1 Lec 1: What is Counselling?

1.1 Why do people go to counselling?

To vent

Table 1.1 Professional most likely to be consulted for specific problem

Category of problem	Health professional chosen by participants (n)			
	Counsellor	Psychologist	Psychiatrist	Social worker
Grief and loss	**187**	61	23	66
Marriage problem	**169**	57	8	64
Alcohol problem	**167**	74	39	91
Drug problem	**165**	75	49	101
Mental health problem	43	99	**158**	21
Rape	**157**	75	56	102
Financial difficulties	**150**	22	5	110
Sexual abuse	**149**	80	57	102
Stress reduction	**148**	95	37	32
Domestic violence	**146**	34	30	68
Child behaviour	**131**	114	61	77
Depression	**119**	111	94	26
Anxiety	111	**115**	78	20
Phobias	40	**113**	112	9
Eating disorder	64	**107**	98	19
Panic attack	88	**103**	89	21
Hypnotherapy	24	85	**101**	5
Vocational assessment	**91**	71	21	52
Sexual dysfunction	90	**99**	82	24
Learning difficulty	**87**	84	25	62

Note: Data indicate frequencies (n). N = 226. Bold numbers represent highest frequency recorded for each problem professional.
Source: Sharpley, Bond and Agnew (2004). Reproduced with kind permission from Springer Science and Business Media.

Chapter 1 Counselling in the Contemporary Context 13

1.2 Definition of counselling

Counselling is the skilled and principled use of a **relationship** to facilitate self-knowledge, emotional acceptance and growth, and the optimal development of personal resources. The overall aim is to provide an opportunity to work towards living more satisfyingly and resourcefully. Counselling relationships will vary according to need, but may be concerned with developmental issues, addressing and resolving specific problems, making decisions, coping with crisis, developing personal insights and knowledge, working through feelings of inner conflict or improving relationships with others. The counsellor's role is to facilitate the client's work in ways that respect the client's values, personal resources and capacity for self-determination (BAC 1989)

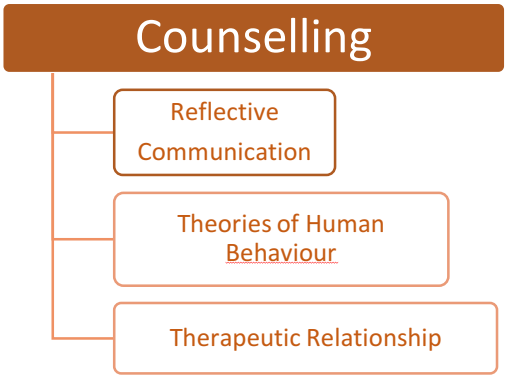
A principled **relationship** characterized by the application of one or more psychological theories and a recognized set of communication skills, modified by experience, intuition and other interpersonal factors, to client's intimate concerns, problems and aspirations. Its predominant ethos is one of facilitation rather than of advice-giving or coercion. It may be of very brief or long duration, take place in an organizational or private practice setting and may or may not overlap with practical, medical and other matters of personal welfare. It is both a distinctive activity undertaken by people agreeing to occupy the role of counsellor and client …and it is an emerging profession …It is a service sought by people in distress or in some degree of confusion who wish to discuss and resolve these in a relationship which is more disciplined and confidential than friendship, and perhaps less stigmatizing than helping relationships offered in traditional medical or psychiatric settings (Feltham and Dryden 1993)

Counsellors are not there to tell clients what to do, it is for them to figure out what to do in their own time/pace.

1.3 PACFA – from definition to description

Psychotherapy and Counselling are professional activities that utilise an interpersonal **relationship** to enable people to develop understanding about themselves and to make *changes* in their lives. Professional Psychotherapists and Counsellors work within a clearly contracted, principled relationship that enables individuals to obtain assistance in exploring and resolving issues of an interpersonal, intrapsychic, or personal nature.
PACFA: Psychotherapy and Counselling Federation Australia

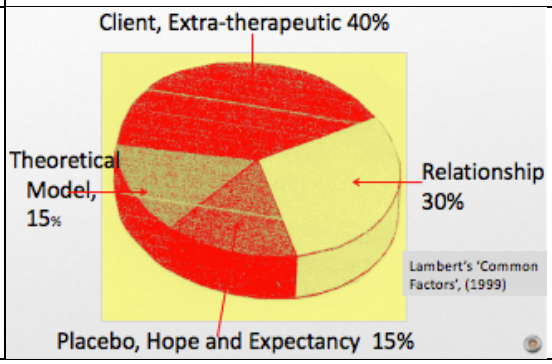
1.4 The three components

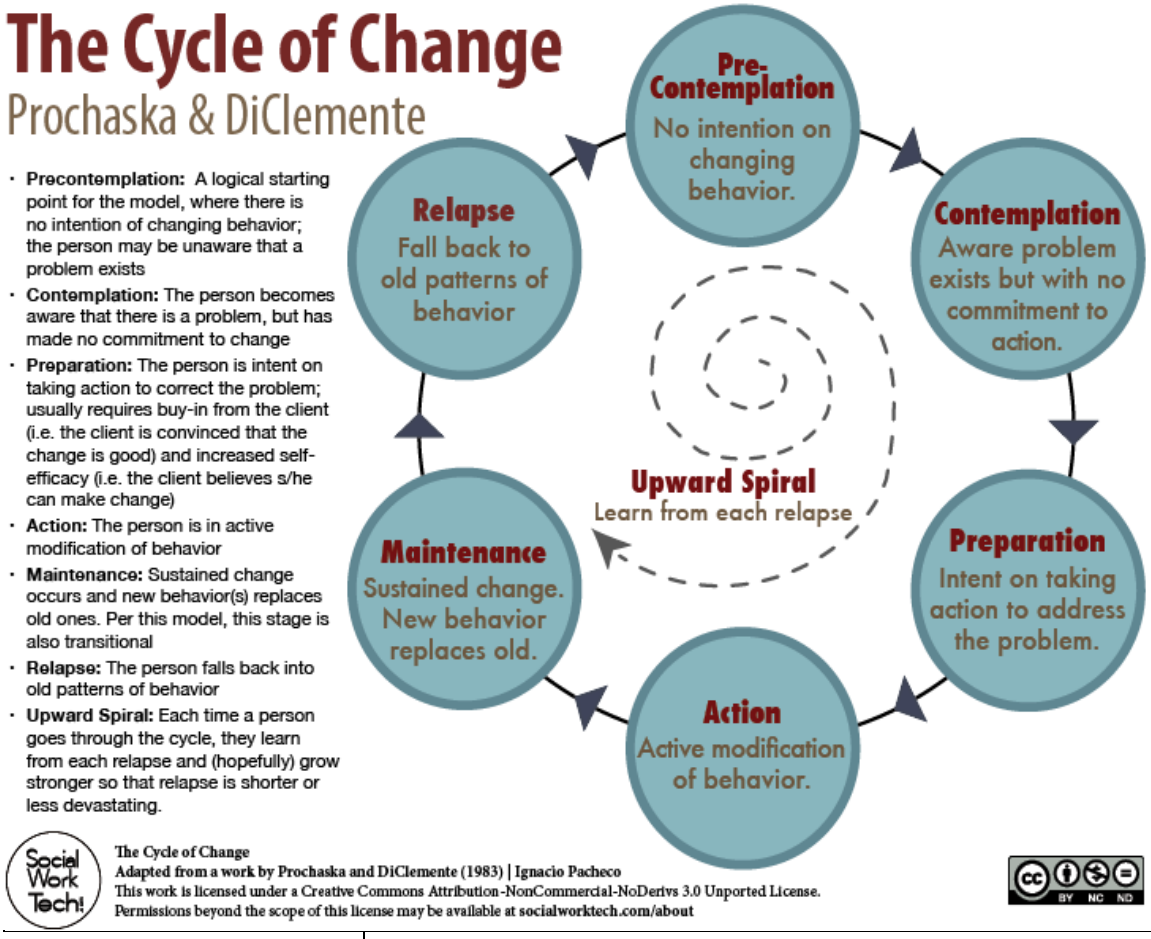


- **Reflective Communication:** the acquisition of a range of micro skills, both basic and advanced, that promotes client self-reflection and autonomous thinking
- **Theories of Human Behaviour:** that seek to explain how humans think, feel and act and the consequences of such behaviours for themselves, others and society
- **Therapeutic Relationship:** the building of a unique non-judgmental relationship between client and counsellor based on trust, respect and empathy

1.5 What is Counselling?	 ➨ **Helping:** often done by relatives, friends, support workers, human service personnel; often spontaneously. Involves advising, caring, problem solving, teaching ➨ **Counselling:** a professional activity that uses a reflective style of communication, within an interpersonal relationship to help individuals develop self-awareness and make changes in their lives ➨ **Psychotherapy:** an in depth and intensive process which involves the <u>restructuring</u> of the personality
1.5.1 Counselling is …..	➨ a process ➨ a self-help process ➨ empowering and liberating ➨ a relationship ➨ present focused ➨ for change ➨ action oriented (not real action as such, but just being in a certain way) ➨ reality based ➨ interactional ➨ about problem behaviour not problem people
1.5.2 History of Counselling	➨ Counselling emerged in the late 1800s and early 1900s ➨ Events including WWI, WWII and the Great Depression influenced the evolution of counselling throughout the early 20th century. ➨ The 1950s saw a profound change in counselling with the establishment of associations including the American Personnel and Guidance Association and the Society of Counselling Psychology, along with the new guidance and counselling theories (such as behavioural theories and cognitive theories). ➨ Counselling as a distinct profession increased steadily from the 1960s. ➨ Throughout the 1980s, counselling diversified and counsellors began to be employed in significant numbers in schools. ➨ Current trends ➨ 400-500 different ‘theories’ ➨ practiced in a variety of settings ➨ various modes of delivery ➨ steps towards regulation in the last 20 years (more on this later in the semester)
	https://prezi.com/lpdsqf1h6n75/trinity540-counseling-history-timeline/ • Hippocrates o Developed 1st counselling techniques and interventions o Introduced the concept of prognosis ▪ Thinking about what the outcome might be • Dorothea Dix o Started Social reform of 1880s in US system o Be kind to people who are suffering • Modern day counselling: early beginnings in vocations and testing o Getting to know the person
1.5.3 Counselling works	➨ counselling always works much better than no counselling ➨ some clients recover faster than others ➨ all approaches achieve equivalent results for general life issues ➨ counselling can make a minority of clients worse
1.5.4 What we used to think …	• That the efficiency of a particular approach to therapy is due to the unique aspects of that therapy • Psychoanalytic – interpretation • CBT – Modification of cognitions • EMDR – Eye movement • Narrative therapy – externalisation • Gestalt – Empty chair
1.5.5 What we now	• The curative properties of a given psychotherapy lie not in its unique components but in

know …		common components shared by all therapies.
		• Frank and Frank (1991 – *Persuasion and Healing)* identified four effective characteristics (shared by all therapies)
		  • An emotionally charged, confiding relationship with a helping person
		  • A healing setting
		  • E.g. bedroom is not one
		  • A rationale, conceptual scheme or myth that provides a plausible explanation for the patient's symptoms and prescribes a ritual or procedure for resolving them
		  • A ritual or procedure that requires the active participation of both patient and therapist that is believed by both to be the means of restoring the patient's health. (pp 42, 43)
		• Lambert assigned <u>percentages</u> to common factors…

