Therapeutic Approaches And Counselling

Psychotherapy is a voluntary relationship between the one seeking treatment or the

client and the one who treats or the therapist.

1. Purpose: To help the client to solve the psychological problems being faced by her or him.

2. Aim: To change the maladaptive behaviours, decrease the sense of personal distress, and help the client to adapt better to his/her environment.

3. The relationship is conducive for building the trust of the client so that problems may be freely discussed.

Characteristics:

1. There is systematic application of principles underlying the different theories of therapy.

2. Only persons who have received practical training under expert supervision can practise psychotherapy.

3. The situation involved a therapist and client who seeks and receives help for his/her emotional problems (this person is the focus of attention in the therapeutic process).

4. The interaction of the therapist and the client results in the consolidation or formation of the therapeutic relationship. This is a confidential, interpersonal, and dynamic relationship.

Goals:

(i) Reinforcing client's resolve for betterment.

(ii) Lessening emotional pressure.

(iii) Unfolding the potential for positive growth.

(iv) Modifying habits.

(v) Changing thinking patterns.

(vi) Increasing self-awareness.

(vii) Improving interpersonal relations and communication.

(viii) Facilitating decision-making.

(ix) Becoming aware of one's choices in life.

(x) Relating to one's social environment in a more creative and self-aware manner.

Therapeutic Relationship:

The special relationship between the client and the therapist is known as the therapeutic

relationship or alliance.

Components:

1. Contractual Nature of the Relationship: Two willing individuals, the client and the therapist, enter into a partnership which aims at helping the client overcome his/ her problems.

2. Limited Duration of the Therapy: This alliance lasts until the client becomes able to deal with his/her problems and take control of his/her life.

Properties:

(i) It is a trusting and confiding relationship.

(ii) The high level of trust enables the client to unburden herself/himself to the therapist and confide her/his psychological and personal problems to the latter.

Classification of Psychotherapies

A. PSYCHODYNAMIC THERAPY (Sigmund Freud, Carl Jung, Neo-Freudians)
Methods of Eliciting the Nature of Intrapsychic Conflict:

1. Free Association:

(i) Therapeutic relationship is established, the client feels comfortable—therapist makes client lie down on the couch, close their eyes and asks them to speak whatever comes to mind without censoring it.

(ii) Client is encouraged to freely associate one thought with another (free association).

(iii) Censoring superego and the watchful ego are kept in abeyance—client speaks whatever comes to mind in a relaxed and trusting atmosphere.

(iv) Therapist does not interrupt; the free flow of ideas, desires and conflicts of the unconscious, which had been suppressed by the ego, emerge into the conscious mind.

2. Dream Analysis:

(i) Client is asked to write down his/her dreams upon waking up.

(ii) Drams are symbols of the unfulfilled desires of the unconscious.

(iii) Dreams use symbols which signify intrapsychic forces because they are indirect expressions and hence would not alert the ego.

(iv) If unfulfilled desires are expressed directly, the ever-vigilant ego would suppress them, leading to anxiety.

(v) Symbols are interpreted according to an accepted convention of translation as the indicators of unfulfilled desires and conflicts.

Modality of Treatment:

(a) Transference: The client starts identifying the therapist with the authority figures of the past, usually childhood.

(i) The therapist maintains a non-judgmental and permissive attitude and allows the client to continue with this process of emotional identification.

(ii) Transference Neurosis: The therapist becomes a substitute for that person in the present—the client acts out the frustrations, anger, fear, that he/she harboured towards that person in the past, but could not express at the time.

• Positive Transference: The client idolizes, or falls in love with the therapist, and seeks the therapist's approval.

• Negative Transference: The client has feelings of hostility, anger and resentment*towards the therapist.

(b) Resistance: The client opposes the progress of therapy in order to protect himself/herself from the recall of painful unconscious memories.

(i) Conscious Resistance: The client deliberately hides some information

(ii) Unconscious Resistance: The client becomes silent during the therapy session, recalls trivial details without recalling the emotional ones, misses appointments, and comes late for therapy sessions.

(iii) The therapist overcomes the resistance by repeatedly confronting the patient about it and by uncovering emotions such as anxiety, fear 0'r shame, which are causing the resistance.

(c) Interpretation: The therapist uses the unconscious material that has been uncovered to make the client aware of the psychic contents and conflicts which have led to the occurrence of certain events, symptoms and conflicts.

(i) Subtle process, the pinnacle of psychoanalysis.

(ii) Two analytical techniques:

• Confrontation: The therapist points out to the client an aspect of his/her psyche that must be faced by the client.

