record your discussion in the form of a transcript.

ASSIGNMENT

1. Either:

Submit the articles that you found in your set task, and explain why you believe them to represent the concepts that you have outlined. Limit your answer to 1 page.

Or

Submit your transcript.

Indicate where you have summarized and where you have reframed. Did your attempts to summarise and reframe succeed in producing the desired responses.

2. Give examples of when it would be inappropriate (taking into account the counsellors own feelings or thoughts) for the counsellor to use confrontation? Submit approx. ½ page.

3. What do you see as the chief elements of good confrontation?

Use 2 case studies (real or imaginary) to outline appropriate use of confrontation.

Submit 1 page.

4. How can reframing be used to change a client's perspective on things?

Give an example (real or imaginary) where you may be able to use reframing effectively.

Submit 200 – 300 words.

CHANGING BELIEFS & NORMALISING

Aim

To understand the negative impact of self-destructive beliefs and to appreciate the value of normalising in the counselling process.

We all as individuals have our own attitudes, thoughts and beliefs. Everyone has a right to their own views. However, sometimes these ways of thinking can cause the client harm and, moreover, they do not realize that they are thinking or acting in such a way that is problematic to them.

There are many reasons why clients may have self-destructive beliefs:

- Lack of awareness

The client does not realise the effect that their thoughts and beliefs has on their personal well-being and those around them

- Ignorance

The client does not wish to know certain things about themselves because they consider that they would have to change their behaviour.

- Awareness without care

Many people are aware of their destructive thoughts and behaviours but don't seem to want to help themselves to get out of it.

CBT (cognitive behaviour therapy)

CBT involves looking at the way we think (cognitive) about ourselves, the world and others and how our behaviour affects our thoughts and feelings. CBT can help individuals to change how they think and what they do. The changes can help them for the better. CBT focuses on the here and now of problems, rather than looking for vents and symptoms that have caused distress in the past.

CBT has been helpful in conditions such as depression, social phobia, bulimia, post-traumatic stress disorder and so on.

CBT works by breaking down overwhelming problems into smaller parts to see how they are connected and how they affect you. The parts are –

Situation – the problem, event or difficult situation.

From this situations follows:

- Thoughts
- Emotions
- Physical feelings
- Actions

Each of the areas affects the others. So how we think about a problem can affect how you feel physically and emotionally. It can also alter what we do about things. We can respond in a helpful and unhelpful way to situations.

Example

You see a friend walking towards you on the other side of the road. They walk right past you without acknowledging you.

	Helpful	Unhelpful
Thoughts	I wonder if something is wrong. They seemed really preoccupied.	He ignored. He doesn't like me.
Emotional	Concern for the other person	Rejection, sadness, upset
Physical	None, feel fine	Stomach cramps, low energy, sickness
Action	Get in touch to see if they are OK.	Go home and avoid him next time you see him.

Can you see how the same situation has two very different results depending on how the person thinks about the situation? Perhaps the person has just lost his job and was thinking what he would do. He may have been so preoccupied he didn't notice you. By thinking that the situation was him avoiding you, then you avoid him next time, you have created an unhelpful situation for yourself – and for him. Also, how you thought affected what you did and how you felt.

So we have a situation, which affects our thoughts, feelings and actions. This can be a vicious circle, making you feel worse and even create new situations that don't actually exist. CBT can help people to break the vicious circle of unhelpful thoughts, feelings and behaviour.

Activity

Think of a situation you have been in where you have responded in a helpful way. Consider what could have happened if you responded to it in an unhelpful way.

Changing Self-Destructive Beliefs

The counsellor must recognize and acknowledge the client's own views and ways of thinking and behaving as a human right.

The counsellor's role is to help clients change so that they can feel better. They should be able to detect when a client's thoughts, attitudes and beliefs are self-destructive.

A counsellor may achieve this through confrontation.

It must be noted that the counsellor ought not to try to impose their own values onto the client, but merely enlighten them to the fact that there are other choices available. By doing this the counsellor may be able to help the client effect a positive change to their feelings, thoughts and behaviours.

It is often the case that clients were previously unaware that they were able to change their thoughts and beliefs in order to lead more satisfying lives.

There are 2 main types of self-destructive beliefs:

1. Should/Must/Ought/Have to

Clients will often make statements that include these words.

If the statements are made with conviction and enthusiasm, then they have come to these decisions themselves and that is fine, because they obviously want to do these things.

If they are showing reluctance or seem uncomfortable about making these statements, then it is possible that they are feeling compelled to make these types of statements not out of their own choice.

If they disregard the 'should' statements, then they may be feeling guilty with consequent negative results.

Here the goal of counselling is to help the client to become more comfortable with their decisions, and not to feel guilty about or resentful.

Where Do These Beliefs Come From

Obviously we begin life with no experience and no understanding of right and wrong. We learn our value systems from those around us.

During adolescence we rebel against some of these values that we have learnt from others.

As adults we have the relevant experience to determine our own beliefs. This may involve keeping some of the beliefs that were handed down to us, and replacing some of them with our own.

Sometimes when an adult uses a 'should' or similar statement, it is possible that they are still holding onto beliefs that they have held since their childhood, but that are not appropriate for them now.

The idea is to get the client to 'own' their choices as being morally right and fitting for them, rather than as being something that was imposed on them during their childhood.