1.5.6 What Works in Therapy		client, extra-therapeutic: • Client's intelligent, openness to change placebo, hope and expectancy • just by going to counselling will help you feel better



1.5.7 What is an outcome?	➨ Resolution of the original problem
	  ➢ new understanding or perspective on the problem
	  ➢ acceptance of the problem
	  ➢ taking action to change problem situation
	➨ Learning
	  ➢ new understanding, skills and strategies to better handle similar problems in the future
	➨ Interpersonal impact
	  ➢ better equipped to contribute to healthy relationships and well-being of others

1.5.7.1 Factors that contribute to a	1. Support – providing reassurance, empathy, trust and carthasis (release of emotions, not just about venting, but crying etc).

positive outcome	2. Facilitation of learning which includes cognitive learning, paying attention to feelings and feedback (from others) • Knowledge type of learning 3. Action, including behaviour regulation, cognitive mastery, reality testing, and practising new behaviours (Lambert and Bergin, 1994). 4. Reflective practice, supported by supervision, a focus on change processes, and awareness of the social and cultural contexts of individual problems are also important (Boswell et al., 2010). • Engage in self-reflection ➢ What did I say/do that strengthen/weaken the relationship • Continues professional supervision throughout career 5. Being empathic … https://www.youtube.com/watch?v=5O11_Ma20Rk • Not problem solve, even if you think you know the answer
1.5.7.2 Reasons people give for NOT attending counselling …	1. Having counselling is a sign of weakness 2. Counselling is for crazy people – I'm not crazy 3. People will end up finding out I'm having counselling 4. I wouldn't know what to say/talk about 5. I can just talk to my friends 6. I don't know how "just talking" to a complete stranger could help 7. I'd feel like I was betraying my family/friend/partner 8. Talking about my problems will just make it worse – it'll open a can of worms 9. What if my professional indemnity insurer finds out? Stigmas in getting help in emotional problems
1.6 Goals of the Unit	• enhanced self-awareness • insight into your developmental history • developing self-monitoring skills • mature understanding of human behaviour • more skilled as a helper • help discovery of your potential • being a good advocate for the counselling profession • assist in the choice of a career path in counselling
1.7 Readings Chapter 1: What is Counselling; Chapter 2: The Counselling Relationship - Geldard, David, Geldard,Kathryn	• Geldard, D & K. *Basic Personal Counselling,* Part 1 • Mc Leod, J. *An Introduction to Counselling,* Chapter 1

2 Lec 2: Counselling Microskills – basic

2.1 HOW do you counsel?

- It's about joining with a client and communicating effectively within the parameters of facilitating a shift or change.
- Specific communication tools are used to assist the counsellor in understanding what the client is REALLY saying.
- The underlying principle should always be one of Beneficence – "First, do no harm". Is the tool/strategy/microskill the right one for this client, at this time, in these circumstances.

2.2 Atypical communication

Not part of everyday communication:
has to be learnt through:

- reading appropriate texts
- modeling by competent counsellors
- video taped demonstrations
- observing real life counselling sessions
- intensive practice

2.3 Reflective Communication is

a) Tuning into the client's agenda, getting on the client's wave length, perceiving the experience from within his/her 'frame of reference'
b) Reflecting that experience back to the client; holding it up in a manner that the client begins to get a clearer, sharper picture of his/her experience/thought(s)/feelings

It is therefore ….

- **active** listening
- client centered
- exploratory
- Non (overtly) evaluative/ non-judgmental
- Non-directive
- empathic

2.3.1 Active Listening

- Not just hearing
- Not polite silence
- Listening with your eyes
- Entering the client's 'frame of reference'
- Communicating to the clients that you are fully present
- Requires a range of specific communication skills. Micro-skills are "individual skills that can be learnt which greatly enhance the quality and effectiveness of the counselling relationship".

https://www.youtube.com/watch?v=OS0Tg0IjCp4

2.3.2 Micro Skills: the building blocks of Active Listening. Basic skills (for the purpose of this unit)

Non-Verbal

- attending
- observing

Verbal

- minimal responses (verbal and non-verbal)
- paraphrasing – reflecting content
- reflecting feelings
- reflecting feeling and content
- effective questioning
- summarising

2.4 Listening Variables

2.4.1 Physiological Influencers

- Sensory acuity, especially auditory **and** visual, is basic to listening. Age-related deterioration of sensory mechanisms can lead to loss of both the verbal content **and** the nonverbal dimensions of the communication.
- Age also is an important listening variable. Children, adolescents, young adults, older adults, **and** elders report different listening needs, different listening goals, **and** different listening strategies as they account for listening expectations **and** for listening experiences alike.
    - Depends on what your needs are is what you will hear (selective hearing)

	▶ Gender: Brain imaging research (Phillips, Lowe, Lurito, Dzemidzic, & Mathews, 2001) demonstrate that men **and** women have different attention styles **and** cognitive processing styles to the communicative interaction. ▶ Men **and** women "learn to listen for different purposes **and** have different listening goals. The primary contrast appears in task versus interpersonal understanding: Males tend to hear facts, while females are more aware of the mood of the communication" (Booth-Butterfield, 1984, p. 39).

2.4.2 Psychological Influencers	▶ Attitudinal state: A positive listening attitude, along with listening knowledge, is a critical ingredient of effective listening. Be interested!
	▶ Being open to hearing differing points of view **and** to speakers whose styles are not necessarily attractive or engaging.
	  ○ Some people's style can be loud and harsh, and if counsellors let this affect their feeling, then they will not be able to hear exactly what these people are saying
	▶ Positive listening attitudes are not often communicated: "You're not listening." "You never listen to me." "Be quiet **and** listen." We hear these comments more often than: "Thanks for listening" or "You're a good listener."
	▶ Communication apprehension: "the fear of misinterpreting, inadequately processing, **and**/or not being able to adjust psychologically to messages sent by others". Listening anxiety stemming from stressful situations can lead to distorted messages **and** misunderstandings.
	  ○ E.g. not remembering what you said and hear after a job interview
	▶ Roberts **and** Vinson (1998) determined that the importance of the topic is the crucial factor in establishing a listener's willingness to listen.
	▶ Listening preferences. Listeners choose different ways to listen:
	  ○ (1) a people-oriented style, which focuses on the emotional **and** relational aspects of a communication; broadly speaking, women tend to have this style
	  ○ (2) a content-oriented style, centred on processing complex information;
	  ○ (3) an action-oriented style, where the listener prefers clear, efficient information;
	  ○ (4) a time-oriented style, where the listener has a preference for short, limited messages.
	  ○ a good therapist should have all these skills

2.4.3 Contextual Influencers	▶ Roles, culture, **and** time.
	▶ We listen differently in different contexts: family members, friends, students, workers, or managers.
	▶ Culture. Anthropologist Edward Hall (Hall & Hall, 1989) described how different cultures manage information in different ways.
	  ○ Low-context cultures, such as the United States and Australia, require communicators to give **and** receive a considerable amount of verbal information,
	  ○ High-context cultures, such as Japan **and** Saudi Arabia, requires less extensive verbal messages
	▶ Time. People deal with information differently at different times of the day. Information presented in the afternoon may be retained longer than that offered in the morning. (Wolvin, 2009)
	▶ Listeners can listen (**and** think) about four times faster than the normal conversation rate. There is a "time gap" in the system for attention to wander **and** to lose focus.

2.5 Attending	▶ checking comfort level
	  ○ physical comfort, e.g. chair, water, temperature, tissues
	▶ physical attending – SOLER
	  ○ "Sit squarely"; "Open posture"; "Lean towards the other"; "Eye contact; "Relax"
	▶ conveying availability and presence
	  ○ making clients feel like you are listening to their messages
	▶ expressiveness
	▶ mirroring posture
	  ○ we have mirror neurons, so if we are connected with someone, we will naturally mirror what others are doing
	▶ avoid stereotypical counsellor mannerisms

2.6 Observing	▶ body language

	▶ verbal-nonverbal congruence
	  ○ mismatch on what is being said and client's affect
	▶ facial expressions
	▶ para-language
	  ○ clients' gesture may change when a particular topic is touched
	▶ movements
	▶ physical attire
	▶ emotional state
	▶ energy level
	▶ dyadic interaction (couple counselling)

2.7 Minimal Responses	By showing subtle action can encourage clients to keep talking as you are showing that you are paying attention. • Verbal – one or two words, a phrase, an utterance. eg, uh huh, mmmm, yes, and, ok, … • Non-verbal – a movement, eg, a nod of the head or movement of the arms or hands ▶ confirms active listening ▶ encourages client to keep talking ▶ emphasises significance ▶ establishes clarity **not**: use minimal responses to make (wrong) assumption ▶ endorsing ▶ agreeing ▶ sympathising, consoling ▶ patting on the back
2.8 Paraphrasing: reflecting content	▶ isolating the salient content of the client's response ▶ reflecting that back to the client in a clear, more succinct manner ▶ must be brief, not an expansion or a random convoluted summary of content ▶ inaccurate paraphrases? **Not** ▶ parroting ▶ interpreting ▶ labeling ○ e.g. you are in the sun because you are fit ▶ putting new ideas/thoughts into the client's head

2.9 Reflecting Feeling	▶ isolating what the client is experiencing *emotionally*
	▶ sensitive reflecting back to the client these feeling/s
	▶ identifying both explicit and implicit expression of feeling
	▶ identifying the level of intensity
	▶ facilitating the expression of feelings and providing a 'space' for catharsis
	▶ watch arbitrary labeling; giving clients feelings
	▶ counsellor needs to deal with his/her feelings
	  ○ what are the appropriate and inappropriate feelings
	▶ contributes most to building an empathic relationship
	▶ it's important to practice, e.g.
	  ○ when I feel angry I feel ….. e.g. it consumes me/impulsive/out of control
	  ○ when I feel accepted I feel …. E.g. valued
	
	TIP for counselling:
	• start looking for and learning about feeling words, e.g. http://www.psychpage.com/learning/library/assess/feelings.html
	• Emotional lexicon: words associate with basic emotions (anger, fear, anticipation, trust, surprise, sadness, joy, and disgust) and two sentiments (negative and positive)

2.10 Reflecting Feeling and Content	▶ with experience it is often convenient to link feeling with content in a single response ○ Eg, you're feeling betrayed (feeling) because your sister went behind your back and spoke to your husband about your issues (information). ▶ the response must be skillfully integrated; succinct and not wordy

	▶ reflection of feeling can at times be more powerful: helps client stay with the emotional experience rather than move to a head level ○ move from heart level to head level, when clients talks about the feeling, counsellors reply with the content ▶ helpful in checking congruence between client's thoughts and feelings ▶ helpful in mirroring the intensity of the client's experience- cognitive or emotional

