APPROACHES AND TECHNIQUES OF COUNSELING

Diploma in Psychological Guidance and Counselling

Paper-IV

Dept. of Psychology

Acharya Nagarjuna University

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FOREWORD

Since its establishment in 1976, Acharya Nagarjuna University has been forging ahead in the path of progress and dynamism, offering a variety of courses and research contributions. I am extremely happy that by gaining 'A' grade from the NAAC in the year 2016, Acharya Nagarjuna University is offering educational opportunities at the UG, PG levels apart from research degrees to students from over 443 affiliated colleges spread over the two districts of Guntur and Prakasam.

The University has also started the Centre for Distance Education in 2003-04 with the aim of taking higher education to the door step of all the sectors of the society. The centre will be a great help to those who cannot join in colleges, those who cannot afford the exorbitant fees as regular students, and even to housewives desirous of pursuing higher studies. Acharya Nagarjuna University has started offering B.A., and B.Com courses at the Degree level and M.A., M.Com., M.Sc., M.B.A., and L.L.M., courses at the PG level from the academic year 2003-2004 onwards.

To facilitate easier understanding by students studying through the distance mode, these self-instruction materials have been prepared by eminent and experienced teachers. The lessons have been drafted with great care and expertise in the stipulated time by these teachers. Constructive ideas and scholarly suggestions are welcome from students and teachers involved respectively. Such ideas will be incorporated for the greater efficacy of this distance mode of education. For clarification of doubts and feedback, weekly classes and contact classes will be arranged at the UG and PG levels respectively.

It is my aim that students getting higher education through the Centre for Distance Education should improve their qualification, have better employment opportunities and in turn be part of country's progress. It is my fond desire that in the years to come, the Centre for Distance Education will go from strength to strength in the form of new courses and by catering to larger number of people. My congratulations to all the Directors, Academic Coordinators, Editors and Lesson- writers of the Centre who have helped in these endeavours.

Prof. P. Raja Sekhar
Vice-Chancellor
Acharya Nagarjuna University

DDGC04: - APPROACHES AND TECHNIQUES OF COUNSELING

PAPER – IV

Unit-I - Introduction to approaches to counseling - Psycho analytical and dynamic approaches to counseling Techniques.

Unit-II - Behaviouristic approach to counseling-techniques.

Unit-III - Cognitive approach to counseling, C B T techniques.

Unit-IV - Person centered approach – techniques.

Unit-V - Group counseling and other techniques

Lesson 1:-Introduction to approaches to counseling

Learning Objectives

The student will learn and develop interest in the following concepts

1. What is counselling
2. What are approaches
3. What are different counselling approaches
4. What is counselling to the client and to the counsellor
5. Role of ACA in development of counselling internationally

Psychological Counseling is a method of professional interaction between the therapist and the client. Counseling is a learning-oriented process that takes place in an interactive relationship with the goal of assisting a person in learning more about themselves and applying that knowledge to become a more effective member of society.

Rogers (1961) defines the counseling as helping relationship as one “in which at least one of the parties has the intent of promoting the growth, the development, maturity, improved functioning, and improved coping with life of the other”.

Pepinsky & Pepinsky (1954) Counselling is a process involving an interaction between a counselor and a client in a private setting, with the purpose of helping “the client change his behavior so that he may obtain a satisfactory resolution of his needs”.

Pepinsky and Pepinsky (1954) defined the relationship “as a hypothetical construct to designate the inferred character of the observable interaction between the two individuals”.

The British Association for Counselling (BAC), now the BACP, may have been the first professional association to adopt a definition of professional counselling.

Counselling is the competent and principled use of connection to assist self-knowledge, emotional acceptance and growth, and the optimal development of personal resources, according to a definition published in 1986. The overarching goal is to give people the opportunity to work toward a more fulfilling and resourceful life. Counseling relationships may focus on developmental concerns, addressing and resolving specific problems, making decisions, coping with crisis, developing personal insights and knowledge, working through feelings of inner conflict, or enhancing interpersonal relationships, depending on the need.

The role of the counsellor is to assist clients in working in ways that respect their values, personal resources, and ability to make independent decisions.

In 1997 the Governing Council of the American Counselling Association (ACA) accepted the following definition of professional counselling:

“Counseling is the application of mental health, psychological or human development principles, through cognitive, affective, behavioral or systemic interventions, strategies that address wellness, personalgrowth, or career development, as well as pathology.” The definition also includes these additional attributes:

1.Counseling is concerned with health, personal development, career, and pathological issues. Counselors, in other words, work in areas where there exist interpersonal ties. Intra- and interpersonal concerns about finding purpose and adjusting in situations such as schools, family, and employment are among these domains.

2.Counseling is provided to people who are deemed to be functioning normally as well as those who are experiencing more serious issues. Counseling caters to a wide range of people's needs. Counseling clients have developmental or situational issues that require assistance with adjustment or remediation. Their issues usually require immediate attention, but treatment may be expanded to cover diseases listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

3.Theory is at the heart of counselling. Counselors employ a wide range of theoretical approaches, including cognitive, affective, behavioural, and systemic approaches. These theories can assist individuals, groups, and families.

4.Counseling is an interventional or developmental process. Counselors focus on the goals of their clients. As a result, counselling requires both decision and change. In some cases, "counselling is a dress rehearsal for action."

Many people may have questions about what professional counselling is and what it means to be a counsellor. As a result, we understand what professional therapy entails: a joint effort between the counsellor and the client. Professional counsellors assist clients in identifying goals and potential solutions to emotional difficulties, as well as improving communication and coping skills, boosting self-esteem, and promoting behaviour change and optimal mental health.

A profession is a job for which someone has been trained and for which they labour. It's how they make money or make a livelihood. People frequently study for years in order to do their

jobs.... Sometimes the term "profession" refers only to learned professions, although it can also refer to other occupations.

A profession, on the other hand, is a form of activity that demands specialized knowledge and expertise in a specific sector. Lawyers, doctors, engineers, and professors, in addition to psychiatric counselors, are examples of occupations.

A professional is a person who is a member of a profession or who makes a living from a certain professional activity. Some definitions of the term "professional" confine it to occupations that serve some major component of public interest or the common good.

In an ideal world, therapy would end when the problem for which, the psychologist sought help becomes more manageable or is resolved. Psychotherapy is a mutually beneficial relationship between the individual seeking treatment, known as the client, and the person who treats them, known as the therapist.

1. Purpose: To assist the client in resolving the psychological issues that she or he is experiencing.

2. Goal: To help the client change maladaptive behaviours, reduce personal discomfort, and better adapt to his or her environment.

3. The relationship is beneficial to the client's establishment of trust, allowing concerns to be freely communicated.

Characteristics:

1. The concepts underpinning the various theories of therapy are applied in a methodical manner.

2. Psychotherapy can only be practiced by those who have obtained practical training under expert supervision.

3. The scenario comprised a therapist and a client seeking and receiving assistance for emotional issues (this person is the focus of attention in the therapeutic process).

4. The therapeutic relationship is formed or solidified as a result of the contact between the therapist and the client. This is a Confidential (personal), Interpersonal (dynamic), and Dynamic (confidential) relationship.

Goals:

(i) Strengthening the client's resolve to improve.

(ii) Reducing emotional stress

(iii) Unveiling the good growth potential.

(ii) Changing habits

(v) Altering thought processes.

(vi) A greater sense of self-awareness.

(vii) Improving communication and interpersonal relationships.

(viii) Making decision-making easier.

(ix) Becoming conscious of one's life choices.

(x) Having a more creative and self-aware relationship with one's social environment.

Here are some of the key points that differentiate the counselling Approaches: the professional can expertise as many approaches as possible.

S.No	Counseling Type	Key Points
1	**Psychodynamic**	Focused on how past experiences affect current problems Concerned with unconscious drives and conflicting aspects of personality Traditionally, the therapist takes the expert role
2	**Interpersonal Counseling**	Diagnosis focused Concerned with interpersonal relationships Therapist functions as a client's ally
3	**Client-Centered Therapy**	Humanistic approach Focused on realizing human potential Supports client discovery Counselor is empathetic, nonjudgmental, and nondirective
4	**Existential Therapy**	Focused on what it means to be alive Non-symptom focused Clients guided in discovering unfulfilled needs and realizing potential
5	**Cognitive-Behavioral Therapy**	Focused on how both thoughts and behaviors affect outcomes Evidence-based, effective, and highly versatile
6	**Mindfulness-Based Counseling**	Focused on feelings and thoughts in the moment, without judgment

		Includes CBT with a Buddhist-based mindfulness component Highly versatile
7	**Rational Emotive Therapy**	Focused on how faulty thinking relates to distress Therapist is active and directive
8	**Reality Therapy**	Focused on the present day Non-symptom focused Promotes individual responsibility and taking control of one's life Counselor is positive and nonjudgmental
9	**Constructionist Therapy**	Focused on how cultural influences and interpretations shape meanings Strong interest in language Client driven, counselor acts as collaborator
10	**Systemic Therapy**	Focused on how systems (e.g., school, work, family) affect underlying issues Therapist collaborates with people across and within systems
11	**Narrative Therapy**	Focused on the stories we tell ourselves about who we are Counselor works collaboratively to create alternate stories
12	**Creative Therapy**	Focused on the use of artistic expression as a cathartic release of positive feelings Highly versatile — music and various art mediums may be used

The present contemporary counselling techniques have the theoretical concepts as the base and compile the situation based or client based therapy.

Objective Type Questions

1. Can a professional and experienced psychological counsellor develop situation based therapy or client requirement method? **Yes** / No
2. "in which at least one of the parties has the intent of promoting the growth, the development, maturity, improved functioning, and improved coping with life of the other".Whose definition is this for counselling ? --- (Ans- **Carl Rogers**)
3. " Focused on how faulty thinking relates to distress, Therapist is active and directive" Which therapy is based on this concept? (ans - **Rational Emotive Therapy).**

4. “Focused on the stories we tell ourselves about who we are Counselor works collaboratively to create alternate stories” Which therapy is based on this concept? (ans - **Narrative Therapy)**
5. “Focused on feelings and thoughts in the moment, without judgment Includes CBT with a Buddhist-based mindfulness component Highly versatile” Which therapy is based on this concept? (ans - **Mindfulness-Based Counseling**

Lesson 2:-psychos analytical are psychodynamic approaches to counseling.

Learning Objectives:

The student of counseling psychology develops concepts, and the following base for theoretical approaches to counseling

1. Sigmund Freuds contributions to psychoanalysis
2. What is psycho analytical theory
3. What is psychodynamic approach
4. What is dynamic aspect in the dynamic approach
5. How Freud's theories understand the human behavior

Psychos Analytical Are Psychodynamic Approaches to Counseling

Psycho analytic Approach:

The id, ego, and superego, according to Sigmund Freud, are the three aspects that make up the personality. Internal and basic urges and needs drive the id, which is a facet of personality. Hunger, thirst, and the need for sex, or libido, are examples of instinctive responses. Our instinctual talents give rise to the id, which is also known as the unconscious. The id follows the pleasure principle, which states that it avoids pain and seeks pleasure. Because of its innate nature, the id is impulsive and sometimes ignorant of the consequences of its actions. The reality principle drives the ego.

By attempting to achieve the idrive d's in the most realistic ways, the ego attempts to balance the id and superego. It tries to make sense of the iinstincts d's and appease the urges that will benefit the individual in the long run. It assists in distinguishing between what is real and practical in our drives, as well as being realistic about the criteria that the superego sets for the individual. Furthermore, the Ego is how we perceive ourselves. This is intentional, but it isn't necessarily true. For example, someone may believe they are the most attractive person on the planet; nevertheless, this is only their view, and not everyone will share it.

The ethical principle drives the superego. It behaves in accordance with the higher morality of thought and conduct. Rather of acting intuitively like the id, the superego tries to behave in socially acceptable ways. It uses morality to encourage socially acceptable behaviour by judging our sense of good and wrong and utilising guilt to urge it. Furthermore, the Superego is

influenced by those around us. They have an impact on what we believe and how we see things, thus this might vary based on how people were raised and the culture in which they lived.

The Superego is also in charge of establishing a happy medium between the Id and the Ego. When there are humanistic desires, the Id can become too strong. In terms of how we see ourselves, the Ego can be highly unrealistic.

Psycho analytical This approach developed by Sigmund Freud in the early 1900s, involves analyzing the root causes of behaviour and feelings by exploring the unconscious mind and the conscious mind's relation to it. Psychoanalysis can take on a variety of forms, varying from practitioner to practitioner. Psychoanalytical and psychodynamic therapies are based on an individual's unconscious thoughts and perceptions that have developed throughout their childhood, and how these affect their current behaviour and thoughts.
Psychoanalysis focuses on an individual's unconscious, deep rooted thoughts that often stem from childhood. Through free association, dreams or fantasies, clients can learn how to interpret deeply buried memories or experiences that may be causing them distress.

i)View of Human Nature

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

ii) Id, Ego and Super Ego

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

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

Superego is the third concept which can be equaled to that of a judge and it is ruled by the

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

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

iii) Ego-Defense Mechanisms

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

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

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

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

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

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

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

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

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

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

iv) Role of a Counselor

Counselors who practice psychoanalysis play the role of experts. They encourage their clients to talk about whatever comes in their mind, especially childhood experiences. After a few face to face interactions such an environment is created, often have the client lie down while the analyst remains out of view, in which the client feels free to express difficult

thoughts. The role of the analyst is to let the clients gain insight by reliving and working through the unresolved past experiences that come into focus during sessions. The development of transference is encouraged to help clients deal realistically with unconscious material.

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

v) Goals

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

stresses environmental adjustment, especially in the areas of work and intimacy.

vi) Techniques

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

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

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

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

Ego- Defense Mechanisms:

The ego maintains a healthy state of awareness by balancing the id, superego, and reality. As a result, it distorts reality to protect the individual from stress and anxiety. This keeps potentially dangerous unconscious thoughts and material out of the conscious mind. Repression, reaction formation, denial, projection, displacement, sublimation, regression, and rationalisation are examples of defence mechanisms.

Humans are defined as having sexual and violent urges via the prism of psychoanalysis. Human behaviour, according to psychoanalytic theorists, is deterministic. It is governed by illogical forces, the unconscious, innate and biological urges, as well as irrational forces and the unconscious. Psychoanalytic theorists do not believe in free will because of this deterministic nature.

Psychosexual development

Sigmund Freud's perspective on personality formation (psyche). It's a stage hypothesis that says progress happens in phases as libido is directed to different sections of the body. Oral, Anal, Phallic (Oedipus complex), Latency, and Genital are the stages in order of progression. The Genital stage is reached when people have enough sexual energy to meet all of their requirements during the preceding stages. Individuals who do not having their basic needs addressed at a certain stage get fixated, or "stuck" in that stage.

Neo-analytic theory

The relevance of the unconscious, dream interpretations, defensive mechanisms, and the essential influence of childhood events were all believed by Neo-Analytic/ Neo-Freudians who also had issues to Freud's theory and work with psychosexual development. They do not believe that personality development ceases at the age of six, but rather that it occurs

throughout one's lifetime. They expanded on Freud's theory by include more environmental influences and emphasising the role of both conscious and unconscious thought.

Erik Erikson (Psychosocial Development), Anna Freud, Carl Jung, Alfred Adler, Karen Horney, and the school of object relations are among the most influential theorists. Erikson's Psychosocial Development theory is divided into eight stages. **Trust vs. mistrust, autonomy vs. shame, initiative vs. guilt, inferiority vs. industry, identity vs. confusion, intimacy vs. isolation, generatively vs. stagnation, and integrity vs. despair are the stages.** These are crucial to psychoanalytic theory because they describe the various stages that people go through in their lives. Each stage has a significant impact on their life outcomes since they are confronted with conflicts at each level, and whichever path they choose will result in specific outcomes.

Psychodynamic therapy:

(Sigmund Freud, Carl Jung, Neo-Freudians)

Methods of Eliciting the Nature of Intra-psychic Conflict

Psychodynamic therapy is a type of psychotherapy that involves the use of Therapy is perhaps the most well-known and widely used approach for counselling. This form of counselling, which is based on Freudian theory, entails forging strong therapist–client bonds.

The goal is to help clients acquire the psychological tools they'll need to deal with difficult emotions and situations. Freud was also interested in how early life experiences and unconscious urges influenced conduct.

Psychodynamic therapy focuses on the client's current behaviour as a manifestation of unconscious processes. Client self-awareness and knowledge of the impact of the past on current behaviour are the goals of psychodynamic therapy. In its most basic form, a psychodynamic method allows the client to evaluate unresolved tensions and symptoms that stem from previous dysfunctional relationships and manifest as the need and desire to abuse substances.

From psychoanalytic theory, several alternative techniques of short psychodynamic psychotherapy have emerged, which have been therapeutically applied to a wide range of psychiatric illnesses.

The earliest of the current therapies is psychodynamic therapy. As a result, it is founded on a well-developed and complex philosophy of human growth and interaction.

Psychoanalytic thought influenced and informed the theory that underpins psychodynamic treatment. Each of the four major schools of psychoanalytic thought has affected psychodynamic therapy in some way. Freudian, Ego Psychology, Object Relations, and Self Psychology are the four schools.

Each of the four schools of psychoanalytic theory offers distinct ideas of personality formation, psychopathology formation, and change, as well as therapy approaches, indications, and contraindications. Psychodynamic therapy differs from psychoanalysis in various ways, including the fact that it does not require all analytic tools and is not delivered by analysts with a psychoanalytic background. Psychodynamic treatment also takes place over a shorter length of time and with fewer visits than psychoanalysis.

The following remark exemplifies this focus:

"The conscious mind can be compared as a fountain dancing in the sun before sinking back into the great underground pool of sub-consciousness from which it emerges". Which means the present problems or non-adaptive behaviours can have its roots unconsciously in their childhood experiences.

In this type of therapy, the therapist keeps his personality out of picture. This is a vital aspect of psychodynamic psychotherapy. This enables therapist to be like a blank canvas onto which patients can transfer and project deep feelings about themselves.

Their parents and other significant players in their life. It is then up to the therapists to handle all the feelings and information that emerge, to gradually help patients to deal with all this "baggage". In this way the therapist helps patients gain a better understanding of what their disturbances are and how their mind works.

Silence: This is long term therapy, for some it may go on for years. In initial days of therapy, frequency of therapy may be more for each of a week. During therapy also in this psychodynamic or psychoanalytic therapy, most of the time the therapist will be very calm and client may be just sitting on coach for longer periods, even then the therapists assumes that the therapy went on as scheduled and an important work has been done in these quite sessions.

Dynamic role of unconsciousness: The therapists uses certain techniques or tests for facilitating the client to recover his memories to consciousness from unconscious state, or may be some child hood experiences.

Repression:

Repression is the exclusion of upsetting memories, thoughts, or sensations from the conscious mind, according to psychoanalytic theory. These unpleasant mental contents are pushed into the unconscious mind, sometimes involving sexual or aggressive urges or painful childhood memories.

An adult who was bitten by a horrible spider/ scorpion as a child develops a severe phobia of spiders/ scorpion later in life with no remembrance of the incident. He or she may not comprehend where the phobia comes from because the memory of the spider/scorpion bite has been suppressed.

Even though the two terminologies used for people usually think that both Psychoanalysis and Psychodynamic are on and the same. But , aAccording to many therapists who practice this therapeutic orientation, the terms "psychoanalysis" and "psychodynamic therapy" are often used interchangeably are also aware of small distinction among two but feel it is negligible. But actually knowing the distinction if very important. . However, the basic distinction is more relevant in the context of therapy.