These statements are often lingering at a head level rather than at gut feeling level. Confusion sets in thoughts and feelings are not compatible. There must be harmony in order for us to feel comfortable.

Sometimes a client may exhibit a reluctance to express what they have said they should do. In these instances it is a good idea to show them where their 'I should' messages might have evolved from. They may then be able to see that there are alternatives available to them. They might choose to accept one of the alternatives, or stick with their original view.

2. Irrational Beliefs

These types of beliefs have often originated from childhood too, and also often contain the words 'should/must/ought/ have to'.

In addition, they have an intrinsically irrational component.

Another version of this is to have unrealistic expectations of others. E.g. 'She should' or 'She ought to'. The client who does this is projecting their own values and expectations onto others. This is both unrealistic and irrational.

Counsellors often have to deal with clients whose expectations of others are unrealistic. Once the client has recognised that their expectations are unrealistic, i.e. that the other person or persons cannot live up to their expectations, then they will often feel a sense of loss, and will need to grieve.

Where clients present with an irrational belief, the counsellor needs to offer a rational alternative.

For example, "My happiness depends on others around me"... irrational

"My happiness comes from within me"... rational

Changing Irrational Beliefs

When confronted with an irrational belief the counsellor may choose to ask 'do you think that that is a realistic belief?'

By doing this the client then questions themselves, and you may invite them to suggest a rational alternative.

The client may choose to withhold their irrational beliefs if they so choose. Rational beliefs must never be imposed on a client, but only offered as an alternative.

As with confrontation, much care is needed in challenging self-destructive beliefs. It may be of benefit to the client if the counsellor explains their nature, origin and effects so that the client is able to recognize them and challenge them.

Normalising

This can be viewed as a means of quite literally making someone's present plight seem normal. That is, if a client presents with anything ranging from a trauma to everyday life crises, which are preventing them from dealing with everyday scenarios, then by suggesting to them that this is a perfectly normal response given their circumstances, should help to put them at ease.

Obviously caution should be exercised when using this response, as one would have to be sure that the person was not suffering from some other more serious psychological disorder. If in doubt, another opinion should be sought.

Normalizing may be used to:

1. Normalise Emotional States

Often clients may become frightened by intense emotions that accompany their psychological state. They can feel that they are losing control and that they will end up in a psychiatric hospital. However, it is of course possible that the client may require psychiatric help, so this should not be denied. Instead it is better to recognise their fear and respond with something such as 'you are afraid that you are going mad'.

If you are inclined to believe that there is some truth in what the client says, it would be better to let them know.

If you are unsure as to whether the client needs specialist help you may need to spell out the options to them.

2. Normalise Behavioural Changes Due To Developmental Crises

Throughout our lives we are constantly reaching and passing through developmental changes.

Many of our problems arise from situations where we have not successfully dealt with these crises. For example, it is usual for couples to experience problems after the birth of a second or third child. The novelty of the first child has worn off a little and further children can place strains on the relationship. The father may feel that he is not receiving enough attention from his partner. The mother may find the additional child takes up even more of her time (since it is usually the female who devotes more time to the children), and that this causes her to feel resentment especially if she has put her career on hold and given up an active social life.

It would be easy for both partners to assume that there is something wrong with their relationship. The role of the counsellor here would be to indicate to the couple that they are experiencing a completely normal developmental transition that could easily have been predicted. By indicating the inevitability of the situation the counsellor helps the couple to feel at ease and stop feeling like they are failing.

They will also appreciate that there is nothing wrong with their marital situation, but will look for alternative methods of dealing with the present crisis.

It is often the case that people only recognize such developmental changes when they occur to others around them. By normalizing these situations, clients can see them for what they are, and will normally experience a sense of relief.

Appropriate Use of Normalising

It must be stressed that normalizing should be applied with a great deal of care. It should not be used to undermine the client's crisis or dismiss it. It should be used to give the client a better understanding of what they are going through. This should then help the client to recognize and deal with the pain of the situation and hopefully move on.

Case Study – Self Destructive Beliefs

Many of us have self-destructive beliefs. We need to change them to constructive ones. For example –

"I must always win". Logically, 50% or more of the time, we probably won't win. So it is illogical to think we must always win. "My friends should always be loyal to me." Why? Sometimes friends will have other concerns and issues that may mean they have to be loyal to someone else first.

Many people who are overweight will have self-destructive beliefs that are based on negative thinking and self-sabotage. The person may be afraid to lose weight, afraid of success again, afraid of failure and so on. By thinking like this, they are personally sabotaging their own endeavours to lose weight. Look at the comments below –

"I'll always be fat."

"I'm not attractive anyway".

"I have no self control".

"It's my partner's fault for keep buying me chocolates and cakes".

"I'll never be happy until I lose weight".

"If I lose weight I'll sleep around."
"I don't deserve to lose weight because I'm stupid".
"If I lose weight, people will hurt me".
"I'll start tomorrow."
"I never do anything right anyway."

Think about these self-destructive statements and try and find ways in which to make them positive. For example –

"I'll always be fat". – "I may be overweight at the moment, but that doesn't mean I always will be. I have to go to the gym.....etc. etc."

Case Study - Depression

Prevalence of Depression: An estimated 121 million people worldwide currently suffer from depression. 5.8% of men and 9.5% of women per year will experience a period of depression, making depression one of the leading causes of disability worldwide. In the ranking of Disability Adjusted Life years, there is evidence to suggest that depression is 2nd in place as the leading contributor to mortality rates. Depression is contrasted from normal mood changes by the extent of its severity, the cluster of symptoms involved, and the duration of the depressive period. In 10 – 15% of cases, a physical disorder is the cause of depression.