2.11 Questions	▶ gathering relevant information
	▶ clarifying client's thoughts and feelings
	▶ heighten client awareness
	▶ used sparingly
	  ○ too many questions can be off-putting, make clients felt like interrogation
	  ○ this can be hard with clients who are not talkative, therefore a skill to be comfortable with silence is important
	▶ more on the 'open' (requires response that is more than just yes/no) end of the continuum than on the 'closed'
	▶ assists client to open up, disclose more: to be more specific or behaviourally explicit
	▶ help with getting a better understanding of the client's experience
	▶ help to access specific and *relevant* information
	▶ avoid 'why' questions; focus on 'what', 'when', 'where', 'how'
	  ○ questions start with why often have a judgement tone, e.g. why did you quit the job before a new one?
	Not
	▶ intrusive; to satisfy counsellor's curiosity; gather irrelevant information
	  ○ can be tempting to want to find out irrelevant info because you are interested in people
	▶ leading, directing, suggesting
	▶ interrogating

2.11.1 Types of Questions	▶ transitional - establishing <u>connections</u>, links; often to an earlier part of the discussion. Eg, earlier you mentioned ***, I'm wondering how you are feeling about that now?
	  ○ used when you are stuck and unsure what to say
	▶ exploring choice – Eg, in what other ways could you respond to that?
	▶ circular – perspective of the other. Eg, how do you imagine your brother would feel about ***
	▶ scaling – tracking change Eg, on a scale of 1 – 10, how useful was that strategy?
	▶ goaling - establishing direction. Eg, if could imagine not feeling stressed at work, what would the first improvement be?
	▶ leading – points the prospective answer in a particular direction
	  ○ e.g. for someone wants to lose weight
	  ○ Close leading question: have you thought about getting up early to go for a walk?
	  ○ This is a leading question because counsellor is telling the client on what to do. Close: yes/no
	  ○ Rather than explore the feeling and talk about it, why they are depressed after gain 5kg. Counsellors come up with ideas on tips and answers on how to lose weight
	
	Avoid …. (Ivey & Ivey, 2003)
	▶ *Bombardment/grilling:* asking too many questions one after the other. The counsellor is setting the agenda.
	▶ *Multiple questions*: This occurs when counsellors ask several questions at once. E.g. "Please tell me about yourself-– how old are you, where were you born, do you have any children and what do you do for a living?"
	▶ *Questions as statements*: Using questions to sell your own points of view. For example, "Don't you think it would be helpful if you studied more?" "What do you think of trying relaxation exercises instead of what you are doing now?" Also known as closed leading questions. Judgemental questions.
	▶ *Why questions*: Generally, just don't do it …

2.11.2 Summarising	▶ helps client stop and review the ground traversed ▶ reflecting back to the client *salient* aspects of his/her presenting issues ▶ helps to make connections, build bridges, identify themes

	▶ sorts out disconnected material into more manageable units: helps client 'see a pathway through the forest'
	▶ could indicate a turning point, a moment of self-evaluation, identification of a goal, a strategic pause
	▶ timing and context are vital;
	  ○ don't do it every 5 minutes, it can disrupts the flow
	Not
	▶ always essential
	▶ a re-run of what has been covered
	▶ a tabulation of every issue that has been raised
	  ○ not a recording of every issues

2.12 Responses to avoid	▶ Moralising, preaching
	  ○ Be careful on giving your own opinion
	▶ Advising, giving solutions, lecturing, logical arguments, debating
	  ○ Generally speaking, this is not counsellor's job
	▶ Interpreting, Analysing, Diagnosing, labelling
	  ○ Ok to hypothesis, rather than a diagnosis type of analysis. E.g. a few weeks ago you mentioned that, and now you are telling me this. I wonder if there might be a connection
	▶ Reassuring, sympathising, consoling, minimising
	  ○ Car is a write off but you are ok
	▶ Interrogating, probing
	▶ Humouring, diverting
	▶ Completing sentences
	▶ Praising, applauding
	▶ Judging, evaluating disagreeing, blaming

2.13 Readings Gerald_chapter 5-8	• Chapters 5: Joining and Listening pp.41-50 • Chapter 6: Reflection of Content (Paraphrasing) pp.51-60 • Chapter 7: Reflection of Feelings pp. 61-70 • Chapter 8: Reflection of Content and Feelings pp.71-78

3 Lec 3: Advanced MicroSkills

3.1 Advanced Skills

- primary skills are essential but not necessarily sufficient
- a trusting, empathic therapeutic relationship is a necessary **pre-requisite**
- advanced skills are required where there is an 'impasse', a feeling of being 'stuck' or 'going around in circles'
- must be used selectively, with care and sensitivity and at times, after consultation

3.2 Advanced Micro Skills

- normalising
- reframing
- challenging (confrontation)
- exploring options
- highlighting choice
- therapist self-disclosure

3.2.1 Normalising

Making a particular situation seem/confirm normal.

Emotional States

- reduces anxiety and brings emotional relief (no, you're not crazy/odd/dysfunctional)
- allays (diminish) fears of 'falling apart'
- a sensitive response can pave the way for referral where necessary

Developmental and Existential Crises

e.g.

- developmental crisis
  - puberty, moving out of home at 35
- existential crises
  - diagnosis a life-threatening disease at age of 23

- raises awareness of the <u>inevitability</u> of life crises
- reduces the accompanying high levels of stress
- instills (establish) hope and optimism and helps integration
  - when used skilfully can integrate into a broader narrative of people's life
- facilitates 'meaning making' and re-visioning

*Must not involve the minimising or devaluing of the client's experience (Oh, everyone feels like that when *** happens) … using <u>tentative</u> language can assist – "I'm <u>thinking</u> it's <u>probably</u> not unusual to feel/think that in this situation" (suggestive rather than imposing).*

3.2.1.1 Examples

- A mother comes to see you and she is upset because her 15 year old daughter wants to go out on Saturday night with her friends instead of staying at home with the family.
- Possible "normalising" response:
  - "a lot of teenage girls are wanting to establish peer relationships, which is important, however it makes sense that there is a bit of a sense of loss as they become more independent".
  - Kids at that age do want to hang out with their friends
- So, still <u>acknowledging</u> the mother's feelings as well as <u>normalising</u> the situation.

- A client comes to see you regarding a follow up letter she received from her daughter's therapist (cc'd to violent ex-partner) where her children's names were mixed up and misspelled, sentences were incomplete, personal information (from the mother – not the child/client) was notes and an incorrect diagnosis provided. She says she is furious and wonders if she 'should be'
  - When you are professional betrayed, it's not unreasonable to be bothered by it.

3.2.2 Reframing

- Sometimes a client's perspective can be clouded by pessimism, negativity, poor self-esteem, depression etc. These factors will impact upon the client's journey toward improvement/shifting.
- helping client to see a different perspective
- presenting an expanded view of the situation
- reframing behaviour in an adaptive way
  - more positive and helpful

- highlighting alternative possibilities
- reframing loaded words and phrases
  - maybe she is not trying to get on your nerves, but just want to make sure everything is done properly and that's her priority
- expanding perspectives of the self
- drawing attention to the difference between intent and impact
  - I wonder if your parents want to shield you from the embarrasement of walking into class late
- offering a 'positive spin' on perceived failures

Tutorial notes

- sharing new light, different idea/meaning, but also validate existing one
- change someone's frame
  - your parents don't hate you, they just really care for you

Understand the difference

- **reflection of content**: different words, same meaning
- **reframing**: different meaning

3.2.2.1 example

- It's all in the language …
  - A problem as an opportunity
  - A weakness as a strength
    - Shift the frame of 'thinking being used', to people saw that as a strength of yours hence why people come to you
  - An impossibility as a distant possibility
  - A distant possibility as a near possibility
  - Oppression ('against me') as neutral ('doesn't care about me')
  - Unkindness as lack of understanding
    - When a young boy complains how someone is being unkind
    - Reframe it to 'who taught you how to be a nice boy', maybe he is not as fortunate to have someone in teaching him how to be kind.

Textbook examples

Initial frame	Reframe
I am in a tunnel and I can't see a way out.	Every tunnel has an entrance and exit
I know I will never be confident	Being confident starts with having insights about our limits
He/she is out at night and that means that he/she does not love me anymore.	Private time away can help you to appreciate each other much more.

Client: Client involved in car accident has recently returned to work and notices that she is triggered by car sounds.
Reframe by counsellor: accident has made you more aware of the need to pay attention when you hear a car.

- Sometimes is about taking some of the stings out of clients' statement

Exam tip: important to understand the difference between normalising and reframing

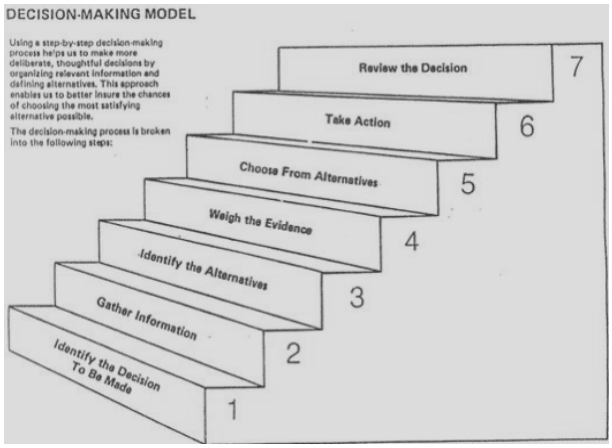
A client comes to see you shortly after separating from a long-term relationship. They discovered their partner had been having an 'extra-marital' affair for about a year and 'cannot believe I was so stupid… such an idiot'
Reframe: I wonder if your devote and care with her was your priority, rather than being sufficient. I wonder if your personality is being more trustworthy than suspicious.
Normalising: it's not unreasonable that you would trust your partner after 18 years.

3.2.3 Challenging

- Challenging/confrontation is often associated with aggression – tends to be poorly-utilised.
- In counselling it's about raising awareness (where a primary skill has failed). Used to highlight discrepancies that the client is unaware of.
- must be respectful and non-threatening
- counsellor must be aware of his/her feelings, motives, goals
  - is it your frustration that clients should have got it by now?