Psychoanalysis; There are two interpretations to the word . First and foremost, it is a theory for comprehending clinical manifestations and possibly even individuals in general. It's also used to define a type of extensive psychotherapy in the most traditional meaning, which entails years of treatment. The treatment is administered by a therapist who is a qualified psychoanalyst and takes place several times a week with the patient on a couch.

To a considerable extent, although not entirely, psychodynamic therapy is guided by psychoanalytic theory, which was established in part based on the intensive kind of therapy mentioned above.

Psychodynamic therapy is psychoanalytic for the most part and makes assumptions about how the mind works that are based on psychoanalytic theory. But the technique is radically different from a traditional psychoanalysis treatment. It is brief—15 sessions would not be unusual—and often similar in number of sessions to CBT. It is mostly delivered once per week and takes place face-to-face. The therapist may not be a certified psychoanalyst, but is someone who trained in psychoanalysis or psychodynamic therapy and considers that his or her therapeutic orientation. In APA's Div. 39 (Psychoanalysis) the term "psychoanalysis" covers the whole range of psychoanalytically oriented therapy, research and treatment.

Psychodynamic therapy For the most part, psychodynamic therapy is psychoanalytic, and it makes assumptions about how the mind works based on psychoanalytic theory. However, the method differs significantly from standard psychoanalysis. It's short—15 sessions isn't uncommon— It is typically offered once a week and is face-to-face. The therapist may or may not be a professional psychoanalytic, but he or she believes psychoanalysis or psychodynamic therapy to be his or her therapeutic perspective. The term "psychoanalysis" is used in APA's Div. 39 (Psychoanalysis) to refer to a wide spectrum of psychoanalytically focused therapy, research, and treatment

While many of Freud's naive views about human nature have been replaced by psychodynamic theory, many of the assumptions that underpin the psychodynamic approach are reminiscent of Freud's work:

1. The unconscious mind is one of the most powerful drivers of human behavior and emotion.
2. No behavior is without cause—all behavior is determined.
3. Childhood experiences exert a significant influence on thoughts, emotions, and behavior as an adult.
4. Important conflicts during childhood development shape our overall personality as adults (Freud, 1899).
5. Freud's theories directly support the methods of psychoanalysis, but also help form the basis of psychodynamic theory and inform the methods and techniques used in today's psychodynamic therapy.

Psychoanalysis: The Freudian Approach

While psychoanalysis and current psychodynamic therapy share a common ancestor, there are numerous key differences between the two therapies:
To begin with, psychoanalysis has a far longer timeline and duration than modern psychodynamic therapy. Psychoanalysis is usually done in two to five weekly sessions over a period of several years (McLeod, 2014).

Second, the physical architecture of the office or treatment room is important—in psychoanalysis, the client (or patient, as they are commonly referred to) sleeps on his or her back on a sofa while the therapist sits behind them, out of sight. It is considerably more typical in current psychodynamic treatment for the therapist and client to face one other, or at least remain in each other's range of vision.

Third, the therapist-client/patient relationship is far more unbalanced than in modern psychodynamic therapies. The therapist's and client's positions reflect a considerable power imbalance, with the therapist functioning as a detached expert with techniques and knowledge that will not be shared with the client. Meanwhile, the client acts as a distressed supplicant, relying on the therapist's expertise in eliciting the therapist's expertise in eliciting the therapist's expertise in eliciting the therapist's expertise in eliciting the therapist's expertise in eliciting the therapist's expertise in elicit (McLeod, 2014).

Some psychoanalytical procedures have survived or been adapted for modern use, but the unequal connection between the therapist and the client does not appear to be present in current psychodynamic therapy. Over the last century, the therapist's job has evolved to change the hierarchy and promote a more equal treatment environment

Objective type Questions

1. Repression is the exclusion of upsetting memories, thoughts, or sensations from the conscious mind, according to psychoanalytic theory. **True /** False
2. The id, ego, and superego, according to Sigmund Freud, are the three aspects that make up the personality. Id is pleasure Principle, Ego is reality principle and Super ego is social or moral principle. **True /** False
3. The Superego is influenced by those around us. They have an impact on what we believe and how we see things, thus this might vary based on how people were raised and the culture in which they lived. **True** / False
4. Psychodynamic treatment also takes place over a shorter length of time and with fewer visits than psychoanalysis. **True** / False
5. The unconscious mind is one of the most powerful drivers of human behavior and emotion according to Freud’s psychoanalytic therapy . **True** / False

Lesson 3:-Techniques used in psycho analytical approach

Learning out comes or learning objectives:

The student will be in a position to understand and apply the following, same after practical training

1. What is psychoanalytic and psycho dynamic approaches in therapy,
2. What is dream interpretation?
3. What is free association method
4. What are projective methods
5. What is transference
6. How the therapist utilizes the clients transference in counseling process
7. What is regression
8. Why the psychosexual developmental stages are in psycho therapy.
9. Why some therapies take more number of sessions and some take less sessions in the therapy process

Sigmund Freud used the techniques like -**Dream interpretation, projective testing, hypnotism, and free association** are some of the methods used to uncover these urges.

Psychodynamic Therapy was once thought to be a lengthy process, but it is currently used as a very short-term solution. Long- and short-term psychodynamic therapy for psychiatric disorders has been shown to be successful in studies.

1. **Free Association:**

"The value of free association is that the patients spoke for themselves, rather than repeating the analyst's thoughts; they work through their own material, rather than parroting another's suggestions," Freud explained.

The practice of free association was supposed to aid in the discovery of ideas that a patient had formed on an unconscious level, such as:

Transference - inadvertently passing feelings about one person to another;

Projection: Internal sentiments or motives are projected instead of being attributed to other things or persons.

Resistance: Holding a mental block against remembering or accepting certain events or thoughts is known as resistance.

The mental conflicts were examined from the perspective that the patients did not realise how such feelings were manifested on a subconscious level, deep within their thoughts, at first

(I)The therapeutic relationship is established, and the client is at ease—the therapist encourages the client to lie down on the sofa – couch , close their eyes, and utter whatever comes to mind without censoring anything.

(ii) The client is encouraged to freely link one idea to another (free association).

(iii) The censoring superego is let go, as does the watchful ego—the client is free to say whatever comes to mind in a comfortable and trusting environment.

(iv) The therapist does not intervene; the unconscious mind's ideas, desires, and conflicts, which had been suppressed by the ego, flow freely into the conscious mind.

2. **Dream Analysis:**

Some dream laboratories are developed and exclusively dream based therapies are practiced. The dreams will be recorded from the subjects sleep time with help of placing electrodes and recording the graphical representations. The subjects or clients, narration for each recording also are recorded. The frequency, duration and intensity, involvement of area of the brain can also be recorded in the dream laboratory.

The dream analysis is done by taking in to consideration, many aspects of the dream, like what they felt, what they have seen in the dream, (sensory experiences) duration, intensity, behaviors attached to it, pre and post effects on the behavior of the client. (on cognition/ emotions etc)

I. Upon waking up, the client is instructed to write down his or her dreams.

2. Drams are metaphors for the unconscious's unfulfilled wishes.

3. Dreams use symbols that represent intra-psychic forces because they are indirect representations that do not cause the ego to feel alarmed.

4. If unsatisfied needs are directly voiced, the ever-vigilant ego will suppress them, causing uneasiness.

5. Symbols are regarded as markers of unfulfilled wishes and conflicts, according to a widely accepted translation norm.

30 Common Dream Symbols :

Dream Interpretation according to Freud

Sigmund Freud had the theory that dreams were about wish fulfillment. Dreams about flying were about wish fulfillment. Or, more specifically, he thought they represented repressed wishes bubbling their way to the surface.

1. **Animals** often represent the part of your psyche that feels connected to nature and survival. Being chased by a predator suggests you're holding back repressed emotions like fear or aggression.

2. **Babies** can symbolize a literal desire to produce offspring, or your own vulnerability or need to feel loved. They can also signify a new start.

3. **Being chased** is one of the most common dream symbols in all cultures. It means you're feeling threatened, so reflect on who's chasing you (they may be symbolic) and why they're a possible threat in real life.

4. **Clothes** make a statement about how we want people to perceive us. If your dream symbol is shabby clothing, you may feel unattractive or worn out. Changing what you wear may reflect a lifestyle change.

5. **Crosses** are interpreted subjectively depending on your religious beliefs. Some see it as symbolizing balance, death, or an end to a particular phase of life. The specific circumstances will help define them.

6. **Exams** can signify self-evaluation, with the content of the exam reflecting the part of your personality or life under inspection.

7. **Death** of a friend or loved one represents change (endings and new beginnings) and is not a psychic prediction of any kind. If you are recently bereaved, it may be an attempt to come to terms with the event.

8. **Falling** is a common dream symbol that relates to our anxieties about letting go, losing control, or somehow failing after a success.

9. **Faulty machinery** in dreams is caused by the language center being shut down while asleep, making it difficult to dial a phone, read the time, or search the internet. It can also represent performance anxiety.

10. **Food** is said to symbolize knowledge, because it nourishes the body just as information nourishes the brain. However, it could just be food.

11. **Demons** are sneaky evil entities which signify repressed emotions. You may

secretly feel the need to change your behaviors for the better.

12. **Hair** has significant ties with sexuality, according to Freud. Abundant hair may symbolize virility, while cutting hair off in a dream shows a loss of libido. Hair loss may also express a literal fear of going bald.

13. **Hands** are always present in dreams but when they are tied up it may represent feelings of futility. Washing your hands may express guilt. Looking closely at your hands in a dream is a good way to become lucid.

14. **Houses** can host many common dream symbols, but the building as a whole represents your inner psyche. Each room or floor can symbolize different emotions, memories and interpretations of meaningful events.

15. **Killing** in your dreams does not make you a closet murderer; it represents your desire to "kill" part of your own personality. It can also symbolize hostility towards a particular person.

16. **Marriage** may be a literal desire to wed or a merging of the feminine and masculine parts of your psyche.

17. **Missing a flight** or any other kind of transport is another common dream, revealing frustration over missing important opportunities in life. It's most common when you're struggling to make a big decision.

18. **Money** can symbolize self worth. If you dream of exchanging money, it may show that you're anticipating some changes in your life.

19. **Mountains** are obstacles, so to dream of successfully climbing a mountain can reveal a true feeling of achievement. Viewing a landscape from atop a mountain can symbolize a life under review without conscious prejudice.

20. **Nudity** is one of the most common dream symbols, revealing your true self to others. You may feel vulnerable and exposed to others. Showing off your nudity may suggest sexual urges or a desire for recognition.

21. **People** (other dream characters) are reflections of your own psyche, and may demonstrate specific aspects of your own personality.

22. **Radios and TVs** can symbolize communication channels between the conscious and unconscious minds. When lucid, ask them a question.

23. **Roads**, aside from being literal manifestations, convey your direction in life. This

may be time to question your current "life path".

24. **Schools** are common dream symbols in children and teenagers but what about dreaming of school in adulthood? It may display a need to know and understand yourself, fueled by life's own lessons.

25. **Sex** dreams can symbolize intimacy and a literal desire for sex. Or they may demonstrate the unification of unconscious emotions with conscious recognition, showing a new awareness and personal growth.

26. **Teachers**, aside from being literal manifestations of people, can represent authority figures with the power to enlighten you.

27. **Teeth** are common dream symbols. Dreaming of losing your teeth may mark a fear of getting old and being unattractive to others.

28. **Being trapped** (physically) is a common nightmare theme, reflecting your real life inability to escape or make the right choice.

29. **Vehicles** may reflect how much control you feel you have over your life - for instance is the car out of control, or is someone else driving you?

30. **Water** comes in many forms, symbolizing the unconscious mind. Calm pools of water reflect inner peace while a choppy ocean can suggest unease.

https://www.world-of-lucid-dreaming.com/30-common-dream-symbols.html

3. Projective Tests:

Projective tests are personality tests that allow people to respond to ambiguous stimuli, ostensibly revealing hidden emotions and internal conflicts that the person projects into the exam. Psychoanalysis claims that humans have both conscious and unconscious attitudes, which led to the development of projective tests. Motivations that are concealed or beyond human awareness.

It's an indirect method because the testee is talking about something that emerges from the self without conscious knowledge or editing.

Reduces the desire to imitate, it is less reliant on verbal ability. activates both conscious and unconscious personality features, The focus is clinical rather than normative, yet it has established norms through time.

Types of Projective Tests :

The Rorschach Inkblot Test- - ambiguous picture – no right or wrong answers

The Thematic Apperception Test (TAT) - enigmatic pictures

The Draw-A-Person Test- the subject's personality by projection of internal attitudes, traits, and behavior patterns upon the external stimuli.

House-Tree-Person - Children, adolescents, and adults aged 3 and up can take the Projective Drawing Test (HTP). The HTP's main goal is to assess components of a person's personality by interpreting artwork and responding to questions.

Hypnosis:

Sigmund Freud coined the phrase "tyranny of suggestion" to describe hypnosis, which he eventually abandoned. He reasoned that if one could induce symptoms by making suggestions to the unconscious, the unconscious might also be capable of producing sickness on its own.

Because the hypnotic state helps people to explore difficult ideas, feelings, and experiences that may have been suppressed from their conscious minds, hypnosis is sometimes used as a supplement to psychotherapy (counseling or therapy).

Hypnosis is a state of consciousness in which a person has focused attention (the selective attention/selective inattention hypothesis, SASI), limited peripheral awareness, and a greater ability to respond to suggestion. Modern hypnosis, on the other hand, began in the late 1800s and was popularized by Franz Mesmer, a German physician recognized as the "Father of Modern Hypnosis." In fact, because it was named after Mesmer, hypnosis was once called as 'Mesmerism.'

Modality of Therapy: In Psychoanalytic approach

(a) Transference: The client begins to associate the therapist with former authoritative figures, usually from infancy.

1. The therapist maintains a **nonjudgmental and permissive attitude** toward the client, allowing him or her to proceed with the emotional identification process.

2. **Transmission Neurosis:** In the present, the therapist functions as a proxy for that person; the client expresses the frustrations, anger, and terror that he or she had towards that person in the past but couldn't express at the time.

• **Positive Transference:** The client idolises or loves the therapist and craves acceptance from him or her.

• **Negative Transference:** The client feels bitterness, hatred, and fury toward the therapist.

(B) Resistance: This is another crucial aspect of the counseling process. To protect himself/herself from the retrieval of traumatic unconscious memories, the client opposes the development of therapy.

1. Conscious Resistance: The client withholds some information on purpose. It is done on purpose.

2. **Unconscious Resistance:** During the therapy session, the client becomes silent, recalls banal events but not emotional ones, misses appointments, and arrives late for therapy sessions. The client may or may not respond to the session.

3.The therapist is able to overcome the barrier multiple times. **Addressing** the patient about it (resistance) and revealing the emotions that are driving the resistance, such as anxiety, fear, or humiliation.

(c) Interpretation: The therapist employs the exposed unconscious information to help the client understand the psychic contents and conflicts that have led to certain events, symptoms, and conflicts.

1. Interpretation is Psychoanalysis' pinnacle, the subtle process.

2. methods of analysis is done by exercising some methods of interpretation.

• **Confrontation:** The therapist draws the client's attention to a part of his or her mind that the client must confront.

• **Clarification:** The therapist separates and highlights vital information from inconsequential ones in order to bring a vague or confused incident into vivid focus.

Working Through: The process of confronting, clarifying, and interpreting a situation repeatedly. So , the therapist Assists the patient in comprehending the source of the problem and integrating the newly discovered information into his or her ego**.**

Insight:

Transference is a long-term process in which unconscious memories are gradually integrated into conscious awareness; through transference, these unconscious events and memories are relived and worked through.

1. The client has a new **viewpoint on himself** or herself at the end of psychoanalysis. Earlier conflicts, defense mechanisms, and bodily symptoms are no longer evident.
2. **Intellectual Insight:** The client obtains a better comprehension of herself or himself on an intellectual level.
3. **Emotional Insight:** An emotional knowledge of one's wrong response to previous traumatic experiences, as well as a willingness to change both emotionally and physically.

Duration of therapy:

• **A one-hour session,** repeated 4-5 times per week, can last several years.

• **Three-phase intense therapy:**

(i)First Phase: The client gets used to the routines, establishes a therapeutic relationship, and recalls surface material from the past and present from consciousness.

(ii) Middle Phase: The subject's transference and resistance are prominent during this phase.

All of these techniques lead to understanding on the client's part, as well as confrontation, clarification, and working through on the therapist's part.

(iii) Termination: The analyst-client relationship is broken up, and the client is ready to quit therapy.

Brief Psychodynamic Therapy

Brief Psychodynamic Therapy			
Therapy (Theorist)	**Length of Treatment**	**Focus**	**Major Techniques**
Time-Limited Psychotherapy (Mann)	12 sessions	Central issue related to conflict about loss (lifelong source of pain, attempts to master it, and conclusions drawn from it regarding the client's self-image)	• Formulation, presentation, and interpretations of the central issue • Interpretation around earlier losses • Termination

Short-Term Anxiety-Provoking Psychotherapy (Nielsen and Barth)	Usually 12 to 15 sessions	Unresolved conflict defined during the evaluation	• Early transference interpretation • Confrontation/clarification/interpretations
Intensive Short-Term Dynamic Psychotherapy (Laikin, Winston, and McCullough)	5 to 30 sessions; up to 40 sessions for severe personality disorders	Experiencing and linking interpersonal conflicts with impulses, feelings, defenses, and anxiety	• Relentless confrontation of defenses • Early transference interpretation • Analysis of character defenses
SE Therapy (Luborsky and Mark)	16 for major depression, 36 for cocaine dependence	Focus on the core conflictual relationship theme	• Supportive: creating therapeutic alliance through sympathetic listening • Expressive: formulating and interpreting the CCRT; relating symptoms to the CCRT and explaining them as coping attempts
Vanderbilt Time-Limited Dynamic Psychotherapy (Binder and Strupp)	25 to 30 sessions	Change in interpersonal functioning, especially change in cyclical maladaptive patterns	• Transference analysis within an interpersonal framework • Recognition, interpretation of the cyclical maladaptive pattern and fantasies associated with it
Brief Adaptive Psychotherapy (Pollack, Flegenheimer, and Winston)	Up to 40 sessions	Maladaptive and inflexible personality traits and emotions and cognitive functioning, especially in the interpersonal domain	• Maintenance of focus • Interpretation of the transference • Recognition, challenge, interpretations, and resolution of early resistance • High level of therapist activity

Dynamic Supportive Psychotherapy (Pinsker, Rosenthal, and McCullough)	Up to 40 sessions	Increase self-esteem, adaptive skills, and ego functions	• Self-esteem boosters: reassurance, praise, encouragement • Reduction of anxiety • Respect adaptive defenses, challenge maladaptive ones • Clarifications, reflections, interpretations • Rationalizations, reframing, advice • Modeling, anticipation, and rehearsal
Self Psychology (Baker)	12 to 30 sessions, not rigidly adhered to	Change intra-psychic patterns. Incorporate more diverse representations of others and changes in information processing	• Analysis of the mirroring, idealizing, and merger transferences • Supportive, empathic
Interpersonal Psychotherapy (Klerman)	Time limited; for substance abuse, the trials have been 3 and 6 months	Eliminating or reducing the primary symptom; improvement in handling current interpersonal problem areas, particularly those associated with substance abuse	• Exploration, clarification, encouragement of affect, analysis of communication, use of the therapeutic relationship and behavior-change techniques

PSYCHOANALYTIC THERAPY

The techniques of psychoanalytic therapy are aimed at increasing awareness, fostering insights into clients' behaviour, and understanding the meanings of symptoms.

There are 6 basic techniques:

1. maintaining the analytic framework
2. free association
3. interpretation

4. dream analysis
5. analysis of resistance
6. analysis of transference

1. Maintaining the analytic framework
It refers to a whole range of procedural and stylistic factors, such as the analyst's relative anonymity, the regularity and consistency of meetings, and starting and ending the sessions on time.