The symptoms of depression include poor concentration and forgetfulness, lack of motivation, tiredness, irritability, poor sleep, and changes in appetite. Depression is an exceptionally disabling condition and is often not acknowledged due to the stigma associated with it (depressed people may wrongly be told that they just need to snap out of it, find something meaningful to do, look on the bright side of life, that they are just being lazy or faking their illness etc..). There is a large body of evidence that demonstrates the correlation between depression, poverty and socio-economic inequality. Education is also a strongly correlated factor.

The vicious cycle of depression and its relationship between economic deprivation and mental illness can be seen as illustrated in the example below:

A mother with 3 children has an episode of depression triggered when her husband abandons the family. Having suffered domestic abuse during the marriage and now subject to material deprivation (income inequality, unemployed and feeling hopeless, angry and desperate), the woman is robbed of her necessary coping skills and energy to overcome her problem. Her lack of social connections, ability to finance treatment and related stresses could well lead to long term depression and a vicious cycle of being trapped in depression.

Treatment of Depression

Only one third of people in the Western world are under appropriate treatment for depression. The treatment and prevention of further recurrence of depression requires systematic and careful planning. Issues involved in the depression may be unique for each patient and they must be evaluated and acknowledged for the patient to obtain the degree of motivation necessary to commit to a treatment plan. Antidepressant medication and cognitive therapies are effective in the short term treatment of depression.

A person's family can be one of the most helpful resources in providing help and support to a depressed person. This can be done by:

- Recognising or having an early appreciation of the onset of depression (the symptoms etc.);
- Helping the patients to start treatment at an appropriate facility, and helping them to continue with the treatment;
- providing adequate supervision and support to minimize the risk of suicide;
- helping the patients to resume their activities and role in life on recovery, and
- obtaining all the necessary guidance and information to prevent further recurrence.

The risk of suicide or self-harming can be determined from the patient's body language and behaviour. Comments concerning suicide or self-harm should not be ignored but explored if possible, so that the depressed person is invited to talk about it and does not feel that others fear the situation.

All objects capable of contributing to a person taking their own life or causing themselves serious self-harm must be removed. The depressed patient should not be pushed to take on too much too soon, even if they appear to be recovering well. Those around the patient need to provide consistent emotional support and understand the patient's emotional state and their inability to help themselves. Showing affection and encouragement when the depressed person is experiencing low self-esteem is vital. They should be encouraged to participate in activities that once gave them pleasure, but to do this slowly. Re-lapses should not be seen as a negative but as a sign that the patient is working through their depression, and that each small step shows them that they can conquer the depression bit by bit.

Living with a depressed person can be a great strain, as the illness may give the impression that a patient does not want help, is unresponsive to affection, or even hostile. Eventually, however with treatment and loving care, patience can get better.

DESIGNING A QUESTIONNAIRE

In your set task below, you are asked to design a questionnaire. Read the set task. Make a list of possible topics, then choose one that you will use. Based on your area of interest, think about what questions you would like to ask.

Ambiguity and Bias

Avoid

- Ambiguous or biased questions - example 'in the light of the superiority of people with brown hair, do you think everyone should have brown hair'?
- Long winded questions – 'on the understanding that people with brown hair are fundamentally superior to people with blonde hair, do you consider, given your understanding of the situation, that everyone should consider the extent to which their hair colour should be changed to the aforementioned colour'??!
- Questions that can be easily misunderstood.
- Questions that will make people defensive.

Closed and Open Questions

Closed questions require certain answers e.g. yes/no/don't know, whilst open questions allow any response. You need to decide what type of answer you want. If you want detailed information on someone's phobias, for example, it is no good asking things such as "Are you scared of spiders?" yes/no. What if they are petrified of snakes, but not spiders? What if they just say "Yes"? Does that mean they are a little bit scared of spiders or are they at the other end of the scale, i.e. go pale, can't even touch a picture of a spider etc. It is a question of degree, hence the use of continuums or scales.

A way to conquer this kind of issue is to use attitude scales.
For example:

Do you consider homework (please circle the one that best describes your view)?

1	2	3	4	5
Very unimportant	Unimportant	Undecided	Important	Very Important

The interviewee can then circle their response. The researchers could then say that 50% of respondents thought that homework was very important and only 2% thought it was very unimportant (as an example).

Or you can consider using scaled statements such as:

Homework is very important (please tick which one best describes your view).

Strongly disagree
Disagree
Neither agree nor disagree
Agree
Strongly agree

Alternatively, you may wish to use closed questions e.g.

Is homework important to you (please circle)? Yes/No.

After using a questionnaire, remember to debrief the interviewees (i.e. tell them what you were researching and allow them to ask you any questions).

You may like to do a draft questionnaire first, and then use it as a pilot study on one interviewee. This will enable you to see if any questions are ambiguous, hard to understand or unsuitable.

SET TASK

Design a questionnaire to determine the existence of self-destructive beliefs (SDB's). Use questions that ask your participants to rate statements on a scale of, say, 1 to 7 where 1=strongly agree and 7=strongly disagree. Administer the questionnaire to several people from different age groups (e.g. 5-11 years, 12-17 years, and 18 years and over).