	➨ skilful confrontation helps clients receive so-called negative message ➨ context and timing is critical can be used for self-understanding, curiosity don't use it as being judgemental as clients could sense that
3.2.3.1 When to Challenge?	Use it when you felt a strong therapeutic relationship is established. ➨ client is in denial ➨ failure to recognise self-destructive and self- defeating behaviours ➨ not accepting the possibility of serious consequences ➨ what happens if you are involved in a car accident under the influence of alcohol and drugs, and the person killed is your love one? ➨ And what happens if clients' response is – I will be too off my face to care about it. (when the addiction is too deep, people won't change over-night. They are comfortable with what they are doing and counselling may not work if the attendance was due to external factor, e.g. a mother made her child to see the counsellor.) ➨ Keep in mind you may not always get the desirable outcome when you challenge the client ➨ Clients do better with challenging are clients that are very committed to personal growth. They are not there just to fix the issue, but to get any benefit they can from therapy. They would embrace the entire experience. ➨ making contradictory statements ➨ going around in circles ➨ unable or refusal to focus on the present ➨ verbal – nonverbal incongruence ➨ when a practical joke turned into a disastrous injury, and the client is laughing when talking about it. The counsellor could challenge the incongruence for his own curiosity. Sometimes the answer can have its reason – our family agreed on a strategy to deal with trauma is to make a joke ➨ rupture of therapeutic relationship ➨ not ready to change – pre-contemplative stage
3.2.3.2 How to challenge …	➨ (Perhaps) begin with a brief summary of what has been communicated (client *feels* heard) ➨ Communication of the counsellor's feelings (maybe) ➨ Clear statement about what the counsellor has noticed that is incongruent. ➨ Examples ➨ Couple who *agreed* to homework then didn't do it. ➨ Client committed to longevity who smokes. ➨ 19 year old who wants to be rich and won't make a phone call to get a different job. ➨ Client who doesn't want to be controlling but insists on exact times his wife will visit her sister
3.2.4 Exploring Options	➨ when clients make a preemptive conclusion that there is 'no solution' or only two polar possibilities ➨ reflecting feelings of being 'stuck', 'trapped', 'imprisoned', 'frozen' ➨ using an open question to facilitate exploration of options ➨ **not** the offering of options except in a tentative way and as a contribution ➨ NOT – why don't you just do this or that (judgmental, it's basically like saying I can't believe that you haven't…) ➨ Tentative- I am wondering if there is something…. ➨ Not right or wrong, but different
3.2.4.1 Generating Options	➨ facilitate a wide spectrum of options ➨ summarise to bring clarity ➨ explore positive and negative outcomes of all options ➨ rank order in terms of preference ➨ encourage the use of both rationality and emotion in decision making ➨ emphasize autonomy and the element of 'choice' (Glasser, 1998. Choice Theory) Once you give permission to someone to do something, the initial rage may go away, e.g.

	• Initial rage: I want to destroy my wife financially
	• And if you tell clients that they can't/shouldn't, they are more incline to do it
	• But if you generate some options:
	  ○ I think it's possible one day you may have loving relationship with your children
	  ○ I think maybe down the track you won't want to financially destroy her
	  ○ Maybe one day you won't care about any of this and go travelling for the rest of your life
	  ○ I don't know but I feel like there are other options.

3.2.5 The significance of 'Choice'	➨ there is always a choice ➨ the difference between what 'I should do' and what 'I want to do' ➨ the myth of a 'right choice' as opposed to a responsible choice ➨ it is the most desirable, sensible, appropriate, effective choice in a context ➨ validating the choice 'not to choose' the inevitability of intrapersonal tension (in physiological sense) in making choices, e.g. head-tension, heat rising on the face ➨ can be useful when flag the feeling of sensation appropriately with the client, an advance skill of normalising the feeling. Message of empathy. 

3.2.6 Therapist Self-Disclosure	➨ *Indirect* self-disclosure is unavoidable
	  ➨ Age, gender, room décor, wedding ring, certain jewellery, forthcoming holidays
	➨ *Direct* disclosure relates to intentional verbal disclosures
	Self-involving disclosure
	  ➨ affirmation of client awareness
	  ➨ I am aware of you are always making an effort to do your homework to get most of the benefit, just like my children
	  ➨ disclosures about the therapeutic process
	  ➨ Comment on nature of the rapport
	  ➨ 'cheer leading' and 'benevolent curiosity'
	  ➨ to be avoided, but can be used if doing life coaching
	Self-Disclosing responses
	  ➨ intentional sharing of the therapist's feelings, thoughts and life experiences
	  ➨ be careful when using this, e.g. your sister sounds so much like my sister

3.2.6.1 Historical context and Therapeutic Orientation	➨ 1912, Freud: "the physician should be impenetrable to the patient and like a mirror (blank screen), reflect nothing but that which is shown to him".
	➨ Humanist movement in the late 60's, self-help & feminist movements in 70's and 80's resulted in an overt shift around fostering an egalitarian relationship between the client and therapist.
	➨ Humanistic and existential therapists highlight importance of transparency.
	➨ 1990s. Influence of high profile individuals self-disclosure. E.g., Oprah self-disclosing her life stories.
	➨ Group psychotherapy: Yalom: "group psychotherapists may – just like any other members in the group – openly share their thoughts and feelings in a judicious and responsible manner, respond to others authentically and acknowledge or refute motives and feelings attributed to them".
	➨ CBT & BT (behavioural therapy): many believe it is problematic to answer questions with a question:
	  ➨ E.g. do you have any kids?
	  ➨ "Can you tell me why you want to know that".
	  ➨ they don't promote self-disclosure
	➨ Narrative Therapy – refer to self-disclosure as "transparency".

3.2.6.2 Intentional Self-Disclosure	➨ the research shows mixed results; must be used with care ➨ can be burdensome to client ➨ add another worry for client

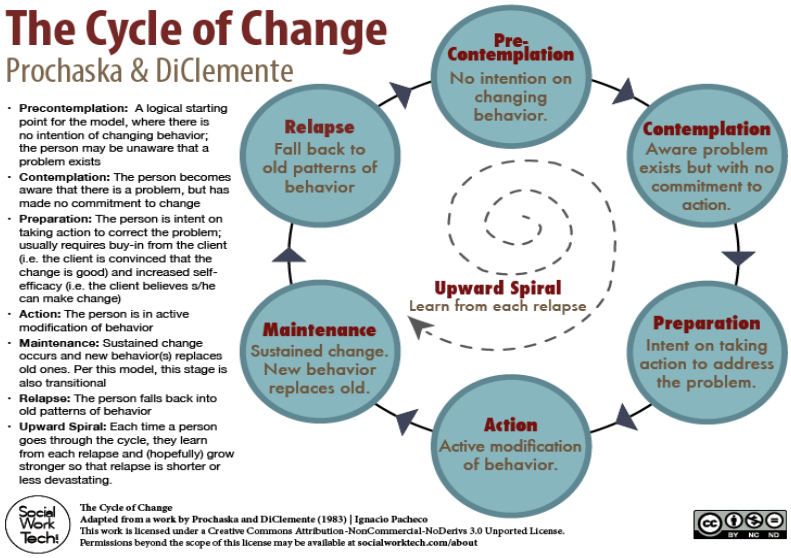
	➨ detracts from the client's story ➨ can become exhibitionistic ➨ awareness of counter-transference issues ➨ what impact does this have on the client, what they think about you, and the impact on the therapeutic relationship ➨ not for the novice/trainee counsellor

3.2.6.3 Useful for certain cohorts	➨ Self-help and 12 step programs
	  ➨ Self-disclosure of your own addiction journey, and self-disclosure is part of the success to recovery
	  ➨ one reason: they are not alone, because before disclosing, these people are living in the shame. After AA meeting, they discover others such as doctors, lawyers.
	➨ Children and those with cognitive impairment
	  ➨ Kids like to hear adult's rebellious behaviours
	➨ Adolescents – can assist in clients feeling more respected than judged and/or patronised
	➨ Religious and spiritual based therapies
	➨ LGBTI
	➨ War veterans with PTSD
	➨ Marginalised individuals
	
	Useful when clients felt you have understanding about what they are going through and how they are feeling.

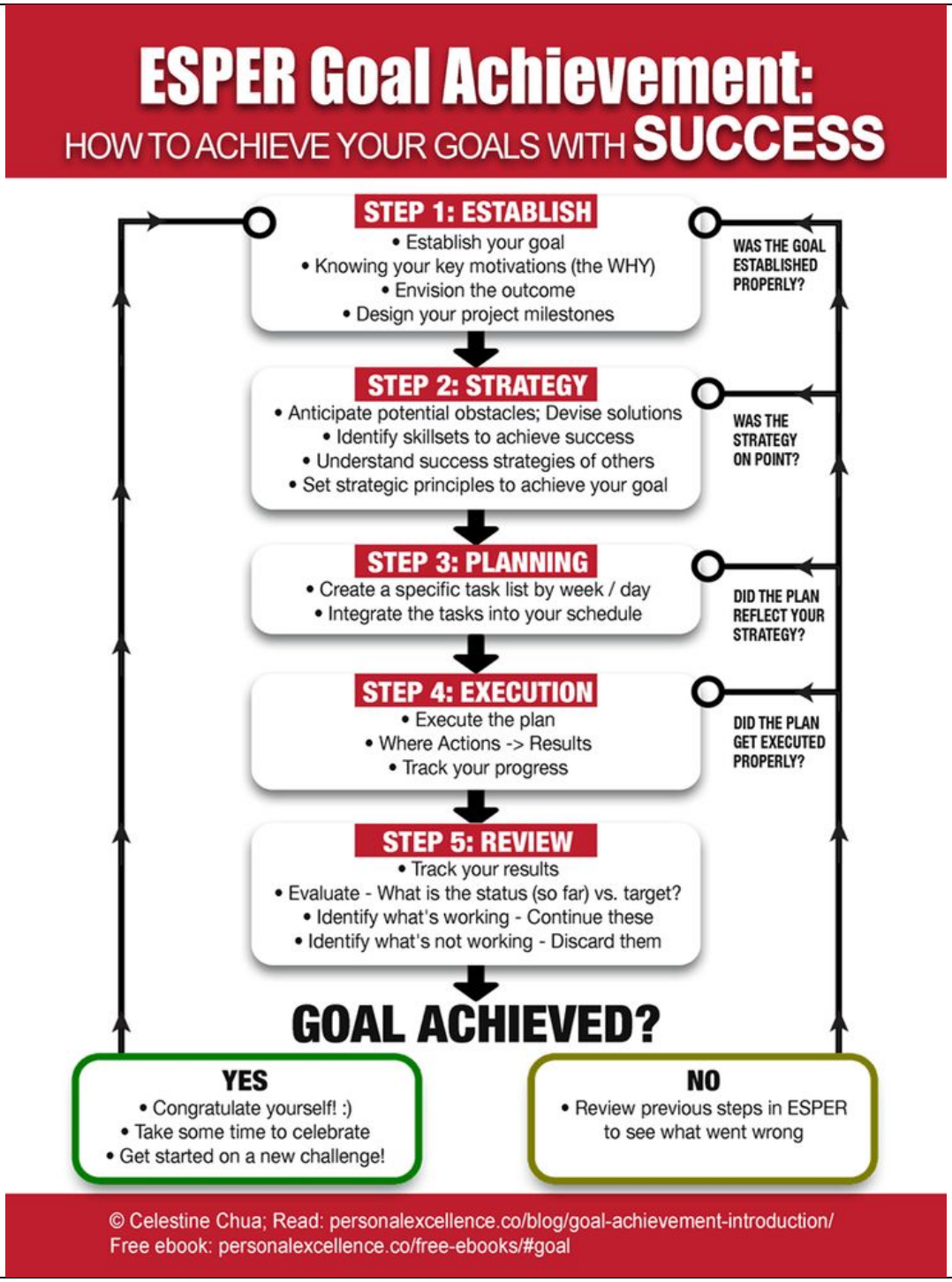
3.2.6.4 Questions to ask yourself-…	➨ What is your reason for self-disclosing to this client at this time? ➨ What is your need to "get closer" to the client about? ➨ What are you trying to achieve via self-disclosure? ➨ Will this self-disclosure detract from the client's issues? ➨ Will this self-disclosure disempower the client? ➨ Will this self-disclosure alter the client's expectations of the counsellor? ➨ Is there any possibility that this self-disclosure will be used against the client at a later stage? ➨ Is the client emotionally stable enough to "hear" the self-disclosure in the way it is intended. ➨ What will happen if you don't self-disclose?
3.3 Readings	Geldard, D & K (2011) Selected Chapters from Part IV (see CMD)