The psychoanalytic process stresses maintaining a particular framework aimed at accomplishing the goals of this type of therapy.

2. Free association
Important to maintain analytic framework.

Clients are encouraged to say whatever comes to mind, regardless how painful, silly, trivial, illogical, or irrelevant it may be.

One of the basic tools used to open the doors to unconscious whishes, fantasies, conflicts, and motivations – Recollection of past experiences.

Therapist's task – listen to surface and hidden meaning of clients' story – identify the repressed material that is locked in the unconscious – interpret the materials and guides the client toward increase insight.

3. Interpretation
Consists of the analyst's pointing out, explaining, and teaching the client the meanings of behaviour that is manifested in in dreams, free association, resistances, and the therapeutic relationship itself.

function – to enable the ego to assimilate new material and to speed up the process of uncovering further unconscious material.

Under contemporary definitions, interpretation includes identifying, clarifying, and translating the clients' material.

General rules – the analyst should interpret material that the client has not yet understand but is capable of tolerating and incorporating, interpretation should always start from the surface and go only as deep as the client is able to go, it is best to point out a resistance of defense before interpreting the emotion or conflict that lies beneath it.

4. Dream analysis
Important procedure for uncovering unconscious material and giving the client insight into some areas of unresolved problems.

During sleep, defenses are lowered and repressed feelings surface.

Freud – dreams as the 'royal road to unconscious', for in them one's unconscious whishes, needs, and fears are expressed.

Dream – 2 levels of content: latent content and manifest content.

Latent Content: hidden, symbolic, unconscious motives, wishes, and fears.

Manifest Content: the dream that appears to the dreamer (painful, threatening, the unconscious sexual and aggressive impulses that make up latent content are transformed into more acceptable manifest content)

The process that the latent content of a dream is transformed into the less threatening manifest content is called *dream work.*

5. Analysis of resistance

Refers to any idea, attitude, feeling, or action (conscious or unconscious) that fosters the status quo and gets in the way of change.

Resistance – is anything that works against the progress of therapy and prevents the client from producing previously unconscious materials.

The client's reluctant to bring to the surface of awareness unconscious material that has been repressed.

6. Analysis of transference

Provide clients with the opportunity to reexperience a variety of feelings that would otherwise be inaccessible.

Allows clients to achieve here-and-now insight into the influence of the past on their present functioning.

Enables clients to work through old conflicts that are keeping them retarding the emotional growth.

ADLERIAN THERAPY

There are 6 techniques:

1. Attending and listening with empathy
2. Following the subjective experience of the client
3. Identifying and clarifying goals

4. suggesting initial hunches about purpose in client symptoms
5. actions
6. interactions

1. Attending and listening with empathy
Attending is paying attention to and being present to someone. This involves both body language and a mental tuning in to the client.

Active Listening is listening to the client's verbal messages, watching the client's nonverbal messages, actively determining the client's feelings, behaviors and experiences and listening to the person as fully as possible by trying to "put it all together.“

Empathy is reflecting the core message of what you heard. Usually this involves naming the feelings and the relevant experience or behaviors – the counselor needs to put himself/herself in the clients’ position to understand them better.

2. Following the subjective experiences of the client

Put focus on the client, not the problem.
Adlerians pay more attention to clients’ past experiences.
Interpret the client’s early memories, seeking to understand the whole person.
Client will explore *private logic* – the concepts about self, others, and life that constitute the philosophy on which individual’s lifestyle is based.

3. Identifying and clarifying goals
The counselor listens to client’s life story – listens for clues to the purposive aspects of the client’s coping and approaches to life.

Counselor will disclose and interpret client’s story in order to create awareness of his/her’s direction in life, the goals and purposes, and current behaviour.

4. Suggesting initial hunches about purpose in client symptoms
Once materials are gathered, the counselor summaries and suggest initial hunches from the data – includes summary of the client’s subjective experience and life story, family constellation and developmental data, early recollection, personal strengths or assets, interfering ideas, and coping coping strategies.

The summaries and hunches are presented to the client and discussed in the session – the client and the counselor together refining specific points.

5. Actions
Putting insights into practice.
The counselor help the client to discover new and more functional alternatives.
Clients are both encouraged and challenged to develop courage to take risks and make

changes in life.
In this techniques, *encouragement* plays vital role.

6. Interactions
Interaction between the counselor and the client is important.
The counselor will ask questions in order to gain more understanding of the client.
The client will tell story of his/her life to the counselor.

Objective Type questions:

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1. **……. Is the projective test, therapist show some pictures and the client has to interpret them. (ans. TAT)**
2. Holding a mental block against remembering or accepting certain events or thoughts is known as resistance.

Lesson 4:-Theoretical aspect of behaviousal approach.

This approach is based on the premise that primary learning comes from experience and applies learning principles to the elimination of unwanted behaviours. The initial concern is to help the client analyse behaviour, define problems, and select goals. Behavioural Therapy is effective for individuals who require treatment for some sort of behaviour change, such as addictions, phobias

and anxiety disorders. It concentrates on the 'here and now' without focusing on

the past to find a reason for the behaviour. The behavioural approach says that

people behave in the way that their environment has taught them to behave, e.g.,

through rewards and punishments, modeling, etc. So this approach attempts to

change the way the environment reinforces particular behaviour and works at

applying learning principles to help people to learn new behaviours by behavioural

experiments, role playing, assertiveness training, and self management training.

Four Aspects of Behaviour Therapy

1) Classical Conditioning

In classical conditioning certain respondent behaviours, such as knee jerks and

salivation, are elicited from a passive organism.

2) Operant Conditioning

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

If the environmental change brought about by the behaviour is reinforcing, the

chances are strengthened that the behaviour will occur again. If the environmental

changes produce no reinforcement, the chances are lessened that the behaviour

will recur.

3) Social Learning Approach

It gives prominence to the reciprocal interactions between an individual's

behaviour and the environment.

4) Cognitive Behaviour Therapy

It emphasises cognitive processes and private events (such as client's self-talk) as mediators of behaviour change.

i) View of Human Nature

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

• respondent learning,

• operant conditioning and

• social modeling.

ii) Role of a Counsellor

A counsellor may take one of the several roles, depending on his or her behavioural orientation. The counsellor functions as a consultant, teacher, advisor and facilitator. The behaviour counsellor tries to help the individual to learn new and more adaptable behaviours and to unlearn old non adaptable behaviours. The behaviour counsellor focuses attention on the individual's ongoing behaviours

Introduction and their consequences in his own environment. He tries to restructure the environment so that more adaptable patterns of behaviour can be learned and non adaptable patterns of behaviour can be unlearned. An effective behavioural counsellor operates from a broader perspective and involves the client in every phase of counselling.

iii) Goals

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

1) Defining the problem

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

2) Take a developmental history

Knowledge about how the client has handled past circumstances.

3) Establish specific goals

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

4) Determine the best method for change

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

iv) Techniques

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

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

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

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

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

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

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

Punishment: Administering negative consequences to undesirable behaviours in an effort to decrease the probability that the behaviour will occur again in the future.

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

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

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

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

The cognitive behavioural approach examines the patient's beliefs and behaviours. Individuals hold beliefs about themselves and relationships that affect behaviour. Negative beliefs lead to maladaptive behaviours. By examining and challenging these beliefs with new information, subsequent new behaviours can change. This approach also examines behaviours directly so that new, more adaptive behaviours can be developed. This approach is especially beneficial for changing habits,

learned behavioural patterns, phobias, and many forms of depression.

Lesson 5:-Techniques of behaviouistic counseling –I

BEHAVIOUR THERAPY OR BEHAVIOURAL PSYCHOTHERAPY

The behavior therapy is derived from learning theories. The classical conditioning, operant conditioning and social learning theories are very important theories on which these behavior therapies are based on.

Clinical psychotherapy that employs strategies developed from behaviourism and/or cognitive psychology is referred to as behaviour therapy. It involves of techniques based on learning theory, such as responder or operant conditioning, that look at specific, learned behaviours and how the environment, or other people's mental states, effects those behaviours. Behaviour analysts and cognitive-behavioral therapists are two types of behaviourists who use these strategies. They prefer therapy outcomes that can be measured scientifically.

Behaviour therapy is a broad term that refers to a variety of strategies that can be used to treat a person's psychological issues.

Functional Analytic Psychotherapy:

Functional analytic psychotherapy is a type of behavioural psychotherapy that is currently in use. A longer-term behaviour therapy is functional analytic psychotherapy. Functional analytic therapy is largely a relationally-based therapy that focuses on in-session reinforcement.

In its origins and character, functional analytic psychotherapy draws significantly on radical behaviourism and functional contextualism. Functional analytic psychotherapy is well-supported by research.

A functional analysis or functional assessment is completed by behaviour therapists and looks at four key areas: stimuli, organism, reaction, and consequences. These four elements are incorporated into a behaviour therapist's assessment.

1. A stimulus is a condition or a trigger in the environment that induces behaviour.

2. A person's internal responses, such as physiological responses, emotions, and cognition, make up an organism.

3. A person's behaviour is defined as a response.

4. The results of the behaviour are the consequences.

The majority of behaviour therapists employ objective assessment procedures such as

1. structured interviews, 2. objective psychological exams, or 3. a combination of the two. 3. various behavioural evaluation scales

These tests are used by behaviour therapists to figure out exactly what a client's problem is and to set a baseline for any maladaptive responses the client may have. With this baseline, the same measure may be used to monitor a client's improvement as therapy progresses, which can assist determine if the therapy is working.

Behavioral therapists are more concerned with the how, when, where, and what questions than with the why questions.

The observation of a person's behaviour in their natural setting is more important in behaviour evaluation.1

The goal of behavioural assessment is to figure out what the environmental and self-imposed variables are. These elements are what allow a person to continue to have maladaptive feelings, thoughts, and behaviours.

In a behavioural evaluation, "person variables" are also taken into account. These "person factors" are derived from a person's social learning background and influence how the environment influences their behaviour. Behavioral competency is an example of a person variable. Behavioural competence examines whether a person possesses the requisite abilities and behaviours to conduct a specific response to a given scenario or stimulus.

The behaviour therapist wants to know two things while making a behavioural assessment:

1. What are the many elements (environmental or psychological) that are supporting the maladaptive behaviour - this entails examining all features of a person, which can be summarised by the (acronym BASIC ID) - Behaviour, affective responses, sensory reactions, images, cognitive processes, interpersonal interactions, and substance usage are all represented by this acronym.

2. What form of behaviour treatment or technique can best assist the client in improving?

The following are just a handful of the many issues that behaviour therapy has functionally analysed:

Intimacy In Couples Relationships Forgiveness In Couples, Chronic Pain, (Stress-Related Behaviour)Child of Alcohol Use Disordered parent Chronic Distress	Substance Abuse, Depression, Anxiety, Insomnia And Obesity. Anorexia,

Methods :

Relaxation training –

Relaxation training entails clients learning to lower arousal to reduce stress by tensing and releasing specific muscle groups throughout their body. This helps the client to be stress free and used as coping strategy.

Systematic Desensitization:

This method is also uses relaxation technique in practice of systamaticall exposing the client to sensitive anxiety provoking situation as part of therapy.

Systematic desensitisation is a treatment in which the client gradually replaces a maladaptive response with a new taught response by going up a hierarchy of anxiety scenarios. Counter conditioning is used in part of systematic desensitization. Counter conditioning is the process of learning new ways to switch from one response to another, while desensitization is the process of switching from a maladaptive habit to a more relaxing one.

Desensitization has also been used to treat phobias, irritability, sleeping problems, and certain speech impairments.

Systematic desensitisation has been found to effectively treat phobias of heights, driving, insects, and any other form of fear. Social anxiety, public speaking anxiety, and test anxiety are all examples of anxiety. It has been demonstrated that systematic desensitisation is an effective strategy that can be used to treat a variety of disorders. The disorders and the phobia may be developed by client because of his anxiety. So the therapist by attending to

the present problem of the client is also addressing to bring our the deep rooted anxiety in counseling sessions.

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virtual reality exposure:

It is also a type of systematic decensitization but used in different way. The focus is to expose the client to base on his situation, to a variety of situating virtually.Virtual reality therapy uses computer-based simulations to create realistic representations of difficult situations. Fear of heights, fear of flying, and a range of other anxiety disorders are treated with virtual reality treatment. VRT has also been used to help patients with substance misuse issues lower their sensitivity to certain triggers that make them want to use drugs.

The use of virtual reality treatment (VRT) to treat a fear of heights has been proven to be helpful. It's also been proved to aid with a number of anxiety conditions. Because of the high expense of VRT, therapists are still waiting for the results of controlled trials to see which applications produce the best benefits.

Treatment for suicidal ideation is determined by the severity of the person's sadness and sense of hopelessness. If these things are severe, the person's reaction to tiny victories will be unimportant to them since they do not believe the victory to be a victory. This strategy has generally proven helpful in people who are not suffering from severe depression or dread, as completing basic activities increases confidence and helps them to advance to more challenging scenarios.

Exposure and response prevention techniques :

The basic strategy in which a therapist exposes a client to anxiety-provoking stimuli while preventing avoidance responses is known as exposure and response prevention techniques (also known as flooding and response prevention).

People with anxiety issues, as well as other anxieties or phobias, might benefit from exposure and preventative strategies.

A person normally needs five sessions of exposure therapy to determine the treatment's success. Exposure treatment has been demonstrated to assist the patient after five sessions. Treatment should, however, be continued beyond the initial five sessions.

Flooding :

The Psychologist Thomas Stampfl first introduced the concept of flooding in 1967. The origins are rooted in the exposure therapies and classical conditioning techniques developed by Ivan Pavlov and others in the early 1900s.

The difference between flooding and systematic desensitization is in systematic desensitization (SD), relaxation training is followed by gradual (usually imaginary) exposure to the feared stimuli starting with the least feared stimulus. In contrast, flooding involves immediate exposure to the stimulus. Exposure therapy has been described as the most effective way to treat fear.

Flooding usually employs either in vivo exposure or imaginal exposure methods of exposure therapy. A third option, virtual reality exposure, combines elements of in vivo and imaginal exposure to create a virtual simulation of a situation or object that looks real but actually is not.

Social skills training :

Clients learn how to acquire reinforcers and reduce life penalty through social skills training. In a meta-analysis, the biggest impact size for developing social skills was found in operant conditioning procedures, followed by modeling, coaching, and social cognition strategies in that order. Social skills training, in particular for schizophrenia, have some empirical support. Behavioral treatments, on the other hand, have fallen out of favor in the case of schizophrenia.

Modeling :

The modelling process entails a person being forced to observe other people who exhibit adaptive behaviour that the client should emulate. This exposure includes not only the "model person's" cues, but also the conditions in which a specific behaviour occurs, so that the relationship between the appropriateness of certain behaviour and the situation in which that behaviour occurs can be noticed.

Fears and phobias have been treated via modeling. Fear of snakes, as well as a fear of water and social learning abilities, have all been treated using modelling.

This technique is frequently likened to another behavioural therapy technique that use modelling procedures. The modelling technique appears to be less effective when compared to desensitisation. The more the interaction between the patient and the subject he is modelling, however, the more effective the treatment will be.

Behavioral rehearsal and home work :

A client receives a desired behaviour during a therapy session and then practices and records that behaviour between sessions with the behavioural rehearsal and homework treatment.

Aversion therapy and punishment:

Aversion treatment and punishment is a strategy that uses an aversive (painful or unpleasant) stimulus to prevent unwanted behaviours from occurring. Aversion therapy and punishment, also known as habit reversal training, has been found to be quite helpful in treating tics. Sexual deviance and alcohol use disorder have both been treated with aversive therapy strategies.

It is concerned with two procedures:

1) The techniques are used to reduce the risk of a given behaviour occurring frequently, and

2) Methods for lowering the attraction of particular behaviours and the stimuli that produce them.

Shock therapy treatments, unpleasant medication therapies, and response cost contingent punishment, which involves taking away a reward, are examples of negative stimulus or punishment that can be utilised. Aversive therapy techniques have been used to treat sexual deviations as well as alcohol use disorder.

Lesson 6:-Techniques of behavioustic counseling –II

Applied behaviour analysis use behavioural techniques to change certain behaviours that are deemed socially or personally significant.

There are four main characteristics of applied behaviour analysis:

1. The focus of the first behaviour analysis is on overt behaviours in a practical situation. Treatments are created in order to change the link between overt behaviour and its effects.
2. Another feature of applied behaviour analysis is the method by which it (behaviour analysis) evaluates treatment effects. The investigation is focused on the one individual being treated, and the individual subject is the centre of the study.
3. It focuses on what the environment does to produce major behaviour changes as a third feature.
4. The use of strategies derived from operant and classical conditioning, such as reinforcement, punishment, stimulus control, and any other learning principles that may apply, is the final characteristic of applied behaviour analysis.

Token economies:

Token economies are a sort of behaviour treatment in which clients are rewarded with tokens, which are a type of currency that may be used to purchase desired benefits, such as watching television or eating a snack, when they accomplish certain behaviours. Token economies are mostly employed in therapeutic and institutional contexts. For a token economy to work, the entire workforce must be consistent in their administration of the programme. Procedures must be properly specified so that clients do not become confused. Instead of finding for ways to punish patients or deny them rewards, the staff should focus on reinforcing good behaviours so that the clients repeat the desired behaviour.

Over time, the tokens should be replaced with less tangible benefits, such as compliments, so that the client is prepared when they leave the institution and does not expect to be rewarded for every desired behaviour.

Token economies are usually prevalent in psychiatric facilities and are employed in restricted contexts. They can be used to assist patients with various mental diseases, but the focus is not on the therapy of the mental illness, but rather on the patient's behavioural elements.

When treating chronic schizophrenia patients in psychiatric facilities, token economies have been demonstrated to be successful. The patients' behaviour was controlled by contingent tokens, according to the findings.

contingency contracting:

Another method of behaviour therapy is to hold a client or patient responsible for their actions in order to modify them. This is known as a contingency contract, which is a formal written contract between two or more people that describes the particular expected behaviours that the therapist wishes to modify, as well as the associated rewards and sanctions.

A contingency contract must have five characteristics in order to be considered official.

1. It must first state what each person will receive if the intended behaviour is successfully completed.

2. Those participating must also keep an eye on their actions.

3. Third, if the desired behaviour is not being carried out in the manner agreed upon in the contract, the contract's consequences must be carried out.

4. Fourth, if the parties involved follow the contract, they must be rewarded with bonuses.

5. The final component entails documenting compliance and noncompliance when implementing this treatment in order to provide consistent feedback on the desired behaviour and the provision of reinforcers to all parties involved.

Contingency contracting has been utilised to deal with delinquents' behaviour issues as well as on-task behaviour in kids.

Contingency contracts have been shown to be useful in modifying individuals' undesirable behaviours. It has been shown to be beneficial in treating delinquents' behaviour problems regardless of the contract's exact characteristics.

Response costs:

Response costs are a technique that is closely related to token economies. With or without token economies, this technique can be applied. Response costs are the punishment side of token economies, when a reward or privilege is taken away if someone engages in unfavourable behaviour. This strategy, like token economies, is mostly employed in institutional and therapeutic contexts.

The response cost technique has been used to treat a wide range of behaviours, including smoking, overeating, stuttering, and schizophrenic speech.

Response costs: has been demonstrated to operate in a number of clinical populations ranging from sociopaths to school children in suppressing a variety of behaviours such as smoking, overeating, or stuttering. When the penalty contingent is removed, these behaviours that were suppressed via this strategy frequently do not rebound. In addition, when applying the response cost technique, unwanted side effects that are common with punishment are rarely observed.