You can tell the participants that they are taking part in a survey on attitudes and society, or personality and attitudes (for example). You do not have to disclose to them that you are checking the existence of SDB's until afterwards.

ASSIGNMENT

1. Report on your set task. Did you find the existence of any SDB's? Did you find any correlation between age and the existence of SDB's? If so, explain your findings. (If not, try and interpret your findings anyway). Submit your questionnaires and approx. 1 page report.
2. What methods can be used to challenge SDB's? Submit a paragraph or two.
3. What is meant by normalizing? Quote a case study that you have observed (or read about, or constructed) to explain how normalising can be used to effectively deal with a developmental crisis. Submit approx 200 – 300 words.
4. What precautions should be observed when using normalizing and why? Submit to ½ page.

FINDING SOLUTIONS

Aim

To enable the student to understand how a client can make choices, overcome psychological blocks and facilitate actions.

Often during the counselling process goals will naturally emerge for the client. However, if they do not emerge, the counsellor will need to assist the client in positive goal-setting.

When a client is still unable to find solutions to their problems, the counsellor should try and reflect back this feeling of being stuck and encourage the client to try and seek other options.

Rather than offer options themselves, the counsellor is allowing the client to take part in the counselling process by finding their own solutions.

Clearly some options will be disregarded initially, though they may be used later on. If a client has failed to see an obvious option, then the counsellor may hint at this, but care should be taken not to make it seem like advice. It is far more preferable to make it appear as merely a suggestion, and allow the client to feel empowered by reaching a solution themselves.

Moving Forward

The counselling process, when it is working, helps the client move from a problematic phase to one of discovering new choices. The client should be able to envision possibilities and plans for the future that will bring these possibilities into fruition.

There are different ways in which a client may search for solutions:

- **Creativity**

By honing in on their own creative resources (which everyone has), the client can begin to see choices. They need to overcome fear, habits, dependency on others for solutions, perfectionism and fear of being different or standing out in social groups that they wish to belong to.

- **Divergent (lateral) Thinking**

By realizing that there is often no one right answer but many that can be right.

- **Brainstorming**

This is a great way of getting clients to think divergently and more creatively, and so move toward choices for a better future and ways of achieving goals.

The technique works best if the counsellors and the client's judgements are held at bay. That is when ideas evolve they are not evaluated by either party but simply added to the list for discussion later on.

The client should also be encouraged to come up with as many ideas as possible by allowing them to keep generating them without cutting them short.

They can also 'piggyback' off these thoughts to develop them further and come up with further options.

Another way when ideas are running out is to get the client to develop 'wild' possibilities which often later on during criticism will contain elements of worthwhile possibilities.

- **Considering the Future**

Encouraging the client to consider how options may evolve in the future is another method of assisting them to explore options. It will most likely be necessary for the counsellor to help the client to nurture their creative capacity, and this may be a slow process so patience is required.

- **Use of Role Models**

Sometimes clients will find it easier to unleash their creative capacity and engage in divergent thinking more easily if they are encouraged to identify with models of people that they see as being where they would like to be at.

Reviewing the Choices

Once the client has identified the choices, they can work through them.

The client should consider the pros and cons of each alternative, but also take into account their own gut feelings about them. They have to feel totally at ease with their choice, or they will most likely not stick to it.

This gut level feeling is probably more important than cognitive considerations.

Creating Choices

The client's choices and goals need to have certain qualities if they are going to be effective.

- They need to have clear and specific goals
- The goals will need to make a difference to the client's life
- They need to endorse wisdom
- They need to be realistic but challenging
- They need to be sustainable
- They should be adaptable to changing circumstances
- They must be consistent with the client's values
- They should be achievable within a realistic time-frame

Making Choices

The biggest dilemma faced when making a decision is that when faced with two options, whichever one we opt for means that we necessarily incur some sort of loss by not selecting the other option.

It is the lack of assessment of the losses involved in decision-making that prevents people from making decisions far more so than the gains attributed to making them. It is necessary to get a client to consider the potential loss as well as the gains, so that they can decide which loss, if any, is acceptable.

Since we can have thoughts and feelings that operate at opposite ends of a pole, it is quite feasible to say that by making a choice, part of us may be happy, but another part of us may experience the loss. It is possible to explore these polarities by suggesting to a client that both parts exist simultaneously, and that this is OK. The counsellor can then get the client to disclose those feelings that arise from the two different options. They should then be able to accept a consequent loss more easily.

The Right Choice

It is important to help your client to understand that there is in fact no 'right' choice. The options involved in making a decision are never black and white, but will contain shades of grey. This should help them to let go of one of the options and make a decision.

-Sometimes it may be possible to arrive at a solution that involves parts of both or all the options.

No Choice

There are times when no decision can be arrived at by the client within the counselling session. On these occasions it is preferable to allow the client to remain stuck, rather than pressurize them into making a decision. By making them feel that it is OK to stay in this position, the client will feel more relaxed about leaving the counselling in this frame of mind.

If the counsellor also makes it clear that the client can return they will also feel more comfortable.

Occasionally the client will reach a decision prior to the next session. On other occasions the counsellor will need to work through the consequences of the client being stuck, and may need to get the client to vocalise their feelings.

The client may remain stuck for some time, and this should be emphasized to the client as being OK. It is often necessary for this to happen, before progress can be made.