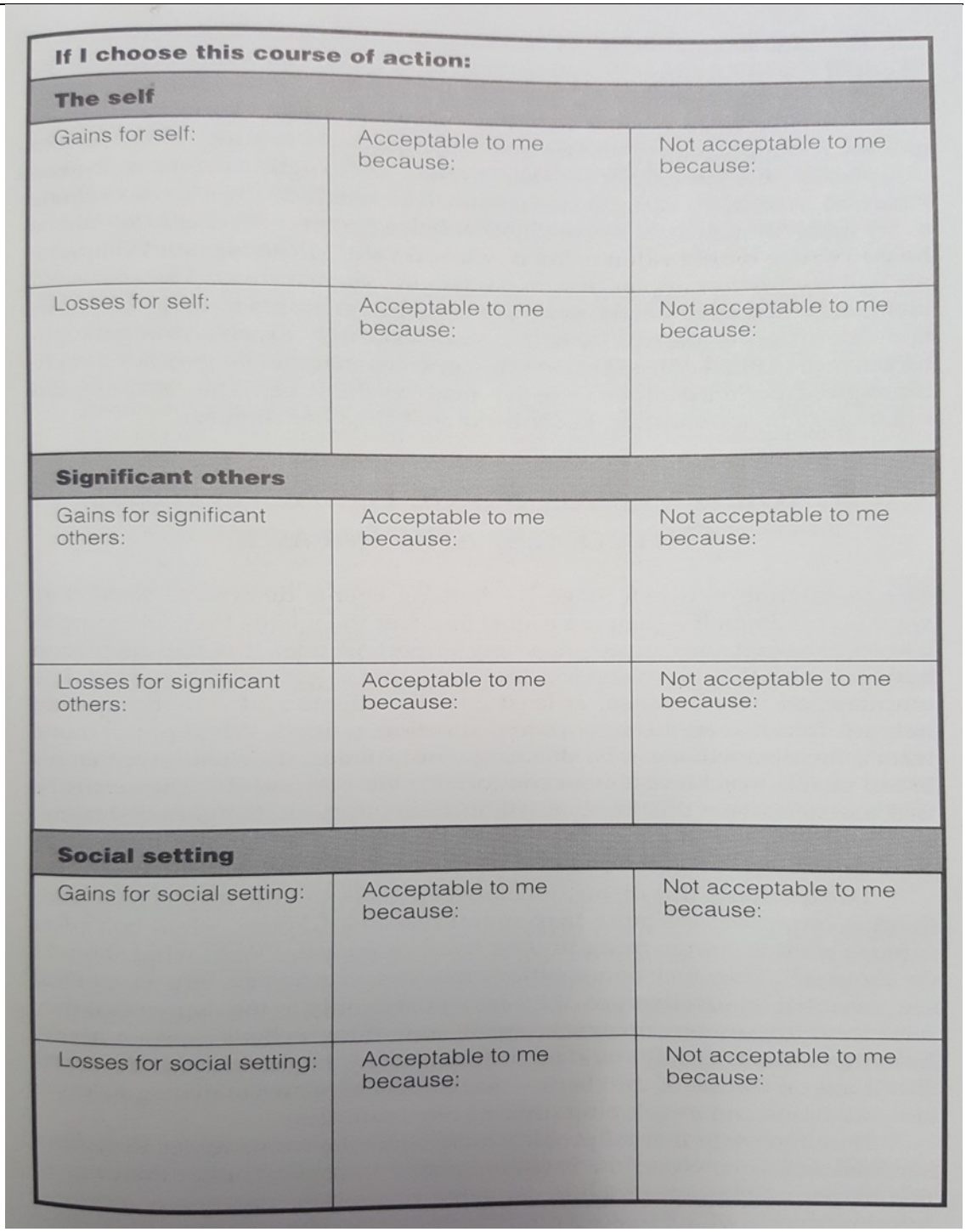
4 Lec 4: GOALING/GOAL-SETTING IN COUNSELLING

LEARNING OBJECTIVES…
- Identify the purpose of goal setting with clients and the forms these goals may take
- Discuss the functions of counselling goals
- Identify what an effective goal would look like
- Distinguish between outcome goals and process goals
- Discuss goals as moving from good intentions to specific behaviours
- Discuss the characteristics of an effective goal and how to help clients develop effective goals
- Consider the skills associated with goal setting
- Discuss the contexts in which goal setting may be more challenging

4.1 THE PURPOSE OF GOAL SETTING…	•Clients can experience psychological blocks, they may lack confidence or necessary skills to move forward -> require help to move to action •We can facilitate clients' progress by helping them design, choose, craft, shape and develop goals
4.2 TWO ASPECTS TO GOAL SETTING…	•To help clients (and you) determine what they want to get from their sessions with you •To help clients identify how they will achieve a task or goal outside of the therapeutic context
	
4.3 FUNCTIONS OF COUNSELLING GOALS… (HACKNEY & CORMIER, 2013)	•Goals can be motivational •Goals can be educational •Goals can serve an evaluative function •Goals can be made across a range of contexts •Material Goals •Family and Friends Goals •Educational/ Intellectual/ Professional Goals •Health Goals •Leisure Goals •Spiritual Goals •Creative Goals •Emotional/ Psychological Growth
4.4 WHAT SHOULD AN EFFECTIVE GOAL INVOLVE? (EGAN, 2010)	•Outcome-oriented •Specific •Substantive and challenging •Venturesome and prudent •Realistic •Sustainable •Flexible •Congruent with values •Reasonable time frame
4.4.1 EXAMPLES OF OUTCOME GOAL	•"I want to start doing some exercise" •"Within 6 months I will be running 5km in less than 40 minutes at least four times a week"

	(EGAN, 2010)	•Think about goals as accomplishments
4.4.2	MOVING FROM A GOOD INTENTION TO A SPECIFIC GOAL (EGAN, 2010)	•"This session has been an eye opener. I realised that my wife and kids don't see my investment - or overinvestment - in work as something I am doing for them. I have been fooling myself-telling myself-that I am working hard to get them all they want and need. I just realised that In fact I am spending most of my time at work because I like it. My work is mainly for me. It's time to realign some of my priorities. " •Declaration of intent: "I don't think I'm spending so much time at work in order to run away from family life. But family life is deteriorating because I'm just not around enough. I must spend more time with my wife and kids. Actually, it's not just a case of must. I want to." •Broad aim •Counsellor: "Tell me what spending more time at home will look like?" •"I am going to consistently spend 3 out of 4 weekends a month at home. •During the week I'll work no more than two evenings." (Specific goal) •Counsellor: what will you be doing with all this time at home? •"I will be doing things with my wife and kids – quality time… doing things, picnics… taking them fishing… playing footy…" (Breaking down goal into actions/tasks)
4.4.3	REALISTIC AND CONGRUENT GOALS	• Under the client's control •Attainable within the client's life context (I can come home early 3 times a week…) •Congruent with the client's values and beliefs (My family is important, I want them to have shared memories…) •Client has access to the necessary skills and resources •Client has explored consequences of change (will work less – or maybe more sustainably…)
4.4.4	SUBSTANTIVE AND CHALLENGING GOALS	•Makes a significant contribution towards the desired outcome (creates quality time, memories…) •Requires commitment and effort from the client – stretches him/her •Balance between 'goal difficulty' and 'goal performance' – relates to client self-efficacy about making wise and purposive choices
4.4.5	NEGOTIATING A TIME FRAME	•Not 'sometime or other'; 'when ready' ("when do you think you will be ready to do this?") •Identifying immediate outcomes in the context of therapy ("how will our work together here help you?") •Facilitating intermediate outcomes – transferring modified behaviours to real life situations ("What kind of changes in your everyday life will you notice in the next two weeks?") •Affirming final outcomes – constructive and sustainable change (" you have achieved … how will this continue to be part of your life..?)
4.4.6	FLEXIBILITY AND EVALUATION	•Goals adapted to changing circumstances ("with the new baby coming, what will you need to change or adapt with your exercise regime?") •Open to trade offs between goal specificity and goal flexibility ("will you need a bit more time to achieve your goal?") •Maximizing achievements – 'cheer-leading' ("You have been doing so well with … keep going" … used in life-coaching) •Building in and identifying potential rewards, reassessing and evaluating outcomes
4.4.7	THE FIRST STEP	•Emphasise here and now action ("what small thing can you start doing today..?") •Assessing level of motivation (" tell me on a scale of 1-10 how motivated you are to do this….?") •Identifying potential hurdles ("What could get in the way of you spending more time with your family?") •Explore secondary gains •Relapse prevention strategies ("What will help you to get back to being with your kids more ?") •Exploring consequences ("Are there things you will sacrifice …? Are there people in your life who will support/not support you? ") •Recognizing meta-goals/super-ordinate goals ("What will be important to you to keep you going?")
4.5	THE SHADOW SIDE OF GOAL SETTING (EGAN)	•Goal setting pushes clients out of "safe"/familiar place of talking, exploring, "caring and sharing". Both counsellor and client may resist the shift. •Some people are "happier" living in victimhood. "Victimhood and self-responsibility make poor

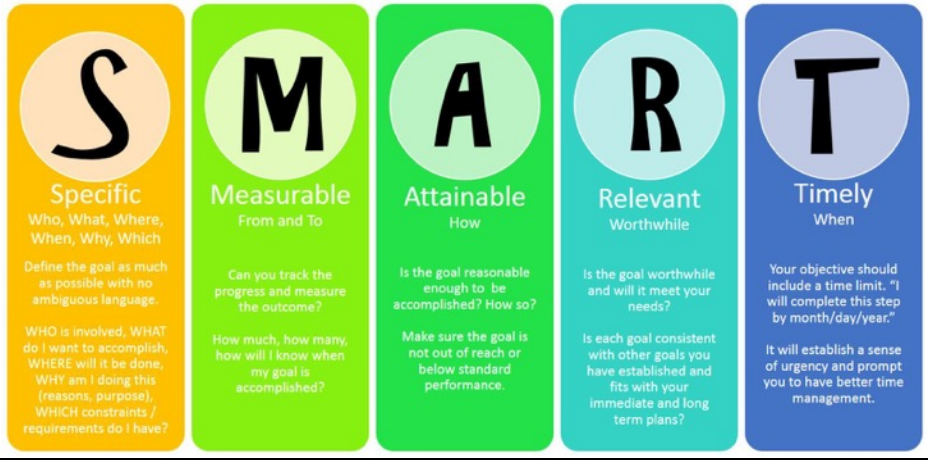
	bed-fellows". •Goal-setting can involves work, effort, pain, struggle. •Although achieving a goal can be liberating, it can be subsequently cause an unwanted consequence – eg, achieving a career goal might result in lost family relationship
4.6 SKILLS ASSOCIATED WITH GOAL SETTING (HACKNEY & CORMIER, 2013)	•Verbal skills •Visualising activities •Verbal confrontations •Affirming responses •Structuring skills (Useful tools when clients need help understanding the goal-setting process) •Goal-setting map •Timelines •Successive approximation (shaping) – use of rewards
	