• Clarification: The therapist brings a vague or confusing event into sharp focus by separating and highlighting important details about the event from unimportant ones.

Working Through: The repeated process of using confrontation, clarification and interpretation.

(i) Helps the patient understand the source of the problem and to integrate the uncovered material into his/her ego.

Insight: A gradual process wherein the unconscious memories are repeatedly integrated into conscious awareness; these unconscious events and memories are re-experienced in transference and are worked through.

(i) End-point of psychoanalysis, client gains a new understanding on him/ herself-conflicts of the past, defence mechanisms and physical symptoms are no longer present.

(ii) Intellectual Insight: The client starts understand herself/himself better at an intellectual level.

(iii) Emotional Insight: The emotional understanding, acceptance of one's irrational reaction to the unpleasant events of the past, and the willingness to change emotionally as well as making the change.

Duration of Treatment

• Lasts several years with a one-hour session for 4-5 days per week.

• Intense treatment, three phases.

(i) Initial Phase: Client becomes familiar with the routines, establishes a therapeutic relationship, and recollects the superficial material from the consciousness about the past and present.

(ii) Middle Phase: Characterised by transference, resistance on the part

of the client, and confrontation, clarification and working through on the therapist's part; all these processes finally lead to insight.

(iii) Third Phase: Termination; the relationship with the analyst is dissolved and the client prepares to leave the therapy.

B. BEHAVIOUR THERAPY

• Focused on the behaviour and thoughts of the client in the present.

• The past is relevant only to the extent of understanding the origins of the faulty behaviour and thought patterns, not relieved.

• Behaviour therapies are clinical application of learning theories.

• Consists of a large set of specific techniques and interventions—symptoms of the client and the clinical diagnosis are the guiding factors in the selection of the specific techniques or interventions to be applied.

• Open therapy, i.e., the therapist shares his/her method with the client.

Method of Treatment:

(i) The client is interviewed with a view to analyse his/her behaviour patterns.

(ii) Behavioural analysis is conducted to find:

(a) Malfunctioning Behaviours: Behaviours which cause distress to the client.

(b) Antecedent Factors: Those causes which predispose the person to indulge in that behaviour

(c) Maintaining Factors: Those factors which lead to the persistence of the faulty behaviour.

(iii) Aim: To eliminate the faulty behaviours and substitute them with adaptive behaviour patterns.

(a) Antecedent Operations: Control behaviour by changing something that precedes such behaviour.

(b) Establishing Operations: Induce a change in behaviour by increasing or decreasing the reinforcing value of a particular consequence.

(c) Consequent Operation: i.e., Giving reinforcement eg. Praise.

Behavioural Techniques:

1. Negative Reinforcement: Following an undesired response with an outcome that is painful or not liked.

2. Aversive Conditioning: Repeated association of undesired response with an aversive consequence present reality.

3. Positive Reinforcement: Given to increase the deficit if an adaptive behaviour occurs rarely.

4. Token Economy: Give a token as a reward every time a wanted behaviour occurs, which can be collected and exchanged for a reward.

5. Differential Reinforcement: Unwanted behaviour can be reduced (negative reinforcement) and wanted behaviour (positive reinforcement) can be increased simultaneously.

The other method is to positively reinforce the wanted behaviour and ignore the unwanted behaviour—less painful and equally effective.

6. Systematic Desensitization: A technique introduced by Wolpe for treating phobias or irrational fears.

(i) The client is interviewed to elicit fear provoking situations.

(ii) With the client, the therapist prepares a hierarchy of anxiety—provoking stimuli with the least anxiety-provoking stimuli at the bottom.

(iii) The therapist relaxes the client and asks the client to think about the least anxiety-provoking situation.

(iv) The client is asked to stop thinking of the situation if tension is felt.

(v) Over sessions, the client is able to imagine more severe fear provoking situations while maintaining the relaxation.

(vi) The client gets systematically desensitized to the fear.

Operates on the principle of reciprocal inhibition—the presence of two mutually opposing forces (relaxation response vs. anxiety-provoking scene) at the same time, inhibits the weaker force.

The client is able to tolerate progressively greater levels of anxiety because of his/her relaxed state.

7. Modelling: The procedure wherein the client learns to behave in a certain way by observing the behaviour of a role model or the therapist who initially acts as the rok; model. Vicarious learning, learning by observing others, is used and through a process of rewarding small changes in behaviour, the client gradually learns to acquire the behaviour of the model.

C. COGNITIVE THERAPY

1. Rational Emotive Therapy (RET) (Albert Ellis):

• Irrational beliefs mediate between the antecedent events and their consequences.