Facilitating Actions

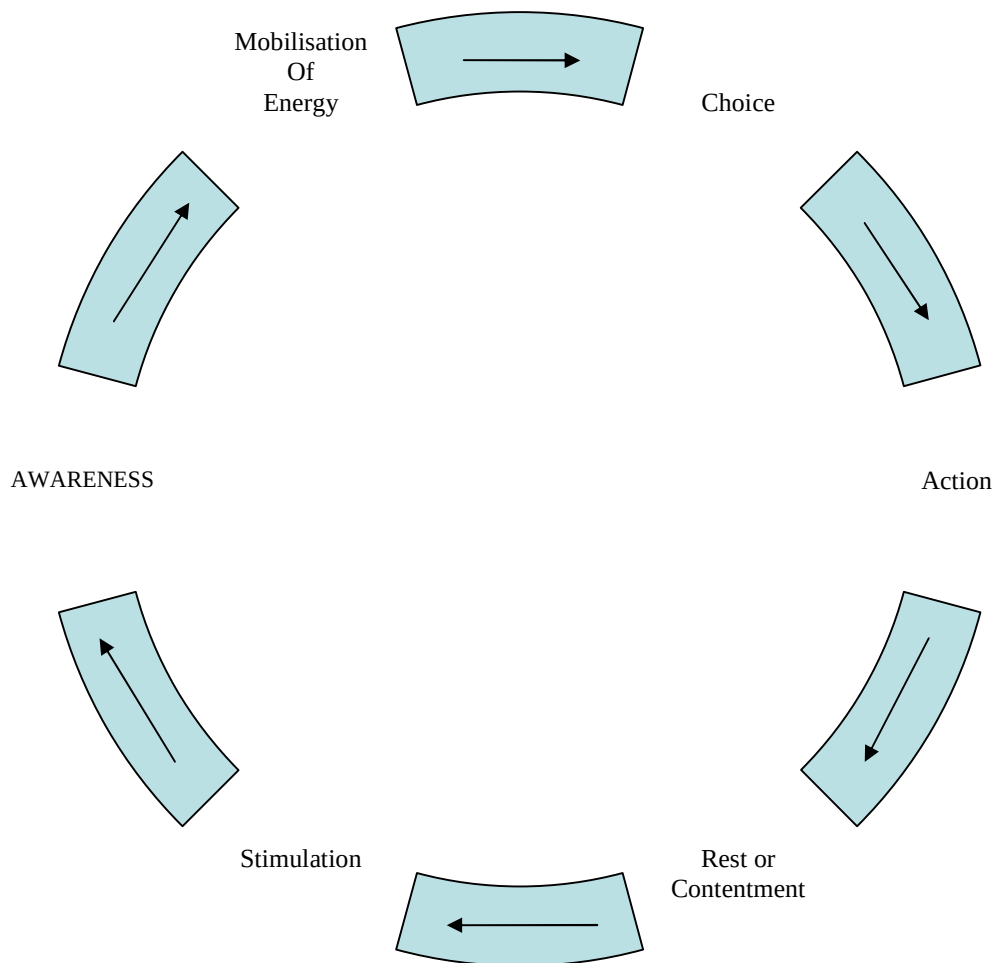
The micro-skills and resolutions offered so far may be enough to help many clients. For others their current difficulties have arisen out of deep-seated problems, and may well return if these problems are not addressed.

In these instances it is paramount to help the client to move on by enabling them to make changes in their life situations.

Rather than try and push clients toward making a change (because they will no doubt resist), it is better to try and understand the awareness cycle that they are going through.

This cycle was first demonstrated by Gestalt Psychologists, and particularly Zinker (1978). A modified version is presented below.

Gestalt awareness circle



The Circle Explained

Most clients will present to the counsellor when they are at the *stimulation* point on the circle. The counsellor needs to steer them around the circle until they get to the point of *rest or contentment*. This is done by raising the client's *awareness*.

Stimulation

Here the client is unable to focus on their options and are totally confused.

Raising Awareness

By raising the client's awareness of their inner feelings the counsellor is able to help the client to *mobilize their energy*. This way they can work constructively to resolve their problems.

Sometimes this raised awareness helps the client to move unobstructed around the awareness circle, making *choices*, taking *actions* and reaching the state of *rest*.

Our lives involve repeatedly travelling around the awareness circle.

Psychological Blocks

Blocks usually occur either before choice or before action. A counsellor ought not to try and push the client into making a choice or action, but is better off trying to point out to the client that they are facing a block that is impeding them.

A common problem is the old adage "better the devil you know than the one you don't".

Someone who makes decisions and actions to change their life has to cope not only with their own feelings, but also those of others.

If a client does something new then there is a risk involved in that could result in pain. It could be easier to go on as at present with a known pain, than to stick your neck out and enter into unknown pain.

It can be seen therefore that a client's choices and actions can often be blocked by fears and anxieties.

These may include the following:

- inability to deal with one's own feelings
- inability to deal with the feelings of others
- fear of the consequences
- fear of a repetition of painful past experiences
- inappropriate consideration of 'musts', 'shoulds', and 'oughts'.
- fear of loss of comfort
- lack of skills to achieve desired action

Overcoming Psychological Blocks

It is the role of the counsellor to point out to the client that they are experiencing a block. By raising their awareness of this block, many will be able to explore and deal with it, thus allowing them to move freely around the circle.