If I choose this course of action:		
The self		
Gains for self:	Acceptable to me because:	Not acceptable to me because:
Losses for self:	Acceptable to me because:	Not acceptable to me because:
Significant others		
Gains for significant others:	Acceptable to me because:	Not acceptable to me because:
Losses for significant others:	Acceptable to me because:	Not acceptable to me because:
Social setting		
Gains for social setting:	Acceptable to me because:	Not acceptable to me because:
Losses for social setting:	Acceptable to me because:	Not acceptable to me because:

Of course you can add in other areas of life that will be impacted by the decision:
•Workplace
•Sporting team

4.7 A common concept

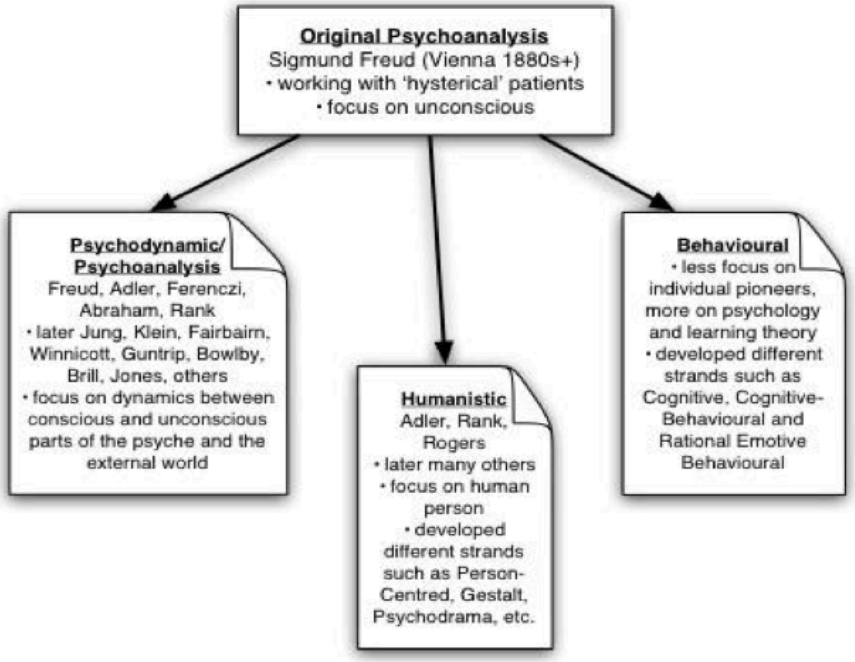


4.8 ADDITIONAL TIPS

•Create a personal mantra. 2 – 5 words that capture the essence of the goal. Use positive

	(ARINA NIKITINA)	language. Write it down and look at it often. •Set up motivating, inspirational environment (open, clutter-free, breaks) •Use inevitability thinking – set conditions that make it difficult to fail (eg, giving someone $20 every time you miss gym)
4.9	GOAL SETTING IN DIFFERENT CONTEXTS	•Goal setting with children •Consider developmental stage •Crises and goal setting • Do not set goals during the middle of crisis •The counsellor will have therapeutic goals. Mutual goal-setting is not possible •Multicultural contexts •Monk, Winslade, Sinclair (2008) – refer to Sue and Sue (2007) – Asian Americans, African Americans, Latinos, Native Americans – have short term/immediate goals; whites – long-range goals. "Goal setting is a product of class differences and economic advantage".
4.10	THERAPEUTIC MODELS AND GOAL-SETTING	•Different models of therapy will seek to achieve broad goals with clients.

Psychoanalysis	**Resolve unconscious conflict; healthy defenses**
Person-centred Tx	Resolve incongruence between self-and experience
Existential Tx	Understanding of life; authenticity, freedom
REBT	Rational thoughts/life philosophy, knowledge of ABCs
Reality Tx	Healthy choices that satisfy basic needs – esp attachment needs
SFT (Solution Focused Therapist)	Resolve the complaint
Narrative Tx	Reauthor preferred narrative



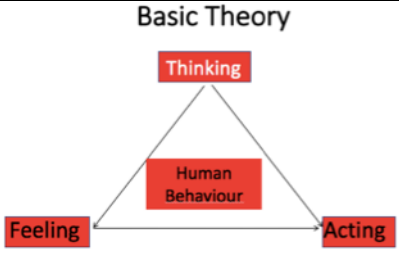
5.1 Albert Ellis (1913-2007)

- Dysfunctional family background. Grew up in the Bronx. Not a fan of school
- Health (diabetes) and emotional problems in early years
- Varied career background, struggled to stick with one career path
- Reaction to early psychoanalytic training developed a therapeutic approach that would help him personally – insight alone is not curative … why counts for …
  - U can understand and know why, but it doesn't necessary evoke change
- Long and controversial professional career
- Prolific writer (sexuality, relationships) (lots of friends/people sought his counsel, which led him to develop REBT) and energetic, flamboyant practitioner

5.2 Self-experimentation

- Shy with girls (and public speaking):
  - "if I fail, I fail. If I die of discomfort, I die", so be it, but I'm going to do this
- Sit in Bronx gardens – 100 + girls/month
  - Didn't get a date in the first month, but noticed fear had reduced significantly
  - By the end of second month – three dates
- Practice and practice until he became someone who is known as good at public speaking
- Initially known as Rational Therapy. He would have called the resultant therapy – Cognitive-Emotive Behaviour Therapy

5.3 REBT Philosophy

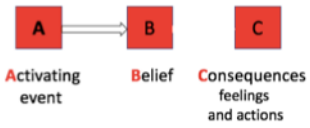


- preceded by early schools of thought that prioritised cognition
- psychological distress largely due to defective *cognitive* processing
  - distorted/incorrect thinking
- humans are <u>biologically</u> programmed to be both rational and irrational in their thinking
- affirms the intrinsic worth of human nature; distinguished *behaviour* from *being*
  - instead of saying, you are a naughty boy, burning down the house was the naughty thing to do
  - look at the behaviour, not the person
- emphasised human fallibility and personal responsibility
  - even for non CBT/REBT therapist, they would still use the concept from this therapy
- emphasised *hedonism*: humans seek pleasure and avoid pain

5.3.1 The A-B-C Theory (Irrational beliefs)

A couple had a massive fight because the wife went to sleep in the spare room because husband was snoring aloud.

- A: partner is missing
- B: she must be crossed at him for something



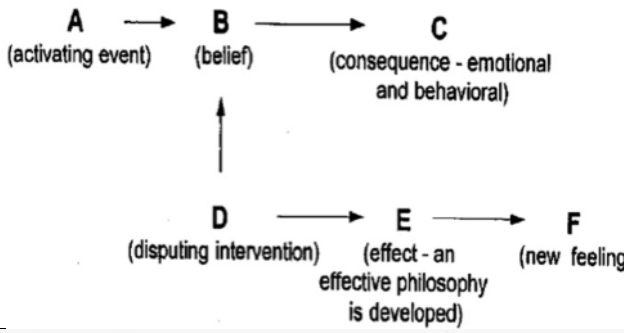
- C: he went to the spare room and said to her "what is your problem"

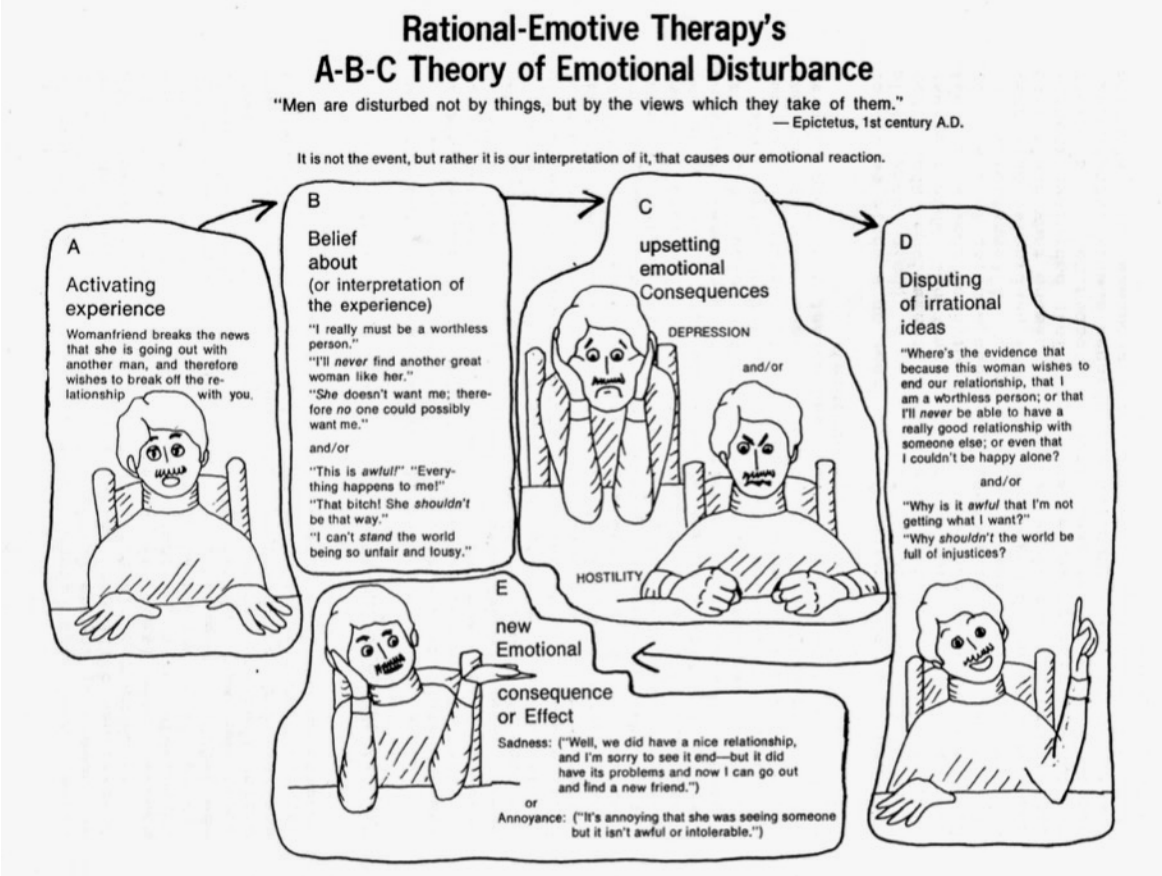
His belief in what the activating event was resulted in this consequence.