• The first step in RET is the antecedent-belief-consequence (ABC) analysis.

Antecedent events, which caused the psychological distress, are noted.

(ii) Client is interviewed to find out irrational beliefs, which distorting the

(iii) The therapist encourages this by being accepting, empathic, genuine and warm to the client.

(iv) The therapist conveys by his/her words and behaviours that he/she is not judging the client and will continue to show the same positive feelings towards the client even if the client is rude or confides all the 'wrong' things that he/she may have done or thought about. This is the unconditional positive regard which the therapist has for the client.

The clinical formulation is an ongoing process. Formulations may require reformulations as clinical insights are gained in the process of therapy. Distorted perception of the antecedent event due to the irrational belief leads to the consequence, i.e., negative emotions and behaviours.

• Non-directive questioning: Process by which irrational beliefs are refuted by the therapist.

(i) Nature of questioning is gentle, without probing or being directive.

(ii) Make the client think deeper into his/her assumptions about life and problems.

• Client changes the irrational beliefs by making a change in his/her philosophy about life—rational belief system replaces the irrational belief system.

2. Aaron Beck's Cognitive Therapy:

(i) Childhood experiences provided by the family and society develop core schemes or systems, which include beliefs and action patterns in the individual.

(ii) Critical events in the individual's life trigger the core, leading to the development of negative automatic thoughts.

(iii) Negative thoughts are persistent irrational thoughts characterised by cognitive distortions.

(iv) Dysfunctional Cognitive Structures: Patterns of thought which are general in nature but which distort the reality in a negative manner.

(v) Repeated occurrence of these thoughts leads to the development of feelings of anxiety and depression.

• The therapist uses questioning, which is gentle, non-threatening disputation of the client's beliefs and thoughts.

• The questions make the client think in a direction opposite to that of the negative automatic thoughts whereby she/he gains insight into the nature of her/his dysfunctional schemas, and is able to alter her/his cognitive structures.

3. Cognitive Behaviour Therapy (CBT):

• Short, comprehensive, effective treatment for a wide range of psychological disorders such as anxiety, depression, panic attacks and borderline personality.

• Adopts a biopsychosocial approach to the delineation of psychopathology.

• Combines cognitive therapy with behavioural techniques.

• Rationale—distress has its origins in the biological, psychological, and social realms.

• Addresses the biological (relaxation procedures), psychological (behaviour and cognitive therapy) and social (environmental manipulations) aspects.

D. Humanistic-Existential Therapy

Self-actualization is defined as an innate force that moves the person to become more complex, balanced, and integrated; integrated means a sense of the whole, being a complete person.

1. Self-actualization requires free emotional expression:

(a) The family and society curb emotional expression, as it is feared that a free expression of emotions can harm society by unleashing destructive forces.

(b) When emotionally expression is curbed, destructive behaviour and negative emotions by thwarting the process of emotional integration.

2. Healing occurs when the client is able to perceive the obstacles to self-actualization in his/her life and is able to remove them.

3. Therapy creates a permissive, non-judgemental and accepting atmosphere in which the client's emotions can be freely expressed.

4. The client has the freedom and responsibility to control his/her own behaviour; the therapist is merely a facilitator and guide. The chief aim of the therapy is to expand the client's awareness.

1. Existential Therapy [Logotherapy (Victor Frankl)]:

• Treatment for the soul.

• Meaning making: Process of finding meaning even in life-threatening circumstances, the basis of which is a person's quest for finding the spiritual truth of one's existence.

• Spiritual Unconscious: The storehouse of love, aesthetic awareness and values of life.

• Existential Anxiety: Neurotic anxiety of spiritual origin (spiritual anxieties leading to meaninglessness).

• Goal: To help patients find meaning and responsibility in their life irrespective of their life circumstances.

• The therapist emphasizes the unique nature of the patient's life and is open (shares his/her feelings, values and own existence).

• Emphasis is on here and now, the therapist will remind the client about the immediacy of the present.

2. Client-centered Therapy (Carl Rogers):

• Introduced the concept of self and freedom and choice as the core of one's being.

• Provides a warm relationship in which the client can reconnect with his/her disintegrated feelings.

• The therapist:

(i) Shows empathy—understands the client's experience as if it were his/her own—sets up an emotional resonance between client and therapist.

(ii) Warmth—the client feels secure and can trust the therapist.

(iii) Has unconditional positive regard, i.e., total acceptance of the client as he/she is, indicates that the positive warmth of the therapist is not dependent on what the client reveals or does in the therapy sessions.