They may also discover that by confronting the blockage they have another more important issue to deal with.

Further Assistance

For many clients merely pointing out the blockage is not sufficient for them to overcome it. In such instances these clients need assistance in eliciting changes to their lifestyles. In addition, other clients may make a decision, but are unable to carry out the necessary action, because they lack the skills or confidence to do so.

The idea is not to make decisions on behalf of the client, but rather help them to organize their lives so that they are able to go and make the decisions that they need to make for themselves.

You can then run through the processes that have been employed to help them reach a decision, so that they can use the same framework to make their own decisions in future.

The following steps may serve as a guide:

- Raise awareness
- Identify the goal
- Delineate step 1 toward achieving the goal (& make it realistic)
- Make step 1 concrete (i.e. clear and specific)
- Decide how to enact step 1 (consider consequences)
- Acquire the skills necessary to carry out step 1
- Decide when to accomplish it (if a clear vision is not formulated, this can lead to inaction)
- Do it (the process is important. If they do not carry out step 1, they will discover what stopped them and make a new decision)
- Reward self for doing so (the counsellor should reward the client by maximizing their achievements, thus encouraging positive decisions and action)
- Reassess the overall goal (they may find that the original goal is no longer desired)

Activity

Using the example above of the person who wants to lose weight. Consider what psychological blocks they may have and how you could help them to resolve it. Make notes for yourself. You do not have to submit them as part of the assignment or set task.

Case Study – Drug Addiction Treatment

1. What is drug addiction treatment?

There are many addictive drugs, and treatments for specific drugs can differ. Treatment also varies depending on the characteristics of the patient.

Problems associated with an individual's drug addiction can vary significantly. People who are addicted to drugs come from all walks of life. Many suffer from mental health, occupational, health, or social problems that make their addictive disorders much more difficult to treat. Even if there are few associated problems, the severity of addiction itself ranges widely among people.

A variety of scientifically based approaches to drug addiction treatment exists. Drug addiction treatment can include behavioural therapy (such as counselling, cognitive therapy, or psychotherapy), medications, or their combination. Behavioural therapies offer people strategies for coping with their drug cravings, teach them ways to avoid drugs and prevent relapse, and help them deal with relapse if it occurs. When a person's drug-related behaviour places him or her at higher risk for AIDS or other infectious diseases, behavioural therapies can help to reduce the risk of disease transmission. Case management and referral to other medical, psychological, and social services are crucial components of treatment for many patients. The best programs provide a combination of therapies and other services to meet the needs of the individual patient, which are shaped by such issues as age, race, culture, sexual orientation, gender, pregnancy, parenting, housing, and employment, as well as physical and sexual abuse. (reproduced with kind permission of www.nida.nih.gov – National Institute of Drug Abuse)

SET TASK

Design a questionnaire to investigate choices or dilemmas. Create around 6 dilemmas (e.g. your boss wants to double your salary, but you will have to relocate to another country).

Get around 6 people to complete the questionnaire. Ask your sample to make a decision as to what they would do.

You might find it easier to get them to make a decision if you offer them a choice on a scale with an odd number of options, so that they have to swing one way or the other. For example, ask them to rate each statement on a scale of 1-7, where 1=strongly agree and 7=strongly disagree.

Try to ascertain whether it is the threat of a greater loss or the promise of a bigger gain that is the primary force behind their decision-making process (you may find no clear distinction).

ASSIGNMENT

1. Submit your 6 questionnaires from the set task, and try to interpret your findings in terms of the theory covered in the first part of this lesson (remember there is no right or wrong answer, we are getting you to examine decision-making processes).
2. Using a case study, explain how the 'circle of awareness' can be applied to assist a client through to the 'rest or satisfaction' stage. Submit approx 200 – 300 words.
3. Explain briefly why psychological blockages may arise, and how you might help a client to overcome psychological blockages.
4. Use a different case study (to Q2) to describe the steps that you would take a client through if further assistance was necessary for them to reach their desired goal. Submit approx ½ page.

ENDING THE COUNSELLING

Aim

To familiarize the student with effective ways to close the counselling session, arranging further meetings and overcoming dependency.

The counsellor must learn the best time to close sessions in a number of different circumstances.

Terminating the Session

It is typical for individual sessions to last in the region of one hour. However, this is not a strict schedule and the counsellor must identify when a session needs to go beyond this, or when there is nothing to be gained by stretching out a session to an hour. Clearly the counsellor must tailor their sessions to the individual needs of clients.

It is also not good practice to keep clients waiting by extending a session into another clients allotted time. This may only serve to exacerbate their anxieties. For this purpose, it is preferable to allow 15 minutes or so at the end of each session which serves not only as a period to consolidate notes, but also as a stop-gap for unforeseen extensions to sessions.

It may also be necessary for the counsellor to debrief between sessions, in order to prepare themselves emotionally for the next session.

Making the Most of the Session

It is the role of the counsellor to keep the counselling session dynamic so as to make the most of the available time. Most of the heavy emotional material is normally released during the first 45 minutes of the session, and the client may begin to flag a little after this.

Once the session is drawn to a close the client will need time to go away and digest the material raised in the session. This may mean that another meeting is scheduled for anything from several days to several weeks time.

It is sometimes necessary to put a client at ease over the duration of individual sessions. Some of them will be anxious that they are taking up too much time or that they are not getting enough time. The counsellor should make it clear that they are in control of the session to allay these concerns.