5.3.2 The A-B-Cs of disputing irrational beliefs

REBT wants to dispute irrational/false/unproven belief

- D: I wonder if there is another reason why she is crossed at me.
- E: I wondered if it's my 20 years of snoring.
- F: What a sensible thoughtful caring partner I have





5.3.3 Irrational Beliefs [Ellis, 1975]

- Must
- Should
- Ought

- I **must** be loved or approved of by every significant person in my life
  - Dispute: do you like every person you come across? And is it reasonable that every person likes you?
- I **must** be competent, adequate, and achieving in all respects if I am to consider myself-worthwhile
- it is terrible and catastrophic when things are not the way they **ought** to be; it's not fair
- I **should** get what I want, when I want it. If I don't get what I want, it's terrible, and I can't stand it; it frustrates me
  - There is no rule about: if I'm nice to you, then you should be nice to me
- one **ought** to be able to rely on others and expect them to act in certain ways
- I **should** be quite upset/concerned about other peoples' problems
  - I just don't care is that wrong? (again, no rules about this)
- other people **must** treat me considerately, fairly, kindly; exactly the way I want them to treat me
  - nice to have, but holding onto this belief would only causes pain

What are your thoughts on the above. Do you at times think in a similar manner?
If you subscribed to these irrational beliefs, you can get frustrated, disappointed
First time hearing these beliefs can be shocking.
We may be modelled at a young age.

5.3.4	Theory of restructuring Irrational Beliefs	➢ Clients create their own emotional reactions and dysfunctional responses
		➢ They stem from irrational beliefs
		➢ Clients have the ability to change the way they react and respond
		➢ **Step one is to recognize and identify the irrational beliefs**
		➢ Clients must see the value of disputing these beliefs
		➢ Change demands hard work
		  ➢ Change years of entrenched thinking/response
		  ➢ Undoing neuro pathway
		➢ It requires the practice of REBT for the rest of life
		  ➢ Just when you think you have fixed it, something else will surface

5.3.5	The Therapeutic Process	➢ Demonstrate through teaching the A-B-C's of how clients create their emotional reactions and dysfunctional behaviours
		  ➢ To teach people to notice what they are saying to themselves about the event
		  ➢ Therapist: tell me when that happens, what are you saying to yourself?
		  ➢ E.g. Husband: Not going to the gym today? Wife heard: You are an elephant, you are lazy and need to go to the gym (wife's historical view of herself)
		➢ Assist clients with identifying and disputing their irrational beliefs and modifying their thinking – **cognitive restructuring**
		  ➢ Wife: Yes, I'm going right now and you can cook your own dinner
		➢ Demonstrate how clients maintain their emotional reactions and dysfunctional behaviours through re-indoctrinating (teach to accept set of beliefs) themselves
		  ➢ Challenge to every irrational belief
		➢ Encourage and assist clients to engage in activities that will counter their irrational beliefs
		➢ Challenge clients to develop a *rational* philosophy of life

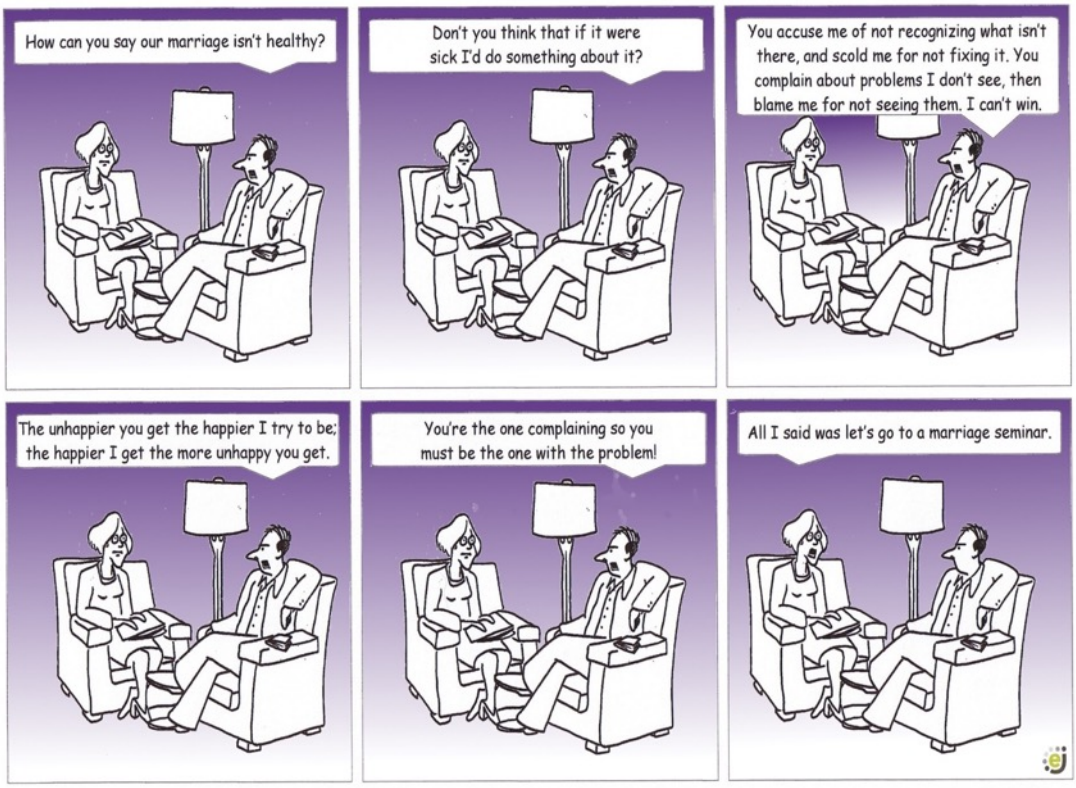
5.3.6	Therapeutic Techniques	A multimodal and integrative approach tailored to suit the individual client with a continuing emphasis on ***cognition*** as opposed to ***affect*** - Focus on what they were thinking - What are you thinking/internal dialogue? What are you saying to yourself? - Therapist may assist by giving some options, and keeps going back to that cognition

5.3.7	Cognitive Techniques	➢ Teaching clients about REBT and ABCDEF
		  ➢ Can work with young children, teach them the link between thoughts and behaviours
		  ➢ If you think you are a bully, and you behave like a bully, how may you feel? Probably feel like a bully (change the word from bully to good person)
		➢ Assist clients in actively disputing their irrational beliefs
		  ➢ Should/must
		➢ Emphasising the value of functional, realistic, rational, logical thinking
		  ➢ Difficult when emotions are strong
		  ➢ REBT should not be used in grief
		  ➢ REBT is absurd and disrespectful when a client just lost a love one
		  ➢ E.g. saying, u know everyone dies
		➢ Encouraging clients to change their *absolutistic* and *musturbatory* thinking by learning new 'self-statements'
		  ➢ Instead of saying, I need to be good at everything, otherwise Im no good
		  ➢ Change to, Im someone puts reasonable effort and feel comfortable with the effort I put in
		➢ Use of humour to counteract the over serious side of a client's thinking
		➢ Cognitive home-work to transfer REBT techniques to real life situations
		  ➢ To teach people to quickly notice what their internal dialogues are

5.3.8	Emotive Techniques	Help clients know the value of unconditional self-acceptance (USA) and unconditional other acceptance (UOA) – even if the behaviour is hard to accept – via:
		
		• Rational-emotive imagery
		  ○ Frequent practice of challenging clients to imagine "the worst possible thing that could happen" – e.g. feeling devastated, feeling stupid etc. Change those intense feelings to more positive ones.
		  ○ To a student whom have high anxiety about walking into class late: what is the worst thing that could happen? Maybe the teach would faint and the whole class would

	laugh ○ Worse possible things are manageable ○ Exercise: write down one thing people don't want to know about you, one thing the world don't want to know about you. Then we will throw in the fire, as a symbolic release of shame. Then instruct people to read it out before threw in the fire. Two things learnt: • The world did not end • It did not alter people's opinion about anyone else in the group (UOA) • role playing and role reversal ○ Useful for people suffer with anxiety ○ Rehearse scenarios. Practice focusing on unhelpful self-talk ○ Role play 5 mins presentation in front of fake objects • CLIENT: people are thinking I am stupid. THERAPIST: really, how do you know that? And what other people think is none of your business • shame/guilt/embarrassment attacking exercises ○ Designed to increase self-acceptance and really know that allegedly embarrassing experiences are not so catastrophic, examples: • client to wear toilet paper behind their pants and walk around shopping centre • wear T-shirt inside out • leave spinach around teeth and have conversations ○ get the client to recognise what they are saying to themselves, and after a few minutes, how are the thoughts shifted? • Use of force/vigour exercises ○ Therapist adopts client's unhelpful belief, client acts as therapist and has to convince "client" about irrationality of the belief • THERAPIST: I just think that everyone should be as nice as I am. CLIENT to challenge the belief ○ REBT believes it entrenches that the ability to challenge irrational believes if you do that
5.3.9 Behavioural Techniques	➢ Adapting many typical behavioural techniques to change thinking ➢ Behavioural homework assignments ➢ Self-monitoring irrational thinking using behaviour diaries and/or cues ○ Some REBT/CBT have workbooks ➢ Bibliotherapy ○ Encourage to read about rational thinking and irrational beliefs, continues psycho education
5.3.10 The Therapeutic Relationship	➢ based on an authoritative stance combined with full *acceptance* and *tolerance* ○ therapist is the teacher, but also with warmth, acceptance, patience ➢ the therapist as active *teacher* rather than an emphasis on warmth and empathy ➢ avoids 'indulgence therapy'; not about clients *feeling* better but *getting* better ○ REBT does not like client only talks about their feeling, and spent majority of the session complaining and being upset ➢ avoids lengthy discussion of 'A's or dwelling on C's ○ not so much details of the event ○ more on what were you saying to yourself ➢ collaborative and skilled use of a variety of techniques ○ equal communication, unlike Person Centred Therapy where clients talk more
5.4 Cognitive Therapy Aaron Beck (1921-still alive) 	➢ Born into a Russian practising Jewish family ➢ Childhood trauma and poor self-worth ➢ Plagued by anxiety arising from numerous phobias ➢ Qualified as a psychiatrist trained in psychoanalysis ➢ Impact of early work on analysis of dreams of depressed clients ➢ Prolific writer and researcher
5.4.1 Basic Philosophy	➢ an evolutionary perspective of human nature: humans trying to make meaning of their environment through cognitive processing ➢ we make meaning of the world by what we think ➢ in part a derivative from and in part a reaction against classical psychoanalysis