Using shaping and grading task assignments:

When a person believes that something in their lives cannot be altered and that life's obligations are overwhelming, they engage in this behaviour.

When complex behaviour needs to be learned, shaping and graded task assignments are used.

The more complicated behaviours that must be acquired are broken down into smaller levels in which the user can achieve small goals before progressing to the more complex behaviour. Each step gets closer to the end aim and allows the user to gradually increase their activity.

This is utilised when a patient feels hopeless and unable to change their circumstances. This pessimism is exacerbated by how the person behaves and responds to others and specific situations, as well as their felt impotence to change the situation. Suicide prevention and depressed or inhibited individuals have benefited from work assignment shaping and grading.

It is critical for a person with suicidal ideation to take little actions at first. Because that individual may consider everything as a large step, the smaller you start, the easier each step will be for them to master. This method has also been used to help people who suffer from agoraphobia, or a dread of being seen in public or doing something embarrassing.

Habit reversal training:

Habit reversal training (HRT) is a highly effective behavioural therapy for persons who have unwanted repeating behaviours or habits. It is based on scientific data. Tics, hair pulling, nail biting, and skin picking, to mention a few, can all be treated with HRT, which is suitable for people of all ages.

Habit reversal training is a therapy that can be used to cure problematic habits produced by a variety of factors. Tourette's syndrome is one of them, and it's characterised by physical or verbal tics like blinking, throat clearing, and repeating obscenities.

It has proven to be quite effective in the treatment of tics. The demand for behavioural psychologists to assist in rehabilitation efforts is increasing.

Reversal of Habits Training Increasing awareness of one's tendencies to pick, pull, and so on. Identifying the conditions, places, activities, and urges that usually cause the behaviour to occur. Tolerance of cravings.

Reducing the cues that lead to recurrent body-focused activity. Habits form when new behaviours become habitual and are carried out with minimal cognitive awareness, according to specialists at Psychology Today. "The behavioural patterns we repeat most often are practically engraved into our cerebral circuits," according to the study. Take a moment to consider the last quote.

"The Third-Generation" Of Behavioural TherapyA slew of novel behavioural therapies have emerged since the 1980s. Steven C. Hayes later referred to this as "the third generation" of behavioural therapy. According to this classification, the first generation of behavioural therapy was developed independently in the 1950s by Joseph Wolpe, Ogden Lindsley, and Hans Eysenck, while the second generation was produced in the 1970s by Aaron Beck.Because it is claimed that this "third wave" of behavioural therapy represents a movement away from cognitivism and back toward radical behaviourism and other forms of behaviourism, in particular functional analysis and behavioural models of verbal behaviour, it is sometimes referred to as clinical behaviour analysis.

This area involves – (Other behavior therapies)

1.Acceptance and commitment therapy (ACT): Of all the third-generation behaviour therapy paradigms, ACT may be the most well-researched. It is built on the foundation of interpersonal frame theory. Later the criticism for using the term evidence based therapy.

2.CBASP (cognitive behavioural analysis system of psychotherapy): Functional analytic psychotherapy is founded on a functional study of the therapeutic connection. It emphasises the therapeutic environment more and reintroduces the use of in-session reinforcement. The premise that in-session reward of behaviour can lead to behavioural change has been supported by 40 years of study.

3.Behavioural activation (BA): A component analysis of cognitive behaviour therapy revealed behavioural activation. The cognitive component had no additive effect in this study. Behavioural activation is based on a reinforcement matching model. A recent assessment of the studies backs up the idea that using behavioural activation in the treatment of depression is clinically useful.

4.Functional analytic psychotherapy (FAP),

5. Integrative behavioural couples therapy: Integrative behavioural couples therapy arose out of discontent with traditional behavioural couples therapy. Skinner (1966) is credited with defining the difference between contingency-shaped and rule-governed behaviour in integrative behavioural couples therapy. This is combined with a comprehensive functional examination of the couple's relationship. Recent research has attempted to interpret a variety of clinical phenomena, including forgiveness, using radical behavioural principles.

6.Metacognitive therapy and training are two types of metacognitive therapy.

These methods are firmly rooted in the behaviour therapy tradition of applied behaviour analysis. According to a review study published in 2008, third-generation behavioural psychotherapies did not meet the requirements for empirically supported treatments at the time.

Characteristics

Behavioral therapies are empirical (data-driven), contextual (focused on the environment and context), functional (interested in the ultimate effect or consequence of a behaviour), probabilistic (viewing behaviour as statistically predictable), monistic (rejecting mind–body dualism and treating the person as a unit), and relational by nature (analysing bidirectional interactions).

Behavioural therapy creates, adapts, and implements behavioural intervention tactics and programmes for clients, as well as training for those who care about them, in order to help them live successful lives in a variety of settings.

Training

Recent behavioural psychotherapy research has focused on the supervisory process. A key element of behavioural supervision models is that the supervisory process closely resembles the behavioural treatment offered.

Methods	
Behaviour management	Habit reversal training
Behaviour modification	Matching law
Clinical behaviour analysis	Modelling

Contingency management	Observational learning
Covert conditioning	Operant conditioning
Decoupling	Professional practice of behaviour analysis
Exposure and response prevention	Respondent conditioning
Flooding	Stimulus control
	Systematic desensitisation

Lesson 7:-Theoretical aspect of cognitive counseling.

Cognitive Therapy

Cognitive therapy (CT) is developed by American psychiatrist Aaron T. Beck in the year 1960. This psychotherapy is very famous, and CT is one therapeutic approach within the group of cognitive behavioral therapies (CBT).

Cognitive therapy has been applied to a very wide range of behavioral health issues including:	
Academic achievement	Phobia
Addiction	Schizophrenia
Anxiety disorders	Substance abuse
Bipolar disorder	Suicidal ideation
Low self-esteem	Weight loss[38]
	Criticisms

Various ancient philosophical systems, particularly Stoicism, have been suggested as having precursors to certain parts of cognitive therapy. "The intellectual underpinnings of cognitive therapy may be traced back to the Stoic thinkers," according to Beck's original treatment handbook for depression.

Cognitive therapy is based on the cognitive model, which states that thoughts, feelings, and behaviour are all linked, and that by identifying and changing unhelpful or inaccurate thinking, problematic behaviour, and distressing emotional responses, people can overcome obstacles and achieve their goals. The individual will engage with the therapist to acquire skills for testing and modifying beliefs, discovering skewed thinking, relating to people in new ways, and changing behaviours.

The cognitive therapist creates a cognitive case conceptualization as a guide to understanding the individual's internal reality, selecting suitable interventions, and identifying areas of discomfort.

After becoming disillusioned with long-term psychodynamic techniques predicated on obtaining insight into underlying emotions, Beck concluded that the way his patients viewed and gave meaning to their daily lives—**a process known as cognition**—was crucial to therapy. Since the 1950s, Albert Ellis had been working on similar concepts (Ellis, 1956). At first, he referred to his method as Rational Therapy (RT), then Rational Emotive Therapy (RET), and finally Rational Emotive Behavior Therapy (REBT).

In 1967, Beck published Depression: Causes and Treatment, which described his method. In

1976, he published Cognitive Therapy and the Emotional Disorders, which expanded his focus to include anxiety disorders, as well as other disorders later on. He also introduced a focus on the underlying "schema"—how people digest information about themselves, the world, and the future.

This new cognitive approach clashed with the prevalent behaviourism of the period, which held that discussing mental reasons was neither scientific nor relevant, and that the only way to practice psychology was to examine stimuli and behavioural responses. The 1970s, on the other hand, saw a "cognitive revolution" in psychology. Cognitive behavioural therapy was born when behavioural modification techniques and cognitive treatment approaches were combined. Although some behavioural components have always been present in cognitive therapy, supporters of Beck's approach aimed to retain and establish it as a distinct, standardised form of cognitive behavioural therapy in which the cognitive shift is the primary mechanism of change.

Foundation

Therapy may entail putting one's preconceptions to the test and seeking fresh information that can help alter those assumptions, resulting in different emotional or behavioural responses. Ideas (to modify emotion and conduct), behaviour (to change feelings and thoughts), or the individual's goals can all be targets for change (by identifying thoughts, feelings or behaviour that conflict with the goals). Beck began by focusing on depression and developing a list of "errors" (cognitive distortions) in thinking that he said could contribute to depression, including arbitrary inference, selective abstraction, over-generalization, magnifying (of negatives), and reduction (of positives) (of positives).

> As an illustration of how CT might operate, consider the following: A man may believe, after making a mistake at work, that "I'm useless and can't do anything well at work." He may then concentrate on the error (which he interprets as proof that his belief is correct), and his feelings of being "useless" are likely to be unpleasant (frustration, sadness, hopelessness). As a result of these thoughts and sentiments, he may tend to avoid problems at work, which could supply him with even more evidence that his belief is correct. As a result, any adaptive response and subsequent positive outcomes become doubtful, and he may become even more focused on any mistakes he makes, reinforcing his original perception that he is "useless." This example may be classified as a self-fulfilling prophesy or "problem cycle" in therapy, and the therapist and patient's efforts would be focused on breaking the cycle.

People who work with a cognitive therapist learn to think and respond in more flexible ways, questioning if their views are totally true and whether they are assisting them in

achieving their goals. Thoughts that do not fit this description may be switched to something more accurate or beneficial, resulting in increased good mood, desirable action, and progress toward the person's objectives. Cognitive therapy is based on a skill-building method, in which the therapist assists the patient in learning and practising these abilities on their own, eventually allowing them to "become their own therapist."

Cognitive Model

Aaron Beck's research findings led to the development of the cognitive model, which explains the psychological processes in depression. It categorizes mental beliefs into three categories:

1. **Automatic thought**
2. **Intermediate belief**
3. **Core belief or basic belief**

The Generic Cognitive Model was developed in 2014 as an upgrade to the cognitive model (GCM). The GCM is a modernised version of Beck's model, which claims that mental diseases can be distinguished by the type of their dysfunctional beliefs. The GCM incorporates a conceptual framework as well as a therapeutic method for recognising shared cognitive processes in mental disorders while also identifying the disorders' unique characteristics.

CT is structured, directive, active, and time-limited, in keeping with the cognitive theory of psychopathology, with the goal of discovering, reality-testing, and correcting faulty cognition and underlying dysfunctional beliefs.

Cognitive restructuring (methods)
Main article: Cognitive restructuring
Cognitive restructuring involves four steps:

Automatic thoughts (ATs) are dysfunctional or negative perceptions of oneself, the world, or the future that are based on already existing ideas about oneself, the world, or the future.
The ATs' cognitive distortions were identified.
The Socratic technique is used to rationally debate ATs.
The creation of a logical reply to the ATs
Automatic ideas can be divided into six categories:
Self-evaluated thoughts
Thoughts about the evaluations of others

Evaluative thoughts about the other person with whom they are interacting
Thoughts about coping strategies and behavioral plans
Thoughts of avoidance
Any other thoughts that were not categorized

Other major techniques include:

Monitoring activities and activity scheduling
Behavioral experiments
Continuous Catching, checking, and changing thoughts
Collaborative empiricism: therapist and patient become investigators and keep themselves focused by examining the evidence to support or reject the patient's cognitions. **Empirical/ scientific evidence** is used to determine whether particular cognitions serve any useful purpose.
Downward arrow technique for implementation
Exposure and response prevention techniques
Cost benefit analysis methods
acting "as if" situations and thoughts

Guided discovery:

By creating fresh experiences that lead to the learning of new abilities and perspectives, the therapist clarifies behavioural problems and incorrect thinking. By correcting cognitive processes, the patient develops more adaptive ways of thinking and coping with external stressors through both cognitive and behavioural strategies.

The Mastery and pleasure technique are
Problem solving – problem oriented empirical technique

Socratic questioning:
Questioning in the Socratic manner

The quintessential cognitive restructuring tools are Socratic inquiries. The purpose of these types of questions is to test assumptions by Imagining viable alternatives: " "What other explanations or perspectives of the issue could there be? What else may have caused it?"

Taking a look at the consequences:

"What happens if you think or believe this? What would be the consequences of thinking

differently and letting go of this belief?"

Distancing:

"What would I say to a certain friend/family member in the same situation, or if they viewed the issue this way?"

Socratic questions include the following:

"Explain how you came to your original position."

"How did you come to believe that your current point of view is the best?"

"Consider three pieces of evidence that either contradict or support this viewpoint. Consider the polar opposite of this point of view and consider it for a moment. What is the most compelling argument in favour of the other viewpoint?"

"Make a list of any specific advantages you gain from holding this view, such as social or psychological advantages. For instance, becoming a member of a group of like-minded people, feeling good about yourself or the world, or believing that your point of view is superior to others," and so on. Are there any other reasons for you to have this opinion other the fact that it is correct?"

"Does holding this opinion, for example, bring some peace of mind that holding another viewpoint would not?"
"It's vital to challenge your viewpoint directly on sometimes and explore whether there are reasons why it could not be true in order to refine it so that it's as precise as possible. What do you think the finest or most compelling counter-argument to this viewpoint is?"

What would you have to go through or learn in order to change your mind about this point of view?

Do you believe there is a truer, more accurate, or more nuanced version of your initial position that you could present right now, based on your current thoughts?

Erroneous assumptions:

False assumptions are founded on "cognitive aberrations," such as the following:

Being Right All of the Time: "We are constantly put on trial to show the correctness of our beliefs and deeds. It's unfathomable for us to be wrong, and we'll go to any extent to prove it. 'I don't care how horrible arguing with me makes you feel; I'm going to win this debate regardless because I'm right,' for example. Being correct is frequently more

important than the feelings of others, including loved ones, around a person who engages in this cognitive distortion."

The Fallacy of Heaven's Reward: "As if someone is keeping score, we expect our sacrifice and self-denial to pay off. When the payoff does not arrive, we become enraged."

Lesson 8:-Cognitive behavioustic techniques.

Cognitive therapy: The main Types (group of Cognitive Therapy)

Cognitive Therapy is based on the cognitive model, stating that thoughts, feelings and behavior are mutually influenced by each other. Shifting cognition is seen as the main mechanism by which lasting emotional and behavioral changes take place. Treatment is very collaborative, tailored, skill-focused, and based on a case conceptualization**.**

Rational emotive behavior therapy (REBT)

It is based on the belief that most problems originate in erroneous or irrational thought. For instance, perfectionists and pessimists usually suffer from issues related to irrational thinking; for example, if a perfectionist encounters a small failure, he or she might perceive it as a much bigger failure. It is better to establish a reasonable standard emotionally, so the individual can live a balanced life. This form of cognitive therapy is an opportunity for the patient to learn of his current distortions and successfully eliminate them.

Cognitive behavioral therapy (CBT) and its "third wave"

It is a system of approaches drawing from both the cognitive and behavioral systems of psychotherapy. Cognitive behavioral therapy is one of the most effective means of treatment for substance abuse and co-occurring mental health disorders. CBT is an umbrella term for a group of therapies, whereas CT is a discrete form of therapy. A number of treatments have developed that have been derived from CBT and are often labeled as the "third wave" of CBT by its advocates acceptance and commitment therapy, cognitive behavioral analysis system of psychotherapy, dialectical behavior therapy, EMDR, metacognitive therapy, metacognitive training.

Application: of Cognitive Therapy for Depressive Patients:

According to Beck's theory of the etiology of depression, depressed people acquire a negative schema of the world in childhood and adolescence; children and adolescents who experience depression acquire this negative schema earlier. Depressed people acquire such schemas through the loss of a parent, rejection by peers, bullying, criticism from teachers or parents, the depressive attitude of a parent or other negative events. When a person with such schemas encounters a situation that resembles the original conditions of the learned schema, the negative schemas are activated.

Beck's negative triad holds that depressed people have negative thoughts about themselves, their experiences in the world, and the future. For instance, a depressed person might think, "I didn't get the job because I'm terrible at interviews. Interviewers

never like me, and no one will ever want to hire me." In the same situation, a person who is not depressed might think, "The interviewer wasn't paying much attention to me. Maybe she already had someone else in mind for the job. Next time I'll have better luck, and I'll get a job soon." Beck also identified a number of other cognitive distortions, which can contribute to depression, including the following: arbitrary inference, selective abstraction, over-generalization, magnification and minimization.

In 2008, Beck proposed an integrative developmental model of depression that aims to incorporate research in genetics and the neuroscience of depression. This model was updated in 2016 to incorporate multiple levels of analyses, new research, and key concepts (e.g., resilience) within the framework of an evolutionary perspective.

Psychotherapy	Psychoanalysis (Psychodynamic)
	Behavioral
	Cognitive Therapy
	Humanistic Therapy
	Individual, Family, Marriage and Group Therapy

Lesson 9:-Cognitive counseling techniques.

What are Cognitive Distortions?

Cognitive distortions are perceptions of ourselves and the world we live in. We unconsciously reinforce erroneous thoughts and beliefs throughout time.

These thought patterns and systems are typically subtle, and it's tough to notice them when they're a regular part of your daily thoughts. That is why they may be so harmful, because it is difficult to alter something you don't see as needing to be changed. The perceives that he is right and normal. Cognitive distortions exist in a variety of forms and magnitudes, but they all have some characteristics.

All cognitive distortions are:

Usually clients who are maladaptive in nature have cognitive distortions. Which are Tendencies or patterns of thinking or believing, That are false or inaccurate, And have the potential to cause psychological damage.

Beck and Burns aren't the only ones who have committed their lives to learning more about depression, cognitive distortions, and how to treat them. Burns' Feeling Good Handbook provides the first eleven distortions (1989).

1. All-or-Nothing Thinking / Polarized Thinking

This distorted thinking, often known as "Black-and-White Thinking," emerges as an inability or unwillingness to see shades of grey. To put it another way, you think in terms of extremes — something is either amazing or terrible, and you believe you are either perfect or a complete disaster.

2. Overgeneralization

This deceptive distortion generalises a single instance or example to a larger pattern. Overgeneralizing can lead to unduly pessimistic views of yourself and your surroundings based on only one or two experiences.

3. Mental Filter

The mental filter distortion, like overgeneralization, focuses on a single unfavourable piece of information while excluding all good ones. By focusing solely on the negative, the mental filter can promote a fairly pessimistic view of everything around you.

4. Disqualifying the Positive

The "Disqualifying the Pleasant" distortion, on the other hand, accepts positive experiences but rejects them rather than embracing them.

This is a particularly dangerous misperception since it makes it easier to maintain negative

thought patterns in the face of overwhelming evidence to the contrary.

5. Jumping to Conclusions – Mind Reading

This "Jumping to Conclusions" distortion arises as the erroneous notion that we can read another person's mind. Of course, we can get a sense of what other people are thinking, but the distortion here pertains to the negative interpretations we make.

6. Jumping to Conclusions – Fortune Telling

Fortune telling is a sister distortion to mind reading in that it relates to the inclination to draw conclusions and make predictions based on little to no evidence and take them as gospel truth.

7. Magnification (Catastrophizing) or Minimization

This distortion, sometimes called as the "Binocular Trick" because of its subtle skewing of your perspective, entails inflating or diminishing the significance, relevance, or possibility of things. It is like one may think he did not do anything to get first rank, or another may say that getting first is not a matter and continue to be as normal student.

8. Emotional Reasoning

One of the most critical to recognise and address Most people aren't surprised by the logic underlying this distortion; rather, they're surprised by the knowledge that we've all bought into it at some point.

The accepting of one's emotions as fact is referred to as emotional reasoning. "I feel it, so it must be true," is one way to put it. Just because we have a gut feeling about something doesn't mean it's true.

9. Should Statements

The temptation to make "should" assertions is another harmful misunderstanding. Should statements are assertions that make to yourself about what you "should," "ought," or "must" do. They can also be used to impose a set of expectations on others that are unlikely to be met.