Preparing for Termination

When working within a set time frame the counsellor will need to start preparing for the end of the session as it gets close. This is done by assessing the progress of the session. It is normally advisable to allow 10 minutes to do this for an hour session.

Any other spare time can be used in a way that the counsellor deems appropriate. Making the client aware that the session is due to end shortly also gives them the opportunity to explore any issues that they have not yet discussed.

Closure

It's often a good idea to summarise the material raised and discussed throughout the session before closing. Also, if possible, some positive feedback is a good idea since clients are always going to be approaching a counsellor when their self esteem is low.

The counsellor could also underline goals for the future both inside and outside of the sessions. It is essential to take control for the termination of the session. This may have to be done assertively, but should never be rude. If a client wishes to linger and chat, then you can stand up and lead the way out of the room saying something to the effect of 'we shall have to leave it there for this week'. You can also wish them good day if you are fearful that your gestures might be perceived as being rude.

Some counsellors prefer to give responsibility for ending the session to their clients, and may have a clock or hourglass on display that encourages the client to learn to pace themselves to get the most out of each session.

Further Meetings

If you have reached a point with a client where you feel that they have resolved their issues, you may not consider that they need to come back. If this is the case, it is always best to inform the client that they would be welcome to come back should they feel the need, but that in your professional opinion they do not need to at the moment.

If you are unsure about asking them back for further appointments because you yourself feel anxious about them not taking up your offer, then it is probably better to ask. At worst they will decline. It is also harder for the client to make an appointment than break one.

Where you feel the need for ongoing sessions, it is important to give the client an idea of the possible duration of the counselling relationship. This should help to counter the client's insecurities about future sessions.

Dependency

On occasion the counsellor may wish to terminate sessions before the client wishes. This can raise issues of dependency. Dependency will perhaps inevitably occur during the counselling relationship.

There are several reasons for this occurring.

- A meaningful relationship will emerge, especially if the counsellor is warm and compassionate (some clients may even wish the relationship to continue after the sessions have ended, though obviously this is encroaching on ethical boundaries).
- Clients may perceive that sharing their most intimate thoughts and feelings with the counsellor will result in an ongoing relationship.
- A number of the clients who seek the help of a counsellor may not have many close friends or family members, and so will naturally strive for closeness and affection through the counselling relationship leading to dependency.

Dependency may also evolve out of the counselling process itself. It is possible that some clients once they have worked through the most difficult issues will then turn their attention to less troublesome issues. The counsellor needs to recognize this as the whole point of the counselling is to help the client to return to society and resolve their own issues. Working through minor issues that do not directly interfere with the client's quality of life is self-defeating.

Dependency of Counsellors

Similarly, it is possible for the counsellor to become dependent on the client. Once again the intimacy of the sharing relationship can lead the counsellor to become dependent on the client. It is therefore essential that the counsellor remains vigilant to prevent them from continuing with the counselling relationship merely to satisfy their own needs.

Dependency is bound to occur from time to time and one of the purposes of ongoing supervision is to identify when this may be occurring.

Ending the Counselling Process

It is often clear to both counsellor and client when it is time to end the whole counselling process. In some instances, particularly where dependency has occurred, it might not be so obvious.

It is therefore necessary for the counsellor to frequently review the progress that is being made in the sessions and update the goals that are being achieved.

If progress is not being made and goals are not being achieved, then it may be necessary for the counsellor to address this issue with their supervisor.

It is of course possible that the counsellor's own unresolved issues are interfering. It could also be that the counsellor does not have the necessary skills in their repertoire to deal with the issues that the client has raised. Supervision may help the counsellor to deal with a client who seems unable to change. Another option is to suggest to the client that they are referred on to someone else who may be better able to help them.

Of course it is important too, to note that some clients will *not* change.

Ending the process may be similar to ending other relationships, and it may be necessary for the counsellor to use questions to challenge the client. They may ask the client how it feels to end the relationship and other similar questions.

Confronting Dependency

If it is necessary to inform the client that dependency has emerged in the counselling relationship, then obviously this has to be dealt with by exercising a great deal of sensitivity. If the dependency is reframed in a positive manner then it will help to lead the process toward termination.

The end of the counselling process will also inevitably lead to a sense of loss. This can be resolved by arranging meetings with the client in the future at longer intervals than the sessions were being held at. For example, if the counsellor was meeting clients on a weekly basis, they might arrange a couple of appointments on a monthly basis.

It can also be useful to have a follow up session say 3 months down the track. This enables the client to have a period to adjust to their independence and it also provides a gentle transition away from dependence. Finally, it is a good way of assessing whether there are any loose ends that need to be tied up.

Chronic Callers

Telephone help lines will often have people who repeatedly call. Some people will call just for a chat, to try to get another counsellor to speak to or so on. Unless the agency offers a service where people are phoning for repeated counselling, this type of caller is actually preventing others from getting help and support they may need. The agency should develop a policy to deal with this –

Firstly, they should review the calls they receive and see how many calls are of this type.

Categorise the chronic callers into different types e.g. Silent, lonely, mentally ill and so on.

Then decide how to respond to them. If the person has a mental health problem. “I’m sorry, I cannot help you with this problem, but if you call ABC on this number They will be able to help you more”.

These policies and procedures should be carefully thought out and stuck to by everyone receiving calls. There may be a different policy or procedure for each different type of chronic caller.