	➢ psychoanalysis did not work in all cases, analysing dreams wasn't useful for some depressed patients ➢ a *constructivist* approach that assumes both an external, objective reality as well as a personal, subjective one ➢ there is reality out there, but we also construct our own reality/meaning ➢ *insight* focused in its attention to cognitive processes that are accessible to introspection ➢ not looking at the sub-consciously of what you are thinking ➢ looking at thoughts we can access with introspection ➢ need to teach people the introspective ➢ mainly a theory of psychological dysfunction
5.4.2 Cognitive Distortions (Aaron Beck)	➢ arbitrary inferences (including catastrophising) o reaching conclusions without sufficient/relevant evidence o e.g. sat night party is going to be terrible because weather is bad ➢ selective abstraction o forming conclusions based on an isolated detail o know one thing about the event/practice and make global assumption on how it supposed to be o e.g. legalise same sex marriage means boys will be wearing skirt to school ➢ overgeneralisation o holding extreme belief on the basis of a single event. Applying rules across different settings/contexts o not visiting dentist ever again, because last dentist visit caused 3 weeks of pain afterwards. (not considering other context/setting) ➢ magnification or minimisation o over-estimating significance of negative events o use of catastrophe scale, client may say parents died is 100, misplacing a book for half an hour is 10 (no big deal), going on a camp (80). Client initially demonstrated anxiety is going on a camp. Therapist then added more higher end events, e.g. break ups. Every time an event was added, going on a camp would drop ➢ personalisation o automated assumption: it's all about ME, I have done something wrong. o Challenge: what if this has to do with someone else, is this a possibility? ➢ labelling and mislabelling o take one characteristic about a person and attribute to the whole person ➢ polarised (dichotomous) thinking o all-or-nothing thinking o it's all good/right, or all bad/wrong ➢ emotional reasoning o how I feel = how it is o I feel terrible so it must be terrible ➢ mind reading o I KNOW what you're thinking o We all do it to some degree ➢ absolutistic thinking
	- mind reading - dichotomous thinking - emotional reasoning - magnification - personalisation



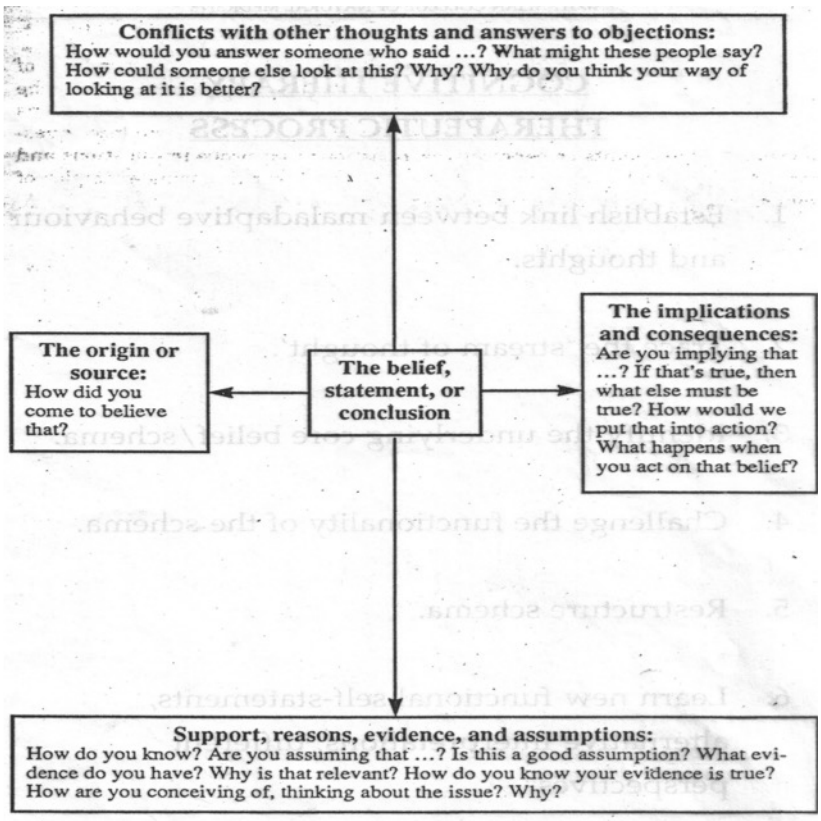
5.4.3 Therapeutic Relationship	➢ core person-centred therapeutic conditions are *necessary* but not sufficient
	  ➢ CBT believes therapeutic relationship isn't enough to affect change
	➢ therapist must be active, skilled in cognitive conceptualization, creative and able to engage in Socratic dialogue
	➢ therapist functions as a catalyst and guide assisting clients make the necessary links between their behaviour and their cognitions (thought patterns)
	  ➢ proactive engagement with client: pointing out distortion has caused a particular behaviour
	➢ an educative partnership which assists clients make their own discoveries through active engagement (***collaborative empiricism***)

5.4.4 Therapeutic Process	➢ establish link between maladaptive behaviour and the client's idiosyncratic thoughts
	➢ teach client to identify the distorted cognitions through <u>deliberate thought monitoring</u>
	  ➢ what am I saying to myself?
	➢ trace the 'stream of thought' identifying the activating schema (core beliefs) – prevents lapses
	  ➢ preventing relapse, and change schema
	  ➢ CBT/REBT: change core belief about self (USA/UOA)
	  ➢ Irrational thinking to leave, and quickly locking rational message to self
	  ➢ By doing this quickly, clients develop different ways of responding
	  ➢ E.g. hearing husband saying "not going to the gym" has different meaning now compare to 20 years ago – working off different schema
	➢ through 'Socratic dialogue' assist client to test the functionality of their thoughts/schema - *guided discovery*
	➢ assist clients to restructure their thoughts/schemas
	➢ client learns new functional self-statements, alternative interpretations, different perspectives

5.4.5 Socratic Dialogue	Part of socratic dialogue is to touch on how that belief came to exist. Challenging the origin can assist in changing that schema. Conflicts with other thoughts and answers to objections - Constant challenging and questioning - Teaching clients to challenge their distorted thinking - How would you feel is you said that to yourself? The origin or source - If you were taught by your parents about that belief - Or u think people from that country are bad tempered, what if your team consist of only those people

Support, reasons, evidence, assumptions

- Is that assumption a helpful way of thinking?
- E.g. kids have been separated from parents for a long time, and they have been told their parents are nice. Before meeting them, therapist tell the kid about 'evidence'. Someone said the teacher Mrs. Smith is not nice, but she treats you well, and you only see her treating others nicely too. So that is evidence. Or, you asked a kid if she ate the biscuits, she said no, you replied, but the evidence tells me that you did because there is crumps on your face



5.4.6 Therapeutic Techniques

- flexible use of any ethical technique that attacks the client's dysfunctional thoughts
- homework as essential component of therapy
- cognitive restructuring through:
  - deactivating automatic thoughts, beliefs and schemas
  - modifying their content and structure
  - constructing more adaptive cognitive structures to neutralize them
  - e.g. Therapist may say, in my experience, no one is all good or all bad
- Socratic questioning
- thought - recording through use of specific instruments
  - diaries
- graded assignments to deal with complex and overwhelming tasks
  - start small, e.g. going to a small shop first, if they are anxious in going to big shops (homework, assignment)

5.5 REBT VS CBT

REBT	CBT
• Directive, persuasive, confrontational ○ Comfortable in challenging clients on what is going on • Inductive process • Therapist as expert teacher • Psycho-educational process • Targeting irrational and non-functional thoughts • Technical competence	• Socratic dialogue, open questioning, facilitating • Deductive process – catalyst and guide • Inaccurate, distorted, rigid deep seated beliefs • Empathy, sensitivity, therapeutic alliance (not sufficient along, need to have other processes in place)

5.6 Feeling Good

Good Feelings contribute significantly to our well being
BUT
we feel the way we think
AND
we do not have to express every thought that enters our head
THEREFORE
we can ***choose*** our thoughts
we can *learn* to think differently

	we have the power to keep a thought or let it go Crux of REBT/CBT - Recognising usefulness of thoughts, unhelpfulness of other thoughts, knowing that we don't have to hold onto particular thoughts/beliefs if they are not serving us well

6 Lec 6: Psychodynamic Theory

6.1 Psychoanalytic Psychodynamic Theory

- Is based on Freud and further developed by other neo-Freudians (neo-analytic approaches)
  major impact on subsequent theories significant influence on lay persons'
- Freudian analysis - understanding of the human psyche requires intensive **long-term** training of the analyst
- Analyst needs to have had their own therapy

- Psychodynamic – psychology that is in a dynamic flux
  - between conscious and unconscious, known and unknown, repressed or emerged from unconscious
- Psychoanalytic – Freud used analysis to find out what is happening within a person
- Full analysis usually about 10 years, twice a week.
- Client learnt about themselves through analysis/interaction through Freudian therapist.
- Eveything comes up between therapist and client is important. Every argument has a value, it will be disected, analysed, understood and link back to the past
- Intensive therapy: 3-5 days/week. If you miss a day, you need to talk about it
- Not suitable for everyone

6.2 Sigmund Freud (1856-1939)

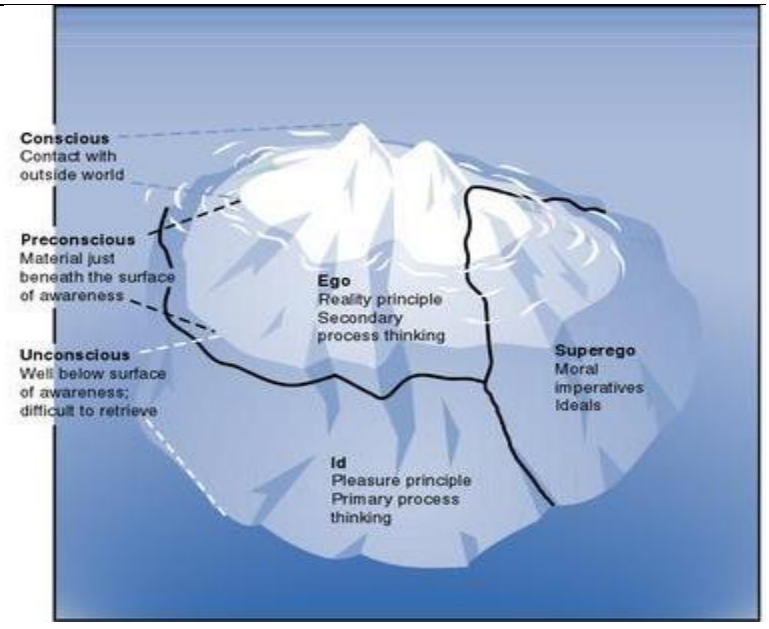
- Born in Vietnam
- First born son of a very poor Jewish parents
- Had many interests – chose to study Medicine
- Originator of Psychoanalysis
- Devoted his life to create the model of the human psyche and personality and psychoanalysis
- Prolific writer (Collected Works in 24 Volumes)
- Ardent worker – had a extremely busy practice
- Died in London in 1939 (end of World War)

- Active and driven mind from an early age
- Wanted to be a scientist, looked and observed people in a scientific way
- Still uses many of Freud language today, e.g. someone is anal. It comes from the anal stage – holding onto things
- Driven personality, saw 10 clients a day, rest of the awaking times he would write, 11-12pm at night he had therapy with his daughter – Ana Freud. Sleep 3-4 hours a day

6.3 Model of Personality

Id

- Pleasure principle
- Primary process thinking
- Like a child, no conscious about others, all about me, my drive, e.g. I am hungry/unhappy
- Basic drives: hunger, sleep



Superego

- Moral principle that guides you, this is where the "should" comes from
- Imperatives ideals
- Ideology that guides us
- I should be like that, working hard. The superego talk
- If you are a Perfectionist, that is your superego driving you

Ego

- Reality principle, the adult part of us
- Secondary