When we cling too strongly to our "should" claims about ourselves, we often feel guilty about not being able to live up to them. We are often disappointed by others' failure to satisfy our expectations when we hold to our "should" claims about them, leading to wrath and resentment.

10. Labeling and Mislabeling

These are essentially severe kinds of overgeneralization, in which we make value judgments about ourselves or others based on a single incident or experience.

When it comes to labelling, mislabeling refers to the use of highly emotional, laden, erroneous, or irrational words.

11. Personalization
As the name implies, this distortion involves taking everything personally or assigning blame to yourself without any logical reason to believe you are to blame.

In addition to these basic cognitive distortions, Beck and Burns have mentioned a few others (Beck, 1976; Burns, 1980):

12. Control Fallacies
A control fallacy manifests as one of two beliefs:
(1) that we have no control over our lives and are helpless victims of fate, or
(2) that we are in complete control of ourselves and our surroundings, giving us responsibility for the feelings of those around us. Both beliefs are damaging, and both are equally inaccurate.

13. Fallacy of Fairness
While we would all prefer to live in a world that is essentially fair, the belief that the world is fundamentally fair is not rooted in reality and can lead to negative emotions when we are confronted with evidence of life's unfairness.

14. Fallacy of Change
Another 'fallacy' is expecting others to change if we put enough pressure or encouragement on them. This misperception is frequently coupled by a conviction that our happiness and success are dependent on others, causing us to assume that pushing others to change is the only way to achieve our goals.

15. Always Being Right
This distortion, which is the assumption that we must always be right, will be recognised by perfectionists and people suffering from Imposter Syndrome (psychological pattern in which an individual doubts their skills, talents, or accomplishments and has a persistent internalized fear of being exposed as a "fraud"). For individuals dealing with this distortion, the possibility of being mistaken is unthinkable, and we will fight to the figurative grave to prove our point.

16. Heaven's Reward Fallacy
This is a well-known misconception, and it's easy to find numerous examples of it on big and tiny screens all around the world. The "Heaven's Reward Fallacy" is defined as the notion that one's difficulties, pain, and hard labour will be rewarded fairly.

Lesson 10:-Theoretical aspect of person centered therapy.

Humanistic-Existential Therapy

The emphasis on understanding human experience and a focus on the client rather than the symptom connect humanistic and existential approaches. Psychological issues (including substance addiction disorders) are seen as the result of a hampered ability to create true, meaningful, and self-directed life choices. As a result, treatments are designed to help clients become more self-aware and understand themselves.

While acceptance and progress are significant phrases in humanistic treatment, client responsibility and freedom are major topics in existential therapy.

People have the potential for self-awareness and choice, according to both humanistic and existential views. The two schools, however, arrive to this conclusion based on distinct theories. Human nature, according to the humanistic viewpoint, is fundamentally worthy, having the ability to form healthy, meaningful relationships and make decisions that benefit oneself and others. The goal of a humanistic therapist is to help people break free from limiting beliefs and attitudes so they can live more fully.

Rather than healing diseases or easing disorders, the therapist promotes growth and self-actualization. This viewpoint focuses on present conscious processes rather than unconscious processes and previous causes, yet it, like the existential approach, believes that people are born with the ability to determine their own lives. Being one's genuine self, according to the humanistic therapist, is the genesis of difficulties.

The therapeutic connection acts as a vehicle or setting in which psychological growth can take place. The humanistic therapist seeks to establish a warm and accepting therapeutic relationship with the client, trusting that the client's inner urge is to manifest in a healthy way.

The existentialist, on the other hand, is more concerned with assisting the client in discovering philosophical meaning in the face of anxiety by encouraging them to think and behave in a genuine and responsible manner. The major concerns people experience, according to existential therapy, are worry over loneliness, isolation, despair, and, eventually, death. People are seeing creativity, love, honesty, and free will as viable pathways to transformation, allowing them to live meaningful lives in the face of uncertainty and hardship.

The Logotherapy was developed by Victor Frankl, a psychiatrist and neurologist. The Greek term logos means "soul," therefore logotherapy implies "soul treatment." This act of discovering meaning, even in life-threatening situations, is referred to by Frankl as "meaning making." The search for the spiritual reality of one's life lies at the heart of meaning creation.

Psychological distress is said to be caused by emotions of loneliness, alienation, and an inability to find meaning and genuine fulfilment in life, according to humanistic-existential therapies. The need for personal growth and self-actualization, as well as a natural urge to grow emotionally, drive human beings. Human beings feel psychological anguish when these demands are not met by society and family. Self-actualisation is defined as an innate or inborn drive that propels a person to become more complex, balanced, and integrated, i.e. achieving complexity and balance without fragmentation. Integrated means having a sense of wholeness, being a full person, and remaining essentially the same person despite a wide range of experiences. Frustration with self-actualization creates suffering in the same way as a lack of food or water does.

Gestalt Psychotherapy is a type of psychotherapy that 'Whole' is the German word gestalt. Freiderick (Fritz) Perls and his wife Laura Perls provided this treatment. Gestalt therapy aims to improve a person's self-awareness and acceptance of themselves. The client is trained to recognise the physical functions and emotions that are being hidden from view. The therapist accomplishes this by encouraging the client to act out feelings and problems in dreams. This treatment can be done in a group environment as well.

Therapy that is focused on the client Carl Rogers was a proponent of client-centered therapy. Rogers merged scientific objectivity with client-centered psychotherapy's personalized practice. Rogers introduced the concept of self into psychotherapy, emphasizing the importance of freedom and choice in one's life. The treatment creates a warm environment for the client to reconnect with her or his shattered emotions. The therapist is warm and has **unconditional positive regard** for the client, which means that she or he understands the client's experience as if it were her or his own. In a **nonjudgmental approach**, the therapist echoes the client's feelings. Rephrasing the client's statements, i.e. seeking basic clarifications to increase the meaning of the client's statements, is how the **reflection** is accomplished. The client's integration is aided by this reflection process. With more adaptability, personal relationships improve. In essence, this treatment assists a client in becoming his or her true self, with the therapist acting as a guide.

Everyone experiences losses (people die, relationships end), and these losses can be stressful since they serve as reminders of human limitations and death. Human impact is moulded by genes, culture, and luck, according to the existential therapist. Existential therapy is based on the idea that people's issues stem from a lack of ability to exercise choice and judgement in order to create meaning in their lives, and that each person is responsible for doing so.

Lesson 11:-Techniques of person centered counseling.

However, external influences may have a role in the individual's restricted ability to make choices and live a meaningful life. Life is considerably more of a battle with negative internal forces for the existential therapist than it is for the humanistic therapist.

In comparison to long-term treatment approaches, short therapy necessitates the rapid creation of a therapeutic bond. These therapies address issues like a loss of meaning in one's life, fear of death or failure, estrangement from others, and spiritual emptiness, all of which contribute to substance misuse problems.

Humanistic and existential treatments delve deeper into issues surrounding drug abuse disorders, frequently serving as a trigger for clients to seek out alternatives to narcotics to fill the gap they are experiencing. The counselor's empathy and acceptance, as well as the client's insight, aid in the client's recovery by allowing her to make new existential choices, beginning with a well-informed decision to use or abstain from substances.

These therapies can help the client develop self-respect, self-motivation, and self-growth, which will make his treatment more effective.

Because they tend to facilitate therapeutic rapport, increase self-awareness, focus on potential inner resources, and establish the client as the person responsible for recovery, humanistic and existential therapeutic approaches may be particularly appropriate for short-term substance abuse treatment. As a result, clients may be more likely to consider recovery as a lifelong process of striving to realise their full potential, rather than a short-term fix.

These treatments may not always immediately attack substance usage because they try to address the underlying reasons of substance abuse problems.

Empathy, promotion of affect, introspective listening, and acceptance of the client's subjective experience are all beneficial features of humanistic and existential methods in any sort of brief treatment session, whether it's psychodynamic, strategic, or cognitive-behavioral therapy. They aid in the development of rapport and lay the groundwork for meaningful participation in all elements of the treatment process.

A focus on lived experience, true (therapeutic) connections, and acknowledgement of the subjective nature of human experience unites a wide range of therapeutic methods. The emphasis is on assisting the client in comprehending how past experiences, current perceptions, and future expectations influence reality.

The ability to choose new ways of being and acting is facilitated by becoming aware of this process.

Humanistic and existential methods can assist clients focus on the idea that individuals do, in fact, make decisions about substance addiction and are in charge of their own recovery in these situations.

Skills That Are Required

It's critical to be sensitive to "teachable" or "therapeutic" times.

These models do not rely on a comprehensive set of methodologies or procedures by their very nature. Rather, the therapist's own philosophy must be compatible with the theoretical basis of these systems. In order to assist the client in making significant change, the therapist must be willing and able to engage the client in a sincere and authentic manner.

Humanistic and Existential Therapies used at any level of recovery to build a foundation of client respect and mutual understanding of the relevance of their experiences.

Client-centered therapy, for example, can be employed right away to create rapport and clarify difficulties as the session progresses.

When a client is able to access emotional experiences or when hurdles must be overcome to assist a client's entry into or maintenance of recovery, **existential therapy** may be most helpful (e.g., to get someone who insists on remaining helpless to accept responsibility).

Narrative therapy can help the client see treatment as an opportunity to take control of his or her life and start a "new chapter." Throughout therapy, **Gestalt techniques** can be employed to foster a true contact with the therapist and the client's own experience.

By focusing on the intangible components of human experience and awareness of untapped spiritual capacity, **transpersonal therapy** can help people grow spiritually. These methods develop self-awareness, which boosts self-esteem and allows clients to take on more responsibility, giving them a sense of control and the ability to make decisions. All of these approaches can be utilised to help people with substance addiction disorders achieve their goals in therapy.

Number and time of sessions:

Many parts of these approaches can be found in other therapy systems, but empathy, meaning, and choice are at the centre of humanistic and existential therapies. They are especially beneficial in the short-term treatment of substance abuse disorders because they improve therapeutic rapport and conscious experience as well as acceptance of responsibility.

Within this paradigm, episodic treatment might be constructed, with the treatment plan concentrating on the client's tasks and experiences in between sessions. Outside of the meetings, humanistic and existential treatments presume that a lot of growth and change happens. These therapies can be lifelong journeys of growth and transformation when they are focused on wider issues.

First and initial Session

In short therapy, the first session is critical for forming an alliance, generating therapeutic rapport, and establishing a climate of mutual respect.

Initiate to develop the alliance

The therapist's genuine approach to the client can help to establish the foundation for an open, collaborative therapeutic partnership.

Make a point of emphasising the client's freedom of choice and the possibility of significant change.Outline the therapy's expectations and objectives (how goals are to be reached) Reflective listening, exhibiting respect, honesty, and openness; evoking trust and confidence; and following other values that emerge from these therapies can all help to build the partnership.

The therapeutic relationship serves as a vehicle or venue for psychological development. The humanistic therapist strives to build a warm and accepting therapeutic connection with the client, believing that the client's inner desire will manifest in a healthy way.

The treatment will be less effective unless the therapist succeeds in engaging the client during this early stage. The degree of significance perceived during the initial therapeutic contact determines the degree of motivation felt by the client following the first session.

A negative experience may discourage a highly motivated client from returning, whereas a great one may encourage a lowly motivated client to perceive the possibility of treatment being beneficial.

The Humanistic Therapy Approach

Apart from behaviourism and psychoanalysis, humanistic psychology is concerned with human potential and the individual's unique personal experience, and is often referred to as the "third force." Many of the principles of behaviourism and psychoanalysis are important to humanistic psychologists. They place a premium on understanding behavior's antecedents, as well as the significance of early experiences and unconscious psychological processes. Humanistic

psychologists, on the other hand, would argue that people are more than just a collection of behaviours or objects of unconscious forces.

As a result, humanistic psychology is frequently referred to as holistic in the sense that it embraces and accepts a wide range of theoretical traditions and therapeutic techniques. For many humanistic therapists, the need of building a collaborative, accepting, real therapy relationship that values the client which is unique to himself.

The humanistic approach is also holistic since it assumes that the client's psychological, biological, social, and spiritual components are all interconnected. People have an inbuilt ability for self-awareness and psychological well-being, according to humanistic psychology.

Abraham Maslow, who popularised the notion of "self-actualization," Carl Rogers, who developed person-centered therapy, and Fritz Perls, whose Gestalt therapy focused on the completeness of an individual's experience at any given time, are some of the prominent proponents of this approach. The following are some of the most important characteristics of humanistic therapy:

Empathic comprehension of the client's point of view and personal experience:
Respect for the client's cultural values and the ability to make decisions
Exploration of issues using a genuine and collaborative approach to assist the client in gaining insight, bravery, and responsibility.
Exploration of the client's objectives and expectations, including articulation of what the client wishes to achieve and gain from treatment.
Clarification of the therapist's role in assisting the client while respecting the client's autonomy.Collaboration and authenticity are used to assess and improve client motivation.
"Where do we go from here?" is a question that is asked professionally or informally during contract negotiations.
Setting the tone for a true, authentic experience is a great way to demonstrate authenticity. Throughout the therapeutic interaction, respect, empathy, and authenticity must be maintained. Placing wisdom in the client's hands may be beneficial later in therapy, but a client who is actively using or has recently stopped (within the last 30 days) may be unable to make rational decisions regarding his well-being or future.

Client-Centered Therapy

Client-centered therapy, as defined by Carl Rogers, presupposes that the client has the keys to healing, but adds that the therapist must provide a connection in which the client

can openly find and test his own reality, with the therapist's true understanding and acceptance. Therapists must establish three conditions for clients to change:

1. Unconditional positive regard
2. A warm, positive, and accepting attitude that includes no evaluation or moral judgment
3. Accurate empathy, whereby the therapist conveys an accurate understanding of the client's world through skilled, active listening.

According to Carson, the client-centered therapist believes that

Each person lives in their own unique realm of experience, in which they are the focus. An individual's most fundamental goal is to maintain, improve, and actualize his or her own self. A person reacts to things according to how he perceives them, in ways that are consistent with his self-concept and worldview. The underlying tendencies of a person are toward health and completeness; under normal circumstances, a person acts rationally and constructively and selects paths toward personal progress and self-actualization.

A client-centered therapist concentrates on the client's self-actualizing core as well as the client's positive forces (i.e., the skills the client has used in the past to deal with certain problems). The client should also be aware of the therapist's unconditional acceptance. This form of treatment tries to reflect what the client feels, remove resistance by persistent acceptance, and help replace negative attitudes with positive ones, rather than interpreting the client's unconscious motivation or conflicts.

Rogers' tactics are especially helpful for therapists trying to confront a substance-abusing client's denial and encourage her to continue treatment. Motivational interviewing strategies, for example, rely largely on Rogerian principles (see TIP 35, Enhancing Motivation for Change in Substance Abuse Treatment [CSAT, 1999c], for more information on motivational interviewing).

The Existential Approach To Therapy

The existential approach to therapy emphasizes the following six propositions:

1. All persons have the capacity for self-awareness.
2. As free beings, everyone must accept the responsibility that comes with freedom.
3. Each person has a unique identity that can only be known through relationships with others.
4. Each person must continually recreate himself. The meaning of life and of existence is never fixed; rather, it constantly changes.
5. Anxiety is part of the human condition.
6. Death is a basic human condition that gives significance to life.

In existential therapy, the central question is "How do I exist?" in the face of ambiguity, conflict, or death. Through courage, a person gains authenticity and is thus able to establish and discover his own significance in the present and future. There are crucial decisions to be taken (for example, in order to have actual freedom and take responsibility for one's life, one must be willing to face uncertainty and give up a false sense of security).

An individual is a "being in the world" with biological, social, and psychological needs, according to the existential viewpoint. Being in the world entails the physical world, the world of interpersonal interactions, and one's own relationship with one's own self . The "genuine" person appreciates symbolism, imagination, and judgement, and is able to employ these tools to generate personal meaning on a regular basis.

Existential therapy focuses on unique issues that arise from a person's existence. These worries are identified by contemporary existential psychotherapist Irvin Yalom as death, solitude, freedom, and emptiness. Existential therapy focuses on the discomfort that a client feels when confronted with life's intrinsic conflict. The therapist's role is to assist the client in focusing on personal responsibility for decisions, and the therapist may use some humanistic approaches and strategies to do so. For example, Yalom sees the therapist as a "fellow traveller" on the journey of life, and he employs empathy and support to extract understanding and choices. He is convinced that group therapy's relational context is an effective strategy since people exist in the presence of others.

Existential Therapy and Time

Although existential therapy was not intended to be used in a time-limited environment, the basic ideas relating to the client's search for meaning in the face of death can be employed in such a setting. Brief therapy, regardless of modality, must be focused on the "now and now." The restrictions of time are a concern in both existential and short therapies.

There are 5 important techniques used in this therapy:

1. Listening
2. Accepting
3. Respecting
4. Understanding
5. Responding

1. Emphatic Listening

The counselor invites the client to describe his/her reasons for coming to talk.

Allow the client time to respond – this behaviour is described as attending or active listening.

Helps create true intimacy between the counselor and the client – trust, comfortable with each other.

It tells the client that you are interested in him/her, want to listen to him/her, and will try to understand both the spoken and the unspoken message in the communication.

2. Accepting
The counselor accepts the client for who he/she is unconditionally – unconditional positive regard.

The counselor is being professional, not prejudice towards the client.

3. Respecting
The counselor respect the client's view of his/her life

Help the client towards a greater degree of independence and integration of the individual with respect towards his/her multicultural background (gender, religion, beliefs, life values, thought, etc.)

4. Understanding
The counselor understand the client's feelings sensitively and accurately.

Emphatic understanding help the counselor sense client's feeling as if they were his/her own without becoming lost in those feelings.

Emphatic understanding helps the counselor to reflect the client's experiences.

5. Responding
The counselor responds to the client's story.

Also responds to seek clarification about the client's feelings and thoughts.

Respond by giving advices or suggestions that can help for the client's personal growth.

GESTALT THERAPY

There are 7 important techniques:

1. Internal dialogue
2. making the rounds

3. reversal
4. rehearsal
5. exaggeration
6. staying with the feeling
7. approach to dream work

1. Internal dialogue
The empty chair technique – using 2 chairs, the client sits in one chair and become fully 'top dog' and shift to the other chair and become fully 'underdog'.

Top dog – righteous, authoritarian, moralistic, demanding, bossy, and manipulative. Underdog – play the role of victim; defensive, apologetic, helpless, weak, and powerless.

The client role playing the technique by himself/herself.

It will help the client to get in touch and experience the conflict more fully – the conflict can be solved by he client's acceptance and integration of both sides.

2. Making the round
Involves asking a person in a group to go up to others in the group and either speak to or do something with each person.

Purpose – to confront, to risk, to disclose the self, to experiment with new behaviour, to grow and change.

To know each member in the group, in a way will gain trust and self-confidence among themselves.

3. Reversal
The client takes the plunge into the very thing that is fraught with anxiety and make contact with those parts of themselves that have been submerged and denied.

This technique helps the client to accept certain personal attributes that they have tried to deny.

4. Rehearsal
The clients rehearse the new behaviour with the counseling.

Helps the client to become aware of the expectations of others, of the degree to which they want to be approved, accepted, and liked.

5. Exaggeration
The client is asked to exaggerate his/her movements or gestures, to makes the inner

meaning clear.

E.g.: if a client reports that his/her legs are shaking, the counselor may ask the client to stand up and exaggerate the shaking and then put words to the shaking limbs.

6. Staying with the feeling
At the moments when the client feel an unpleasant mood or feeling, the counseling may urge the client to stay with the feeling.

The counselor will encourage the client to go deeper into the feeling or behaviour he/she wishes to avoid.

Facing, confronting, and experiencing feelings not only takes courage but also show willingness to endure the pain necessary for unblocking and making way for new levels of growth.