• Client feels secure enough to explore his/her feelings; therapist reflects the feelings of the client in a non-judgemental manner the reflection is achieved by rephrasing the statements of the client, i.e., seeking simple clarifications to enhance the meaning of the client's statements.

3. Gestalt Therapy (Frederick and Laura Pearl):

• Goal: To increase an individual's self-awareness and self -acceptance.

• Client is taught to recognize the bodily processes and the emotions that are being blocked out from awareness.

• Therapist encourages the client to act out fantasies about feelings and conflicts can also be used in group settings.

E. BIOMEDICAL THERAPY

Prescription of medicines is done by psychiatrists (qualified medical doctors who have specialized in the understanding, diagnosis and treatment of mental disorders). The nature of medicine used depends on the nature of the disorder:

(i) Antipsychotic drugs—severe mental disorders (schizophrenia, bipolar disorder).

(ii) Milder drugs—common mental disorders (generalized anxiety, reactive depression).

Cause side-effects which need to be understood and monitored—essential that medication is given under proper medical supervision.

ELECTRO-CONVULSIVE THERAPY (ECT)

(i) Mild electric shock given via electrodes to the brain of the patient to induce convulsions.

(ii) The shock is given by the psychiatrist only when necessary for the improvement of the patient.

(iii) Not a routine treatment and is given only when drugs are not effective

Factors Contributing to Healing:

1. Techniques adopted by the therapist and the implementation of the same with the client, e.g., CBT for an anxious client—relaxation procedures and cognitive restructuring contribute to the healing.

2. The therapeutic alliance, which is formed between the therapist and the patient/ client, has healing properties, because of the regular availability of the therapist, and the warmth and empathy provided by the therapist.

3. Catharsis: A process of emotional unburdening by a client when he/she is being interviewed in the initial sessions of therapy to understand the nature of the problem.

4. Non-specific Factors: These factors occur across different systems of psychotherapy and across different clients/patients and different therapists.

(i) Patient Variables (motivation for change, expectation of improvement).

(ii) Therapist Variables (positive nature, good mental health, absence of unresolved emotional conflicts).

Ethics in Psychotherapy:

1. Informed consent needs to be taken.

2. Confidentiality of the client should be maintained.

3. Alleviating personal distress should be the goal of all attempts of the therapist.

4. Integrity of the practitioner-client relationship is important.

5. Respect for human rights and dignity.

6. Professional competence and skills are essential.

F. ALTERNATIVE THERAPIES Yoga:

• An ancient Indian technique detailed in the Ashtanga Yoga of Patanjali's Yoga Sutras.

• Refers to only the asanas (body posture component) or to pranayama (breathing practices).

• Techniques enhance well-being, mood, attention, mental focus, and stress tolerance.

• Reduces the time to go to sleep and improves the quality of sleep.

• Proper training by a skilled teacher and 30-minute practice everyday maximises the benefits.

Meditation refers to the practice of focusing attention on breath or on an object or thought of a mantra.

A. Sudarshana Kriya Yoga (SKY)

(i) Rapid breathing techniques induce hyperventilation.

(ii) Beneficial, low risk, low cost.

(iii) Used as a public health intervention technique to alleviate PTSD in survivors of mass disasters.

(iv) Reduces depression (research conducted at the National Institute of Mental Health and Neurosciences (NIMHANS).

(v) Reduces stress levels in substance abuse patients, e.g., alcoholics.

B. Kundalini Yoga

(i) Effective in the treatment of mental disorders and OCD.

(ii) Combines pranayama (breathing techniques) with the chanting of mantras.

C. Vipassana Meditation

(i) Mindfulness-based meditation; no fixed object or thought to hold to attention.

(ii) Person passively observes the various bodily sensations and thoughts that are passing through in his or her awareness.

(iii) Helps prevent repeated episodes of depression.

(vi) Helps patients process emotional stimuli better and prevents biases in the processing of these stimuli.

Rehabilitation of the Mentally 111:

• Aim: to empower the patient to become a productive member of society to the maximum extent possible.

• Many patients suffer from negative symptoms such as disinterest and lack of motivation to do work or to interact with people—rehabilitation is required to help such patients become self-sufficient.

• In rehabilitation, the patients are given:

(i) Occupational Therapy: teaches skills such as candle making, paper bag making and weaving to help them to form a work discipline

(ii) Social Skills Training: Develops interpersonal skills through role play, imitation and instruction; objective is to teach the patient to function in a social group.

(iii) Cognitive Retraining: Improves the basic cognitive functions of attention, memory and executive function.

(iv) Vocational Therapy: Once the patient improves sufficiently, gains skills necessary to undertake productive employment.