The type of call needs to be identified.

- Do they ask for counsellors by name, or are they asking for personal details about counsellors?
- The caller tries to move the call in a certain direction e.g. Personal, sexual.
- The caller spins out the conversation.
- The agency should then keep a list of suspected chronic callers.
- All calls should be logged – using a code name if necessary.
- A time limit should be set for each call. Do not make excuses, just say to the caller that they have called several times with the same problem and the service needs to be available to other users.
- Do not encourage them to call back.
- Find out if they have other means of support.
- Try to make a referral to another agency so they can get genuine treatment.

Chronic callers still deserve respectful treatment. There may be some underlying reason why they are calling, but they do not feel able to talk about it yet.

Terminating Silent Phone Calls

Terminating a silent phone call is not necessarily the same as ending a counselling process. There may only have been one phone call or a few phone calls, but they should be dealt with sensitively.

Firstly, if you decide that the call should be ended, you do not want the client to feel rejected. As we discussed earlier, you don’t know why the person is silent, someone else might be in the room, they might be crying and so on. There may be a number of reasons why you need to end the call – you are finishing work, you need to go to the toilet, the agency you work for has a policy of the length of time you will listen to silences and so on.

So, tell the call that it is OK to be silent if they want to, but you have to end the call. Tell them why you are ending the call, "it is agency policy", "I have other callers who are waiting to speak to me" and so on.

Then say that you are happy to talk to them again at any time and give the times that the agency is open. Remind them of the phone number. Give them a final chance to say something. Then say "I'm putting the phone down now.....Goodbye".

Silent Endings

Silent endings are slightly different to silent calls. With a silent ending, the person has spoken to you, but has then gone silent, so you know something of their problems. To end the call now is almost the equivalent of walking out in the middle of a counselling session. But for the reasons above, sometimes we need to end a phone call. The techniques for ending the call are the same, but the counsellor may feel different about ending a call, when they have already spoken to the person. You may try saying things like –

"It is difficult for me to know if you are still there and wanting to talk."

"I will stay on the line for another two minutes, but then I have to go."

Then go through the explanations given earlier after the two minutes are up. The counsellor may feel reluctant to put down the phone or may feel rejected if the client puts the phone down on them. If this does happen, the counsellor will need to think carefully of how to deal with clients if they call again after this has happened.

In summary

There are several things that the counsellor certainly should not do at the end of a session.

These are:

- Ask the client a question
- Reflect back content
- Reflect back feelings

If these are not adhered to they can reignite the session.

COUNSELLING – THE BEGINNING, THE MIDDLE AND THE END

Case Study Of Sexual Abuse Counselling

If a person has been sexually abused, good counselling can help them to overcome problems that have arisen due to the abuse. Counselling should be thought of as having three stages –

- The beginning
- The middle
- And the end.

The beginning stage will begin with disclosure. The client may feel issues of trust, doubt and shame. When they disclose to the counsellor, they may feel a rush of emotions, which can trigger a range of defence mechanisms. They may have vivid recollections of their abuse. They may experience these consciously or whilst dreaming. As the sessions progress, the client may be more willing to share their experiences.

The middle stage is a continuation of the first. There may still be issues of trust, security and safety, particularly if they have had unsuccessful counselling in the past. The counsellor will have to come up to the shortcomings of the previous counsellor as well as helping the client themselves. As the person becomes more comfortable with you as a counsellor, they may relax and share more personal details. They may still find this overwhelming. The role of the counsellor is to normalize these reactions and help them to pace their disclosure, to help them gain control of their own emotions and reactions.

The client may experience relief or an exacerbation of symptoms in the middle stage. They may go up and down. This is normal and to be expected. The client should be encouraged to discuss these ups and downs with the counsellor. At the end of the middle stage the client should feel some relief of symptoms and an improved psychosocial functioning.

The end stage – at this stage, the client may feel reluctant for the counselling to end. Their relationship with the counsellor may be the healthiest interpersonal experience they have had. This can lead to feelings of attachment. The counsellor can help this by gradually reducing meetings, perhaps from weekly to fortnightly then monthly and so on. Or reducing the times of the sessions from an hour to half an hour. The counsellor may also offer the possibility of the occasional session in the future if the client feels the need for it. The end of counselling can be the beginning of other services, such as support groups, educational opportunities, a new job or lifestyle.

OTHER SERVICES

As mentioned in the case study above, the end of counselling may not mean the end of services the client requires. If you or they feel they may benefit from other services, you should recommend them. Such as support groups, online chat rooms specifically for other people with their difficulties, workshops and so on. As you gain more experience within counselling, you will become more aware of the services available within your area.

SET TASK

Observe 2 people. These people could be friends, relatives, colleagues, etc., but will need to have some type of ongoing relationship.
Look for examples of inter-dependency.
Make notes of your observations.

ASSIGNMENT

1. Good time management is an important part of the counselling process. Why?
Submit approx 150 – 200 words.
2. Explain the similarities and differences between terminating a session and terminating the counselling process. 200 – 300 words.
3. What dangers are posed by the client becoming too dependent on the counsellor and vice-versa? How can dependency be addressed and potentially overcome?
Submit approx ½ page.
4. Submit the findings of your set task.
Do you think that the dependency that you observed was detrimental to that particular relationship, or to either individual involved in that relationship? Explain your reasoning. Submit 200 – 300 words.