7. Approach to dream work
Gestalt approach does not intend to interpret and analyze dreams. Instead, the intent is to bring dreams back to life and relive them as though they are happening now.

The dream is acted out, the dreamer becomes a part of his/her dream.

The client will make list of all details of the dream and invent dialogue.

Purpose to create awareness towards the client's own feeling.

BEHAVIOUR THERAPY

There are 5 important techniques:
1. Positive reinforcement
2. Negative reinforcement
3. Extinction
4. Punishment
5. Systematic desensitization

1. Positive reinforcement
Involves the addition off something of value to the individual as a consequence of a certain behaviour.

2. Negative reinforcement
The client is motivated to exhibit a desired behaviour to avoid the unpleasant condition.

3. Extinction

Refers to withholding reinforcement from a previously reinforced response.

E.g.; a child who display temper tantrums is often reinforced by the attention parents give to such behaviour. Therefore, in order to eliminate the behaviour (temper tantrums), parents need to stop from giving attention to the behaviour.

4. Punishment

Aversive control – in which consequences of a certain behaviour result in a decrease of that behaviour.

Goal – to decrease target behaviour (negative behaviour).

5. Systematic desensitization

The client will imagine successively more anxiety arousing situations at the same time that they engage in a behaviour that competes with anxiety.

Gradually, the client will become less sensitive to the anxiety-arousing situation.

RATIONAL EMOTIVE BEHAVIORAL THERAPY (REBT)

REBT practitioners used variety of techniques from many different therapy. Some of them are:

1. Cognitive methods
2. Emotive Techniques
3. Behavioral techniques

REBT generally starts with client's disturbed feelings and intensely explores these feelings in connection with thoughts and behaviours.

COGNITIVE METHODS

a. Disputing irrational beliefs
b. doing cognitive homework
c. changing one's language
d. using humor

EMOTIVE TECHNIQUES

a. rational-emotive imagery
b. role-playing
c. shame-attacking exercises
d. use of force and vigor

BEHAVIORAL TECHNIQUES

a. operant conditioning
b. self-management principles

c. systematic desensitization
d. relaxation techniques
e. modeling

Features of RET and its practice by Albert Ellis which appear to foster the **therapist-client relationship include:** 1. varying therapy style depending on client characteristics; 2. persistently pointing out client's irrational thoughts as a way of demonstrating therapist's helping efforts; 3. successful completion by client of assigned homework; 4. therapy is focused on current, meaningful problems of client; 5. RET therapists' communication to client's of their own faith in the validity of RET therapy; 6. use by therapist of compliments about client's brightness, competence and likelihood of success in therapy.

Lesson – 12 Group counselling – Techniques

Learning Objectives

1. The student will learn what is group counselling.
2. The students can acquire the skills of group counselling.
3. The students can identify situations under which group counselling can be conducted
4. Student of counselling psychology can facilitate for group counselling
5. The students of counselling understand different types of counselling.
6. The student of counselling can use different activities for group to reach target.
7. The student of counselling can actively take sessions and reach the group goals.
8. Students will demonstrate group counseling skills including ethical considerations by preparing and conducting a group exercise.
9. Students will participate in an experiential group counseling experience to apply knowledge base .
10. The prospective group counselor will come to understand both individual and group motivation and interactional patterns to create a counseling environment that encourages positive social interaction, active engagement, and intrinsic motivation.
11. The prospective counselor will learn to use effective verbal and non-verbal communication techniques to foster .active inquiry, collaboration, and supportive interaction in group counseling sessions.
12. The prospective group counselor will learn the value of ongoing and frequent self-evaluation and will learn to seek out frequent opportunities for professional growth and development.

Topics Covered in Brief:

1. Introduction
2. History of group therapy
3. Size of the group:
4. Principles of Group Therapy
5. Goals of Group Therapy
6. Theories of Group Therapy
7. Preferred Group Counseling Techniques/Strategies
8. Applications of Group Therapy
9. Common Misconceptions about Group Therapy

10. Contributions of Group Therapy
11. Group Therapy applied frequently to
12. THE ROLE OF GROUP THERAPY IN TREATMENT
13. Psychoeducational versus process-oriented group therapy
14. Activities in group therapy
15. Making the most of group therapy
16. Ethics of group therapy
17. universal assumptions that underlie group therapy
18. Phases of Group Development
19. Practical aspects of conducting groups
20. Types of Group
21. Guidelines for Conducting Group Therapy
22. Skills required for the Group Therapist
23. Group Process/Group Dynamics
24. Research on Group Therapy

Introduction:

Group therapy, often known as group psychotherapy, is a type of psychotherapy in which one or more therapists work with a small group of clients. People who want to increase their abilities to cope with challenges can benefit from group psychotherapy. Under the supervision of a professional, group therapy focuses on interpersonal connections and helps individuals learn how to get along better with others. Group psychotherapy also serves as a support system for those who are dealing with unique issues or obstacles. People are encouraged to converse with one another in an open and honest manner during meetings. The discussion is led by a professionally trained therapist who provides a meaningful evaluation of the topics or concerns that influence the individuals and the group.

The founders of group psychotherapy in the USA were Joseph H. Pratt, Trigant Burrow and Paul Schilder.
After World War II, group psychotherapy was further developed by Jacob L. Moreno, Samuel Slavson, Hyman Spotnitz, Irvin Yalom, and Lou Ormont.
Yalom's approach to group therapy has been very influential not only in the USA but across the world.
Group therapy is a type of treatment in which emotionally disturbed people are placed in a group under the supervision of one or more therapists with the goal of helping them change. It assists individuals in improving their social functioning and coping with personal, group, and communal difficulties through purposeful group activities.

Usually therapist identify a common need , problems of his clients, patients or students and give therapy/training by planning interactive plans between group members. Team work, social skills, coping with stress, knowing how many of other group members have similar problems as they had etc will help the participants.

The strength of group therapy resides in the one-of-a-kind opportunity to receive diverse viewpoints, support, encouragement, and criticism from other people in a secure and private setting.

These interpersonal encounters can help group members gain a better understanding of themselves and how they connect with others. Group therapy can provide a secure and encouraging environment in which to try out new ideas and ways of being.

People can benefit from group therapy to improve their mental health. At least one mental health practitioner is involved, as well as two or more people in therapy. Many people use it to deal with a specific mental health issue. People frequently feel more supported as they progress because of the group dynamic. Whether your objective is personal development, social skills improvement, or something else, group therapy may be able to assist you.

Group therapy is the most effective treatment approach for many emotional challenges, psychological struggles, and relationship issues that college students confront. The Counseling Center offers a variety of programmes to meet the requirements of our students because group therapy is so beneficial. We are certain that group therapy is one of the most successful and useful methods for addressing the frequent challenges that our students confront, but we recognise that joining a therapy group might be intimidating for some students.

Despite the fact that many students are first apprehensive to participate in group therapy, group members regularly view it as a very beneficial and good experience.

Assumptions

There are certain universal assumptions that underlie group therapy interventions. These include the following:

- Group Experience is Universal
- Group Therapy is used to bring about changes in attitude and behaviour
- Groups produce change which is more permanent
- Groups act as instruments for helping others
- Through Groups, people can grow together

- It is easy to change people in groups than at the individual level

Purpose of Group Therapy

Group therapies can serve a variety of functions. They can be:

- Corrective
- Developmental
- Educative
- Preventive
- Recreational
- Therapeutic

Guidelines for Conducting Group Therapy

Certain broad principles underlie the conduct of group therapy. These include:

- Planned Group Formation
- Specific Objectives
- Purposeful Worker - Group Relationship
- Continuous Individualization
- Guided group Interaction
- Democratic Group self-determination
- Flexible Functional Organization
- Progressive Programme Experiences
- Resource Utilization
- Evaluation

Contributions of Group members and therapist:

People who participate in group therapy can benefit from the **support and encouragement of their peers**. People in the group can see that others are going through similar experiences, which might make them feel less alone.

Members of a group can **serve as role models for others** in the group. Other members of the group can realise that there is hope for healing by watching someone effectively deal with an issue. As **each person grows**, they can become a role model and a **source of encouragement** for others. This can aid in the development of sentiments of accomplishment and success.

Group therapy is frequently **quite inexpensive**. Instead of concentrating on a single client at a time, the therapist can work with a much larger group of people.

Group therapy provides a **secure environment** in which to learn. The environment allows people to **practise habits and actions** in a safe and secure environment. The therapist **can observe firsthand how each person reacts to others and behaves in social circumstances** by working in a group. The **therapist can provide valuable feedback** to each client based on this information.

History of Group Therapy:

During WWII, group therapy became popular. There were insufficient mental health providers at the time to handle war-related mental health disorders. The study of group power, on the other hand, had begun decades before. Gustave Le Bon, a French polymath, released The Crowd: A Study of the Popular Mind in 1895. When a person enters a group situation, Le Bon believes that their behaviour is affected. People in crowds, he observed, put their personal interests aside in favour of the group and became less aware of the implications of their behaviour.

Perhaps the most well-known proponent of group therapy is Irvin Yalom, author of The Theory and Practice of Group Psychotherapy. Yalom's research emphasises the impact of group therapy on people. Furthermore, it identifies qualities that promote collective healing. This method has been influenced by Sigmund Freud, Jacob Moreno, Eric Berne, and Carl Rogers, among others.

The father of group therapy is Joseph Hersey Pratt. He started working with a group of eight pulmonary tuberculosis patients in Greater Boston in 1905. He was offering general-care education classes for tuberculosis patients who had recently been discharged and couldn't find a spot in the sanatoria. He noted how this encounter had affected their emotional states and allowed them to talk about their common issues. This new sort of treatment yielded very great outcomes for Pratt. In the literature, this is known to be the first formally organised therapy group.

In 1936, group therapy was used on convicts in prison and patients discharged from psychiatric facilities. Paul Schilder and Louis Wender were the first to do it. Later, it was expanded to include those with neurosis, alcoholism, and troubled children. During World War II, emotionally distressed war victims were treated through group therapy.

A TYPICAL GROUP THERAPY SESSION

1. Group therapy is usually led by **one or two therapists trained to lead therapeutic groups.**
2. A group therapist carefully selects persons (typically 5 to 10) who will benefit from the group experience and who can work together as learning partners.Group sizes can range from six to twelve members. While groups may be small or large, the group process may be less effective in much larger groups.
3. Typically, groups meet for 1-2 hours each week and address specific concerns shared by group members. The minimum number of recommended sessions is often six, but many people attend for a full year. Group therapy sessions can be held in a variety of settings, such as community centers, therapy offices, hospitals, libraries, members' houses, or churches. Some go to individual therapy in addition to group therapy. People who have received mental health treatment in the past may choose to participate in only group therapy.
4. Most groups meet in a quiet room with the chairs arranged to make sure each person can see everyone else. To begin, members may introduce themselves, discuss their progress, or share the reason they are in group therapy. Group activities depend on the style of the therapist and the group's goals. Some therapists have planned lessons for each session. Others may promote a more free-form discussion style.
5. Each participant attempts to share their own concerns, feelings, ideas, and reactions as openly and honestly as possible during the session. As a result, group members have the opportunity to learn not only about themselves and their personal problems, but also about the importance of helping other members of the group.
6. The minimal number of group therapy sessions, according to author Oded Manor in 'The Handbook of Psychotherapy,' is normally approximately six, but a full year of sessions is more common. Manor also mentions that these gatherings can be open or closed.
7. Group therapy meetings can be open or closed.

- In **open groups**, new members can join the group at any time.
- In a **closed group**, all members join at the same time. Only they participate in the sessions.

It is often easier to join an open group, but it may take longer for new members to get to know existing members. Members of a closed group get to know each other at the same time but may wait longer until they can join a group that works for them.

8. Members may also discuss their progress and experiences since the last meeting. With the facilitation of 1-2 professional group therapists, group therapy is a powerful

instrument for growth and transformation, allowing people to discuss their challenges and worries.

Group Formation

Certain broad principles underlying group interventions are presented below.

- **Selection of Individuals:** Selection of individuals for group therapy should be based on similarity of the problems.
- **Number of members:** Group therapy may be practised with more than two members and less than 15. Optimum number for group therapy is 8-12 members.
- **Seating arrangements**: There should be enough chairs to accommodate the group members. Particular member chair should be left vacant if he/she is absent. Therapist and patients must have similar chairs.
- **Frequency of group session:** Group Therapy can be conducted once in a week or 3-4 times a day depends upon the needs of the group members and clinical settings. Groups that are conducted on a daily basis may be of 45 minutes duration; group duration may be up to 90 minutes if it is once in a week.
- **Time Period:** Length of the group therapy may be extended for a maximum of 25 sessions or for a maximum period of six months.
- **Age range:** Age range of the group members can be relatively similar; ranging from 25 years to 55 years. There should not be too much age disparity.

Principles of Group Therapy:

Irvin D. Yalom (1995) summarises the fundamental therapeutic ideas that have been obtained from self-reports from individuals who have participated in group therapy in his book 'Theory and Practice of Group Psychotherapy.'

process -

Instilling Hope: Members of the group are at various stages of the therapy process. Seeing others who are managing or healing gives encouragement to those who are just starting out.

Universality: Sharing an experience with a community allows people to realise that they are not alone in their struggles. It also helps to alleviate a group member's loneliness, validate their experiences, and boost their self-esteem.

Exchanging information: Members of a group can assist one another by sharing information.

Altruism: Members of a group can share their abilities and provide a hand to others in the group, boosting self-esteem and confidence.
Corrective recapitulation of the primary family group: In certain aspects, the therapeutic group resembles a family. Each group member can look at how their childhood experiences influenced their personality and habits. They can also learn to avoid dangerous or unhelpful actions in real life.

Developing socialisation techniques: Practicing new behaviours in a group context is an excellent way to improve your social skills. The environment is secure and encouraging, allowing group members to try new things without fear of failure.
Imitative behavior: Individuals can model or replicate the behaviour of other members of the group, or they can observe and imitate the conduct of the therapist.
Interpersonal learning: Members of the group can get a better understanding of themselves by engaging with others and receiving feedback from the group and the therapist.

Group cohesiveness: Members of the group feel a sense of belonging and acceptance since they are working for a common objective.
Catharsis: Catharsis is the process of sharing one's feelings and experiences with a group of others in order to alleviate pain, guilt, or stress.
Existential factors: While working in a group can provide support and advice, group therapy can also help people recognise that they are in charge of their own life, actions, and decisions.

Group Therapy's Objectives

1. Gain a better understanding of personal issues and potential solutions, as well as provide and receive criticism and support.
2. Feel more connected to other students going through similar problems.
3. In a secure group context, practise communication skills.
4. Become more aware of how you appear to others.
5. Improve your capacity to recognise and communicate your emotions.
6. Reducing social isolation is one of the most important things you can do.

Goals of Group Therapy:

1. Acquire a better knowledge of personal issues and look into possible remedies.

2. Give and receive help and comments.

3. Feel more connected to other students going through similar problems.

4. In a secure group context, practise communication skills.

5. Become more aware of how you appear to others.

6. Improve your capacity to recognise and communicate your emotions.

7. Reducing social isolation is one of the most important things you can do.

Theories of Group Therapy: Following are the important group therapy models -

1. Brief cognitive group therapy
2. Cognitive-behavioral group therapy
3. Strategic/interactional therapy
4. Brief group humanistic and existential therapies
5. Group psychodynamic therapy.
6. Modified dynamic group therapy (MDGT)
7. Modified interactional group process (MIGP).

1.Brief Cognitive Group Therapy:

The group's cognition may be identified, and the process can be shifted with the use of activities. In group therapy, cognitive approaches function well. Individual members take turns describing an event or setting that tempted them to abuse substances after learning the principles of the cognitive approach. Other members aid the therapist in gathering further information regarding the client's perspective about the event and how it led to substance misuse, if it did or did not (or to negative feelings that might have led to use). Finally, the group members provide the customer a variety of adaptive perspectives on the circumstance.

2.Cognitive-Behavioral Group Therapy:

The group's beliefs and subsequent behaviour are the focus of the cognitive-behavioral strategy. As a result, the group will learn to identify self-defeating beliefs. It is up to the group members to recognise such views in one another. The therapist encourages group members to use behavioural approaches such as homework and visualisation to help them think, feel, and behave differently.

3.Strategic/ Interactional Therapies:

The strategic therapist challenges each group member to explore ineffective attempts at solutions using strategies similar to those employed in family therapy. The therapist encourages group members to examine and process these proposed solutions, recognising

when they are ineffective, and then engaging the group in brainstorming other alternatives. Where appropriate, the therapist also strives to change group members' perspectives of problems and to help them comprehend what is going on. The therapist usually directs the process, while participants offer each other advice and encouragement as they seek out and implement appropriate solutions. For group therapy as well as individual therapy, the concepts of solution-focused therapy are the same. These include using the'miracle' question to set client goals, using scaling questions to track progress, and identifying successful tactics that work for each client. The therapist attempts to foster an encouraging and supportive group culture and dynamic.

Simultaneously, the therapist attempts to prevent the client from going off on tangents ('war stories') or launching personal attacks. The therapist tries to persuade group members to take good action, unlike in family therapy, where everyone is considered as a "consumer."

4.Brief Group Humanistic and Existential Therapies: This category encompasses a number of approaches. The transpersonal method can be tailored for individuals with substance abuse issues and is beneficial in meditation, stress reduction, and relaxation therapy groups. It is beneficial to hear other individuals talk about their opinions while dealing with matters of religion or spirituality. In this way, past demeaning or punitive experiences with organised religion might be recast in a more beneficial and meaningful light.

Gestalt therapy in groups allows for a more thorough integration because each group member can contribute a piece of personal experience. Each group member contributes to the formation of the group, and all of their perspectives must be considered when making a change. Role-playing and group dream analysis are useful and relevant exercises that can assist clients in coming to terms with themselves.

5.Group Psychodynamic Therapy: With the help of the therapist, group psychodynamic therapy allows the group to become both the context and the means of change, in which members motivate each other to support, strengthen, or modify attitudes, feelings, relationships, thinking, and behaviour.

6.Modified Dynamic Group Therapy (MDGT): Based on psychodynamic theory, a modified dynamic group therapy technique for substance-abusing clients was established (Khantzian et al., 1990). MDGT is a 26-week time-limited group psychotherapy that considers substance misuse problems as an expression of ego dysfunction, affect dysregulation, lack of self-care, and dysfunctional interpersonal interactions. Its basic structure is characterised by two meetings per week over a 26-week timeframe. MDGT is a supportive, expressive group experience that helps substance-abusing people to analyse and address their vulnerabilities

in four areas: (1) accessing, tolerating, and regulating feelings; (2) interpersonal challenges; (3) self-care failures; and (4) poor self-esteem. MDGP emphasises group environment safety, comfort, and control, which is congruent with this notion of substance misuse's beginnings. Group facilitation is the most important factor in a therapist's ability to engage and retain substance abusers in treatment by offering structure, continuity, and consistency.

7.Modified Interactional Group Process (MIGP): MIGP is a time-limited synthesis of numerous theorists' work (Yalom, 1995). The higher activity of the leader and the sensitivity to the formation of a secure atmosphere that allows group members to address relational issues without excessive emotional contagion distinguish MIGP from a more typical interactive approach. The therapist's commitment to group agreements or group norms, as well as the continual reinforcement of these agreements throughout the group process, considerably enhances the atmosphere of safety. The facilitator emphasises the value of secrecy, the group's acceptance of responsibility for itself, and self-disclosure.
The building of the safe environment includes procedural agreements, such as starting and terminating the group session on time and ensuring that each member has a seat within the circle, with any absences handled. The therapist assists the clients in recognising that they are the major change agents during this process. The group creates a safe environment for both giving and receiving assistance. MIGP is significantly more helpful than traditional substance misuse groups, which are sometimes confrontational.

This is due to the assumption that when a person is attacked, denial and other defence mechanisms become more rigid. As a result, rather than using shame-based interaction techniques to 'break through denial,' group members are encouraged to support one another and explore for areas of similarity. MIGP focuses on four aspects of the client's life: pleasure and support, self-vulnerability, affect control, and self-care (Flores and Mahon, 1993). These four areas are given special attention because they are vulnerable points in the substance-abusing client's life that can easily lead to relapse and jeopardise recovery.

Preferred Group Counseling Techniques/Strategies

1. **Reflection -** Allow clients to understand fully each person’s comments and how they can relate to what they just stated.
2. **Active Listening** - Allow clients to be very aware of their listening skills within a group and how important they are. This allows the group to be more open with each other when they know their group members are paying attention to their feedback.
3. **Clarification** - Allow clients to be very concrete with others in the group of comments made.

4. **Summarizing** - Allow clients to see the bigger picture of what was said in the group by doing a recap of what was said. Provides comfort within group.
5. Linking - Allow clients to see how their problems connect with others' in the group and they have the same concerns.
6. **Encouraging** - Allow clients to be more open with group and makes sharing personal feelings more inviting.
7. **Focus** - Allow counselor and clients to give attention to groups concerns.
8. **Cutting Off** - Allow counselors to keep the group on topic and give everyone achance to share.
9. **Drawing Out** - Allow counselor to bring forth quiet group members comments.
10. **Rounds** - Allows each client to share within the group.
11. **Dyads** - Allows clients to pair up with a partner and learn more about another client.
12. **Word or Phrase Round** - Allow clients to broaden their vocabulary when describing how they felt about something within the group session.
13. **Comment Round** - Allow clients to share their personal comments about that specific session.
14. **Icebreakers** - Allow clients to warm-up to group members when beginning group.
15. **Modeling** - Allow clients to see counselor as a role model in group work and the behaviors that can be applied to them personally.
16. **Use of Eyes** - Allows counselor to have direct eye contact with group members that are sharing. It will allow the counselor to draw out quiet members to speak. Allow them to members that have lost interest in the topic.
17. **Tone Setting** - Allow clients to establish a mood for their group. Rather it needs to be a tone that is serious, social, supportive, and formal.
18. **Use of Leader's Energy** - Allow clients to see the counselor excitement about their new group, topic, and activities.
19. **Non-Judgmental** - Allow clients to see that this is a positive experience and not to make anyone feel down.
20. **Empathy** - Allow clients to convey to other group members that they understand and will not make fun of anyone.

Applications of Group Therapy: Group therapy has proven to be very effective for the treatment of depression and traumatic stress, such as post-traumatic stress disorder (PTSD) and sexual abuse survivors. Clinical cases have shown that the combination of both individual and group therapy is most beneficial for most clients. Group therapy has proven effective in treating feelings of isolation, difficulties with interpersonal relationships, aging, schizophrenia, bipolar disorder, anorexia, alcohol dependency, death & other losses, and lifestyle issues within a traditional culture.

Common Misconceptions about Group Therapy

People may believe that participating in group therapy forces them to reveal their **deepest thoughts, feelings, and secrets**. They have complete control over what you share, how much you share, and when you share it. A group may be beneficial and uplifting for most people when **they feel safe enough to communicate what's bothering them**. Even if you aren't ready to discuss something, listening to others might be beneficial. It's possible that what they're saying will apply to you.

Because I'll be splitting the time, group therapy will take longer. For two reasons,

1. group therapy is generally more effective than individual therapy. First, one can benefit from the group even if they are quiet and attentive.

2. Second, group **members may bring up issues that strike a chord with you** - things you may not have been aware of or brought up yourself.

Fear that group members will verbally attack one another - It is critical for members to feel comfortable, and leaders will assist in creating that environment. While feedback might be difficult to hear, groups can point out harmful behaviours in a courteous, kind manner, allowing you to hear and act on the information. Group members often perceive feedback (and even confrontation) as a sign of compassion as trust increases. I have a hard time conversing with strangers. In a group, I'll never be able to share. Most people are nervous about speaking in front of a group, but this fear usually dissipates fast. People remember what it's like to be new to a group, so you'll probably get a lot of help once you start talking.

The best type of therapy is group therapy: For many issues, group therapy is the most effective treatment option. When a therapist suggests a group, it's because the therapist believes it's the greatest method to help the client. The therapist and the client can talk about why the referral was made.

Groups are private, which means that nothing spoken in sessions is shared outside of the group. At the first meeting and every time a new member joins a group, the importance of secrecy and concerns about it are discussed with group members.

To get the **most out of group therapy**, participants should accomplish the following:

1. **Attend the group regularly,** regularity and punctuality and attendance are important.
2. **Share** ones hopes and fears for participating in group, it is an opportunity to share, so much utilize the opportunity.
3. **Best platform** :Share with the group what you're struggling with – this is best

platform to discuss the problems.

4. Take some **emotional risks** in group – emotional out bursts may be possible but it's part of the therapy.
5. **Be direct and honest** with your feelings in group- don't mislead or hide feelings as by being open, learning, understanding takes place.
6. Be willing to give and receive feedback- **sharing and shining** possible in group therapy.
7. Share your own experiences and **ask others** about theirs – listening others is first step in success of the therapy.
8. Let the group know both positive and negative feelings that come up in group – group is **mini society**, it includes positive and negative feelings.

Group Therapy applied frequently to:

Group therapy can assist people in achieving a variety of objectives. A therapist may recommend group therapy above other forms of treatment in several cases. This could be because it is a good fit for that person or because it is more effective in treating their problem. People whose mental health makes it difficult to function in daily life may benefit from therapy groups. Others may not have immediate problems but still want training or assistance. Group therapy may also be beneficial to them. The following are some of the subjects that are discussed in group therapy:

Addiction	Parenting
Domestic violence or abuse	Food and eating issues
Divorce	Anger management
Anxiety	Grief and loss
Communication issues	Addiction

Keep in mind that a therapist may not recommend group therapy as a treatment option at first. One reason is because it can be difficult to share personal information in a group setting, especially at the beginning of treatment.

THE ROLE OF GROUP THERAPY IN TREATMENT

Many people use group therapy along side medication, individual therapy, or other types of care. One may be doubltful about receiving treatment in a room of strangers. However, there are many benefits to participating in group therapy.

Diversity of Group Setting:

Members of a group can provide advice on how to cope with situations that many in the group find challenging. They can also lend social support in difficult times. The diversity of a group setting can help people find new strategies for maintaining good mental health.

Listening to Group members:

listening to others speak about their personal experiences can help put our own thoughts into perspective. Group therapy can help comfort people by allowing them to realize they are not alone.

Uniqueness of group therapy: Group therapy is not the same as a self-help or support group. The main difference is that each group therapy session is led by at least one qualified therapist. During sessions, a therapist teaches research-backed techniques. Other types of groups cannot guarantee a qualified therapist will be present to teach concepts, skills, and practices at this level.

Psycho-educational versus process-oriented group therapy

There are many different types of therapeutic groups, but most therapy groups can be divided into two main approaches. These approaches are **psychoeducational group therapy** and **process-oriented group therapy.**

- **Psychoeducational** groups provide members with information about specific issues. They may also teach healthy coping skills. These groups are led by a qualified therapist who directs sessions and sets goals. Bonds between group members are less important here, as the therapist provides most of the content through instruction. In this type of group therapy, the therapist takes on the role of teacher.
- **Process-oriented** groups focus on the group experience. While the therapist leads the group discussion, they act as a facilitator rather than an instructor. They are careful not to become the center of attention. Group members participate by engaging in group discussions and activities. Sharing in these kinds of activities can lead to a sense of belonging and increased self-confidence. In process-oriented group therapy, the group is in charge of their sessions.

Some people wish to gain skills such as **parenting, caregiving, or stress management.** They may benefit from psycho-educational group therapy. Others seek **personal growth to deal with a major life transition**, such as divorce, retirement, or aging. These individuals could benefit from process-oriented group therapy.

Activities in group therapy

Group therapy activities can **help with communication, trust, and personal development**. They could be **conversational in nature**, such as reading and sharing stories. Alternatively, they could be physically demanding team-building exercises. **Ice breakers**, when handled properly, can assist group members get to know one another in a more relaxed setting.

Physical activities such as dance or cooking necessitate collaboration to reach a common aim. These activities are designed to foster trust and respect. Other hobbies that foster creative expression include performing music, acting, and painting. Role-playing, outdoor expeditions, and other games can help to build trust among group members. Outside of treatment, these can also assist group members **grow confidence in themselves and in others**.

Making the most of group therapy

Group therapy may seem scary at first, but it often becomes much easier over time. People who do their best to engage fully in group activities typically get the most out of group treatment.

Those interested in group therapy can consult with a therapist or physician for suggestions on how to find the best group for them. Medical centers and hospitals may also have information on available groups.

When choosing a group, it can be helpful to consider:

- Group size
- What kinds of issues the group addresses
- How much you wish to share with your group members
- If group therapy should be used along with another type of treatment
- If the group is open or closed
- If the group is process-oriented or psychoeducational

Ethics of group therapy

When potential group members meet with the therapist for the first time, they have the right to learn about the group's rules, goals, and procedures. **Confidentiality** rules should be discussed at the outset.

All members of the group must agree to keep each other's **identities private.** They must also keep the details of each meeting private. Nobody should disclose another member's personal past with anyone else unless they have permission.

It's vital to keep in mind that confidentiality agreements aren't always binding. **Therapists are required by law** to report members who express a desire to hurt themselves or others to the police.

The group therapist must maintain a **professional, respectful, and ethical environment**. They need to keep sessions free from discrimination, sexual misconduct, or behaviors that make a member feel uncomfortable, harassed, or threatened.

The therapist must also guarantee that group therapy sessions are **non-judgmental and beneficial** to all participants.

Social Group Work and Group Therapy

Group therapy is considered one of the promising psychosocial treatment modalities which is practiced in clinical settings for persons with emotional problems or mental health issues by qualified mental health professionals such as psychiatrists, clinical psychologists, psychiatric nurses, psychiatric social workers and occupational therapists specialized in mental health. The group therapist is as active participant of the group and helps its members to understand their individual problems as well as interpersonal problems. Group discussion is focused on the current problems in relation to oneself and others. Group therapy aims to bring about reduction in symptoms such as negative symptoms, poor motivation, as well as improvement in social functioning, better adjustment and improved interpersonal relationship skills.

Contra-indications for Group therapy

While a majority of persons seeking treatment for addictive disorders could benefit from group interventions, the following members may not be suitable for group therapy:

- Persons with acute psychotic symptoms
- Those with active suicidal thoughts
- Organic disorders
- Physically unhealthy individuals

- Persons with significant Cognitive decline/deficits
- Persons with severe Personality disorders
- Poorly motivated persons

Phases of Group Development

In closed groups, the following phases are described:

- Forming
- Norming
- Storming
- Performing
- Adjourning

Forming

Members became oriented toward each other, work on being accepted, and learn more about the group. This stage is marked by a period of uncertainty in which members try to determine their places in the group and learn the groups' rules and procedures.

Storming

Conflicts begin to arise as member resist the influence of the group and rebel against accomplishing their tasks. Members confront their various differences, and the management of conflict often becomes the focus of attention.

Norming

The group establishes cohesiveness and commitment. In the process, the members discover new ways to work together. Norms are also set for appropriate behaviour.

Performing

The group works as a unit to achieve group goals. Members develop proficiency in achieving goals and become more flexible in their patterns of working together.

Adjourning

The group disbands. The feelings that members experience are similar to “Separation Stage”.

Practical aspects of conducting groups

It is important that members of the group follow some ground rules with respect to group therapy participation.

For the members

1. Members must be informed about the purpose of group: Purpose is to meet together to discuss their problems.
2. Discipline: Regularity, Punctuality, Confidentiality. Members should agree to attend the group regularly as per schedule. Group members are advised that issues deliberated in the group not to be discussed after the group session or outside of the group.

For the therapist

1. There must be two therapists. Participant recordings can be done interchangeably for each session by the therapists.
2. The Group therapist should have individual session with each member before the therapy starts.
3. The therapist should be aware of his/her own feelings towards the members of the group (the therapist's experience with other groups such as students, colleagues etc., may affect the interaction with the group).

Therapist role

In a therapist facilitated group interventions, various attributes of the therapist have been described;

- Directive approach: S/he has to enable the members to participate in the group intervention process.
- Extensional: When a particular aspect comes up, the therapist has to extend the discussion if it is beneficial.
- Interpretive: The therapist must be able to provide insight that the members of the group have improved. At the same time, premature interpretation must be avoided
- Therapist needs to function as an Enabler and Leader
- Therapist has a responsibility to share knowledge/information
- Helping to form, develop, participate in order to achieve its objectives
- Ability to listen to members' view
- Efficient in handling agency schedule

Skills required for the Group Therapist

Every group therapist must have the skills to work as a part of clinical setting. She/he must know the hospital needs and must possess a growing awareness of oneself as well as the group. The group therapist skills are most evident while actively engaged in a helping capacity with the group. The basic therapy skills required are summarised below:

1. Skill in establishing purposeful relationships
    A. The group therapist must be skilful in gaining the acceptance of the group and in relating to the group on a positive professional basis.
    B. The group therapist must be skilful in helping individuals in the group to accept one another and to join with the group in common pursuits.
2. Skill in analysing the group situation
    A. The group therapist must be skilful in judging the developmental level of the group to determine what the level is, what the group needs, and how quickly the group can be expected to move. This calls for skills in direct observation of groups as a basis for analysis and judgement.
    B. The group therapist must be skilful in helping the group to express ideas, work out objectives, clarify immediate goals, and see both its potentialities and limitations as a group.
3. Skills in participating with the group
    A. The group therapist must be skilful in determining, interpreting, assuming, and modifying his/her own role with the group.
    B. The group therapist must be skilful in helping group members to participate, to locate leadership among themselves, and to take responsibility for their own activities.
4. Skill in dealing with group feeling
    A. The group therapist must be skilful in controlling his/her own feelings about the group and must study each new situation with a high degree of objectivity.
    B. The group therapist must be skilful in helping the groups to release their own feelings, both positive and negative. The therapist must be skilful in helping groups to analyse situations as a part of the working – through of group or intergroup conflicts.
5. Skills in programme development
    A. The group therapist must be skilful in guiding group thinking so that interests and needs will be revealed and understood.
    B. The group therapist must be skilful in helping groups to develop programmes which they want as a means through which their needs may be met.
6. Skill in using agency and community resources
    A. The group therapist must be skilful in locating and then acquainting the

group with various helpful resources which can be utilized by them for programme purposes.

B. The group therapist must be skilful in helping certain individual members to make use of specialised services by means of referral when they have needs, which cannot be met within the group.

7. Skill in Evaluation
    A. The group therapist must have skill in recording the development processes that are going on while working with the group.
    B. The group therapist must be skilful in using group therapy records and in helping the group to review its experiences as a means of improvement.

Group Process/Group Dynamics

In the beginning, members may be dependent on therapist as an authoritative figure. They associate the therapist with magical powers and the ability to solve all their problems.

Various processes occur as the group sessions progress. These include:

Cohesiveness: It is a key element of success to the group. There has to be feeling of identification with the group, feeling of belongingness, willingness to sacrifice personal wishes. Members keep a focus on the main goal, which is to help each other to solve their problem and have warm feelings for each other. The group should not hinder the individual functioning outside. The group should become an end in itself. This means that members should not feel that all the needs are met within group.

Content of the discussion: It is concerned with the current interpersonal problems of daily life and not on the past. It is focused on the current interaction between the members and the therapist; 'go- round' technique is used to make everyone express as a particular matter/technique.

Modelling: Patient identifies with therapist and uses the therapist as a role model for more effective functioning. Negative transference of the members is revealed through anger and negative response. Therapist in response has to be kind and calm. This will in turn be an example to the participants to be calm and serene in similar situations. Retaliation is not good. Other members express the feeling of acceptance. They realise that they alone don't have the problems, but others also have similar problems. (universalization). There would be group pressure to alter the individual's behaviour.

Cliques: Therapist must be aware of formation of group cliques

Group bond: An important factor in group process is group bond. It represents the feelings of cohesion that makes for a group. Group bond is exclusively defined as "sense of belonging". It can be measure a group's effectiveness. However, group bond can also be destructive. Its strength might have been produced by threat or by serious dependence of

the members on each other. Group bond, therefore, may be a powerful aspect of the group process in either a constructive or destructive sense.

Other Group dynamics to be considered: Sometimes an individual is in an even less favourable position than isolation. He is rejected by the group and exposed to open hostility. Again, one must search for the reasons before trying to change them

Therapeutic Factors in Group

A variety of therapeutic factors have been described in group therapy processes. These include universality, altruism, cohesion, catharsis, imparting information, imitation and modelling, instilling hope, developing social skills, learning interpersonal skills and support[5,6]. The most favourable factor perceived by persons with SUD in group intervention is catharsis, followed by group cohesiveness and interpersonal learning. Patients who received group intervention for 15 sessions or more had a significantly more favourable outcome rate than those who received other modes of treatment, in terms of lesser relapse rate. Apparently because of therapeutic techniques used in the group such as feedback, reward, accepting them as they are, joining, membership, confidentiality, support, and identification of their needs and problems has the capacity to bond patients in overall treatment process.

Assessing Group dynamics and Outcome of Group therapy

There are a few tools available for analysing the group therapy process, group dynamics and interaction among group members. Understanding behaviour of the individual in group therapy is essential. Some of the commonly used scales include the Group Climate Questionnaire, Group Cohesiveness Scale and Group Work Engagement Measure, the Therapeutic Factors Scale, Group Session Rating Scale, Individual Group Member Interpersonal Process Scale, Interpersonal Relation Checklist, Group Emotionality Rating System, The Hill Interaction Matrix, Member – Leader scoring system, The Hostility/Support Scale and SYMLOG, which is a measurement method for assessing norms, roles and others dimensions of a group as a whole.

Research on Group Therapy

Process of Group therapy

Advice giving, insight giving, support giving, self-revealing, symptom reporting, abreaction, imparting information were frequently observed group process in a group therapy for persons with alcohol dependence syndrome.

Effectiveness of Group therapy

Group therapy for persons with substance use disorder was significantly effective in reducing number days and quantity of substance use, lesser number of days of family role dysfunction, financial problems, routine family activities, occupational dysfunction. Medium

to large effect size was seen in improving all the domains of quality of life, coping behaviour, and self-efficacy.

Self-Help Group (Alcohol Anonymous) VS Group Therapy

Therapeutic elements such as remaining abstinent, empathy, advice, using anti-craving medicines were found more useful in **De-addiction treatment group** whereas in **Alcoholic anonymous group** acceptance, self-confidence, spirituality, technique **like '*remain sober today*' were more useful.**

Patients attending Alcoholic anonymous group had longer periods of abstinence and lesser number of relapses due to euphoric mood and external factors than the alcohol dependents attended Group therapy at the De-addiction Centre.

AA group members were more satisfied with their life in terms of neighbourhood and community and financial well-being .

These groups however are not strictly comparable, because addiction inpatient facilities get a heterogeneous group of patients at different stages of motivation, whereas people likely to be regular at AA meetings usually represent a group committed to change. Self-Help group *may be* used as a viable option for effective **after care intervention for persons with substance use disorder** who are discharged from the addiction treatment centres.

Glimpses of Group Interventions at Centre for Addiction Medicine :

Group interventions for substance use disorder at NIMHANS started in 1986. First, it was started for outpatients, later it was extended to in-patients as well at psychiatry ward. The aim of group intervention was to encourage the group **members to open and share their experiences with other members and to learn skills to prevent relapse and maintain abstinence.**

Language Based:

In-patient setting runs three group interventions in different languages English, Kannada and Tamil in parallel.

Sometimes, depending upon the number of patients, group interventions would be conducted in Telugu and Hindi as well.

Kind and Form of group

Group is an open one. Members can join and leave the group according to their admission and discharge timings. Groups are **educative in nature**. Their opportunity to learn (gain knowledge) is more as compared to their opportunity to express.

Group structure

Often, **groups are homogenous**; each group contains 8-16 members (often-speaking same language) each session lasts for a duration of 45 minutes to an hour.

Group format

A group session on recreational activities would be conducted as well once in a week by psychiatric social workers and occupational therapist.

A 12 cycle of sessions on group intervention focuses on different groups

Family Support Group

Apart from the group intervention for persons with substance use disorders, Group sessions were also conducted for their family members once in a week since 2006.

The focus is to allow them to ventilate their feelings emotions. In addition, psychiatric social workers educate them about to realize their roles and involvement in recovery process.

Family support group would be in multi-lingual as the people from varied culture seek treatment at centre for addiction medicine.

Group Intervention for women – STUDY OBSERVATIONS

Group intervention for women with substance use disorders commenced in the year 2016, after initiation of **separate services for women**. Presently, four to eight women used to attend the relapse prevention group interventions. Owing to culture sensitivity and varying treatment needs for women with substance use disorder, a separate relapse prevention group has been initiated.

Women recovery group had favourably more reductions in average substance using days, and more satisfaction than mixed gender group intervention.

A women-focused same-gender group intervention may enhance longer-term clinical outcomes among women with substance use disorders.

Affiliated statements such as supportive, shared experiences, and strategy statements were more in women-focused group intervention than in mixed gender group intervention.

Women felt more safe, greater acceptance of different aspects of their self, having their needs met, developing familiarity and confidence, empathy, morality, group cohesion and perceived increased support in women-focused group intervention on gender-relevant topics played an important role in supporting their recovery.

Women focused groups shown improved treatment satisfaction than mixed gender group treatment.

However, both the groups did not differ significantly in terms of reduction in mean number of substance use days . This research finding needs to be interpreted with caution. The fact that there is no difference in reduction in number of substance using days does not warrant that women can be placed in mixed gender group intervention.

Out-Patient Recovery Support Group intervention:

Recovery support group for recovering persons with substance use disorder have been in place since 2010. It occurs three days in a week during out-patient consultation.

Persons who have maintained abstinence for a period of one year have been felicitated during the recovery support group intervention.

In NIMHANS, Dr Murthy felt there is a need for such support group for recovering persons and this provides an opportunity for those not treated in an in-patient setting.

Recovery support group is usually facilitated by a person who has recovered from substance use disorder and enabled by psychiatric social workers.

Recovery support group enables people who abuse substances to witness the recovery of others.

It provides useful information to clients regarding new and alternate ways to recovery. Felicitation of recovery provides positive peer reinforcement for recovering persons for sustenance.

Objective Type Questions:

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1. **One of the following statements is wrong. What is it?**

A	Yalom's approach to group therapy has been very influential not only in the USA but across the world.
B	The founders of group psychotherapy in the United States were Joseph H. Pratt, Trigant Burrow and Paul Schilder.
C	In 1932 Jacob L. Moreno presented his work on group psychotherapy to the American Psychiatric Association, and co-authored a monograph on the subject.
D	**Kurt Lewin and Carl Rogers are founders of Group Psychotherapy**

2. **Group therapy meetings can be open or closed. Yes** / No
3. **Facts about cliques are given below …… find the wrong answer**

A	One of the group dynamic
B	In group therapy these will develop and may interfere in reaching the goal by the therapist.
C	Regardless of age, cliques form to provide social comfort to its members, but from an organizational perspective, they can stand in the way of big picture goals by preventing collaboration and inclusion of diverse perspectives.
D	**Cliques are not part of the group**

4. **In group therapy all members must be of same gender.** Yes **/ No**

5. The order of group formation is ?

A	**Forming, Norming, Storming, Performing, Adjourning**
B	Norming, Storming, Performing, Adjourning, Forming
C	Storming, Performing, Adjourning, Forming, Norming
D	Performing, Adjourning, Forming, Norming, Storming

Lesson 13:- Solution based therapy – I

Learning Objectives:

The student will be aware of the following information by completing this lesson.

1, what is the solution focused therapy.

2. The history of solution focused therapy.

3. The way and how the therapist probes the problem of the client.

4. The questions asked for extracting specific information.

5. The ability to solve problems in one area can be trasfered to the problem area by the client

6. How the insight and finding solution internally is possible than searching it our side.

Solution-Focused Therapy - SBT (Solution Focused Brief Therapy – SFBT) is a therapeutic technique that encourages clients to believe in their own skills to solve difficulties in their lives. Unlike traditional psychotherapy, which focuses on the origins of a problem, SFT provides for a goal-oriented approach to problem-solving. This method enables for forward-looking rather than backward-looking dialogues to take a customer closer to resolving their current challenge.

This method is employed in a variety of situations, including schooling, family therapy, and even professional settings. Mind-broadening capacities can be achieved by creating cooperative and collaborative problem-solving chances. A compelling method to empower individuals to examine how they wish to show up in this world is to illuminate a route of choice.**Influence of Family Therapy**: The focus of traditional therapy has always been on the problem. It has looked at a person's difficulties from beginning to end, as well as how those problems affect that person's life. Years of observing family therapy sessions led to the development of solution-focused therapy theory and applications.

History:

Systems treatments: Solution-focused brief therapy is part of a **larger family of techniques known as systems treatments**, which have **evolved over the last 50 years or so,** beginning in the United States and subsequently spreading throughout the world, including Europe.

Steve de Shazer and Insoo Kim Berg: Steve de Shazer and Insoo Kim Berg, two American social workers, and their team at The Brief Family Therapy Center in Milwaukee, USA, are credited for coining the term SFBT and developing the particular processes required in its application.

There were other key members of this group. Milton Erickson and the group at the Mental Research Institute in Palo Alto – Gregory Bateson, and others – built on their work in the early 1980s.

The solution-focused brief therapy approach grew from the work of American social workers Steve de Shazer, Insoo Kim Berg, and their team at the Milwaukee Brief Family Therapy Center (BFTC) in Milwaukee, Wisconsin.

Steve de Shazer and Berg, primary developers of the approach, co-authored an update of SFBT in 2007, shortly before their respective deaths. SFBT evolved from the Brief Therapy that was practiced at MRI (Mental Research Institute (MRI) in Palo Alto, CA).

1970s

In the 1970s, Steve de Shazer, Insoo Kim Berg, and colleagues practised Brief Family Therapy at a community agency and used one-way mirrors to observe sessions with clients in order to determine which activities were most beneficial to them. When the administration banned one-way mirrors, Steve de Shazer and Insoo Kim Berg formed the Brief Family Therapy Center in Milwaukee, Wisconsin, to continue their work. As a result, SFBT was eventually developed.

In 1982

The creators of SFBT, Insoo Kim Berg and Steve de Shazer, and their colleagues converted their Brief Therapy practise to become Solution-Focused in 1982, which was a watershed moment. A family came to Milwaukee Brief Family Therapy for treatment. The family submitted a list of 27 issues during the exam. The staff was stumped as to what the family should try to do differently. They advised the family to return with a list of things they wanted to happen in the future. **Because of the amazing efficiency of this spontaneous intervention, it was realised that the solution is not always related to the problem. Solution-Focused Brief Therapy was born out of this.**

1980s

Beginning in the late 1980s, the SFBT practise gained popularity and enjoyed enormous growth in the first 15-20 years. In the late 1990s and early 2000s, SFBT became extremely popular in the United Kingdom. It also became a leading brief therapy at the time, with many agencies embracing SFBT as their sole treatment option. It is now one of the most

widely used psychotherapy techniques in the world.

Solution-Focused pastoral Counseling: The field of Christian pastoral counseling has also seen solution-focused brief therapy make inroads into its practices where it is referred to as solution-focused pastoral counseling or brief pastoral counseling.

Research Orientation:

If we look in to the history of solution focused therapy, there some scientifically proven studies which we can take as supportive studies for, Solution Focused Brief Therapy.

Critics claimed that the SFBT paradigm was understudied in its early stages. A review of SFBT research in the year 2000 found only preliminary evidence of its effectiveness. By 2010, however, SFBT research had developed to the point where the data was promising, and many meta-analyses now show that SFBT is effective in treating internalizing issues. SFBT has a broad, thorough, and growing evidence base and is advised for use when it is regarded a good fit for the client and their situation.

SFBT has been studied in two meta-analyses and is backed by a number of federal and state agencies and institutions, including SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP).

There have been 77 empirical research evidences on the effectiveness of SFBT. Two systematic reviews (Kim, 2008; Stams, et al, 2006) and two meta-analyses (Kim, 2008; Stams, et al, 2006) have been published. There are over 2800 examples in total with efficacy data. The studies were all carried out in "real-world" conditions ("effectiveness" vs. "efficacy" research), allowing the conclusions to be more generalized. SFBT is effective for people of all social classes.

Comparatively most desirable therapy:

1. The SFBT is most preferred therapy based its comparative value.
2. As in meta-analyses of other evidence-based treatments such as cognitive behaviour therapy and interpersonal psychotherapy, effective session sizes are modest to moderate.
3. The total efficacy rate after three to five sessions was roughly 60%.
4. The two meta-analyses and systematic reviews, as well as the most recent scholarly work on SFBT, all agree that it is an effective approach to treating psychological problems, with effect sizes comparable to other evidence-based approaches like CBT and IPT, but with fewer average sessions and a more benign approach style.
5. SFBT's more collegial and collaborative approach, unlike most other forms of psychotherapy, does not necessitate conflict or interpretation, nor does it necessitate conflict or interpretation.

6. SFBT is a good first-choice evidence-based psychotherapy treatment for most psychological, behavioural, and relational disorders because of its comparable effectiveness, shorter length, and more benign approach.

Facts and Definition of Solution Focused Therapy:

1. It is a competency-based paradigm that places **less attention** on past failures and difficulties and instead **emphasises clients'** skills, abilities, and resources, resulting in a hopeful and optimistic counselling environment.
2. It focuses on working from the client's understanding of their issue or condition, as well as what the client would wish to change, and it places responsibility for change in the hands of clients by use empowering language and acknowledging them as self-care experts.
3. As a result, it is more considerate of clients as individuals and takes a more balanced approach to problem-solving.
4. SFT is built on the foundation of core counselling abilities such as attending and listening, authenticity, empathy, positive regard, and reflection.
5. Under the umbrella of short treatment, solution-focused therapy first appeared in the United States in the late 1970s and early 1980s. Steve de Shazer (1940-2005), Insoo Kim Berg (1934-2007), and their colleagues in Milwaukee, Wisconsin, pioneered it.
6. The entire solution-focused approach was inductively created in an inner-city outpatient mental health treatment context where clients were accepted without prior screening.
7. Over the course of several years, the architects of SFT spent hundreds of hours observing therapy sessions, meticulously documenting the therapists' questions, behaviours, and emotions, as well as how the therapists' varied activities affected the clients and the therapeutic outcome of the sessions.
8. Questions and actions from clients' progress reports were saved and included into the SFT method.

SFT- Theoretical perspective to Practice –

1. Social constructionism and Wittgenstein's philosophy of language provide the theoretical foundation for SFT. According to social constructionism, an individual's perception of reality is formed through social interaction and language use, including perceptions about the nature of his or her problems, competencies, and potential solutions.
2. According to SFT, problems arise as a result of interactions between people, not as a result of any one person. Interaction and communication with others, a sort of bargaining carried out within the context of language, help people define and

build their sense of what is real.

3. By modifying their interaction behaviours or behaviour interpretations, SFT supports clients in accomplishing something uncommon. This strategy makes no assumptions about the "true" nature of problems.
4. SFT believes that everyone's future is negotiated and built, and it emphasises the present and future. All therapists' professions and client relationships require the use of language. Language's relevance in SFT cannot be emphasised.
5. Gail Miller and Steve de Shazer published a paper in 1998 about how the meanings of words are closely related to how people use them in certain social situations.
6. Problem-focused language emphasises what is wrong with people's lives, and frequently portrays the causes of the problems as tremendous forces beyond one's control or comprehension.
7. Solution-focused language, on the other hand, focuses on finding solutions to issues. "Since we talk ourselves into issues and solutions anyway, why not emphasise solutions?" say solution-focused therapists.
8. This is not to minimise or ignore the hardships and injustices that clients face, but to assist them in overcoming them. This concept is founded on the postmodern assumption that problems and solutions are created via the use of words, and that meaning is malleable.

How the Therapy is given in SFT – The Process

Identification of Problem:

1. Assessment is usually the first step in any therapy, but SFT is different. Therapists that use this method to therapy do not assess how problems develop, nor do they assess the patterns of behaviour that may be perpetuating those problems.
2. Instead, therapists are focused on discovering patterns of behaviour that existed prior to the onset of the problem. Because solution-focused therapists are interested in hearing how their clients create their problems, they are interested in listening to their clients' conceptions of their problems.
3. A deep history intake is not deemed necessary when done first-hand and without any prejudices.

Focus or Goal Setting :

1. With clarity of mind about what is being done therapist helps in , Setting clear, tangible, and achievable goals is critical in solution oriented treatment.

2. Through a Solution Focused dialogue about what clients want different in the future, goals are developed and enhanced. As a result, clients set the goals in SFT Solution Focused Therapy.

3. Goals should be small so that multiple little goals can be accomplished rapidly. Once a basic formulation is in place, therapy focuses on goal exceptions, scaling how close clients are to their objectives or a solution on a frequent basis, and co-constructing beneficial next steps to their chosen futures

Handy SFT Worksheets will be available in the therapy

1. Miracle worksheet
2. Exceptions to the Problem Worksheet
3. Scaling Questions Worksheet
4. SMART – Goal worksheet
5. Experience based worksheet

Therapeutic Relationship:

1. Rapport between therapist and the client is very important. Relationship that is therapeutic both the therapist and the client engage in a tight and collaborative collaboration in solution focused therapy, in which the therapist shows respect for a knowledgeable and resourceful problem solver.
2. Clients do more talking, and what they talk about is regarded the cornerstone of their complaint settlement.
3. To assist the client in reaching a solution, the therapist employs more indirect tactics such as lengthy inquiry concerning previous solutions and exceptions.
4. Through solution-focused asking and reacting, the therapist adopts a "not knowing" and "leading from one step behind" attitude, with the client as the expert. The therapist must take a more constructive and egalitarian posture than the traditional "expert" position.

Different Levels of Therapeutic Relationship:

The Therapeutic Relationship Levels are important as they decide the success rate of therapy. The process of change is conceptualised in Solution Focused Therapy by categorising several forms of client-counsellor relationships. There are two major advantages to determining the sort of client-counsellor connection.

1. For starters, it serves as a reminder to the counsellor that the success of treatment is contingent on collaboration with the client.
2. Second, it aids in determining which therapeutic strategy is most likely to encourage client participation in the change process.
3. The **visitor, the complainant, and the customer** are the three sorts of clients proposed by Solution Focused Therapy.

1) **Visitors** are the clients who has been sent or referred by others. These types of clients do not come forward in search of help and is not suffering emotionally. The therapists usually asks what the client thinks the person referring would like to see changed in his behaviour and to what extent he is prepared to cooperate. So, here by asking this, the therapist is helping the client to think clearly about his problem as well as what is his purpose of visiting Therapist.

2) **Complainants:** The person who is suffering feels need for therapy. These kinds of clients do have a problem and suffers emotionally, but does not (yet) see oneself as part of the problem and/or the solution. They believe that other person or the world needs to change, rather than oneself. The therapist acknowledges the client's suffering and gives suggestions for observing the moments when the problem is not present or exists to a lesser extent, or the moments when part of the miracle is already taking place. These clients are not (yet) ready to carry out a behaviour assignment, in which he or she should do something differently, but may undertake an observation assignment, which does not yet involve a change in behaviour. This can be interpreted as a paradoxical intervention

3) **Customers:** The client who thinks that he is taking some experts help to get away or solve his problem, approaches the therapist. These are ideal clients who see themselves as part of the problem and/or solution and are motivated to change their behaviour. This client may be given a corresponding behaviour assignment ('continue with what works,' 'do something different,' 'act as if the miracle has happened') etc.

SFBT Practice

"solution talk": FBT practitioners employ conversational skills to elicit a discussion about solutions, which is known as "solution talk" and differs from "problem talk." The questions themselves constitute the intervention in SFBT. The **questions direct the client to a discourse that promotes and encourages a change-oriented mindset while reducing negative feelings**. SFBT questions encourage clients to think about their problems in a solution-oriented manner. They give fresh significance to their experiences, finding change potential where it was previously unnoticed.

General introduction

The development process of the therapy:
Berg, de Shazer, and their colleagues spent thousands of hours meticulously analysing live and recorded therapy sessions in order to create the solution-focused method inductively rather than deductively. Any therapist behaviours or statements that consistently resulted in good therapy improvement in the clients were meticulously recorded and included into

the SFBT approach. Most traditional psychotherapy approaches, dating back to Freud, felt that a thorough examination of the history and causes of their clients' issues was required before attempting to establish any form of remedy. Solution-focused therapists have a unique perspective on the therapeutic change process. Based on Steve de Shazer's views, we recognize that while "issue causes may be highly complicated, their remedies do not always have to be."

Traditional therapy (Problem based) vs Solution focused behavior Therapy:

If we take how the traditional and problem focused therapists deal with the problem, the traditional psychotherapy looks at how problems happen, manifest, and resolve. When we look at problem-solving approach is influenced by the medical model, where the symptoms are assessed to diagnose and treat the malady. Other than SFBT, it is the almost universal belief is that the clinician must define and understand the problem to help. To do this, the therapist must develop some information about the nature of problems that they will help resolve and ask questions about the client's symptoms.

The more common problem-solving approach includes a description of the problem, an assessment of the problem, and plan and executes interventions to resolve or mitigate the impact of the problem. This is followed by an evaluation determining the success of the intervention and follow-up if necessary. SFT is a significant divergence from any problem-focused approach to psychotherapy that involves "working through" or intense focus on a problem in order to address it, or that predominantly focuses on the past rather than the present or future. These therapies place a strong emphasis on analysing troubling feelings, thoughts, behaviours, and/or interactions, as well as providing interpretations, confrontation, and client education.

SFT, on the other hand, focuses on clients' strengths and previous triumphs rather than past failures and challenges. It assists clients in developing a desired vision of the future in which the problem is solved and the client's exceptions, strengths, and resources are explored and enhanced in order to co-create a client-specific pathway to realising the vision of the future. As a result, each client develops his or her own solution based on his or her own goals, tactics, skills, and resources.

Even when the client decides to employ outside resources to solve a problem, Therapeutic Interventions with Children it is the client who defines the nature of those resources and how they will be useful. Problem-focused therapy can last anywhere from a few weeks to several months or even years, with up to fifty or more sessions. In SFT, on the other hand, an average of six chats appears to be adequate. Solution Focused Behavior Therapy (SFBT) might be best defined by what it does not do because SFBT presents an innovative and

radically different approach from traditional psychotherapy. SFBT posits and follows that a therapist can help clients resolve their problems without identifying the details or source problem and completely avoids exploring the details and context of the problem.

SFBT believes that an assessment of the problem is entirely unnecessary. Focusing on the problem actually may serve to shift the client away from the solution. This is because SFBT fundamentally believes that the nature of the solution can be completely different from the problemSFBT is strengths-based and supports clients' self-determination. Using the client's language, SFBT uses the client's perspective and fosters cooperation. The focus on the strengths and resources of clients is a factor in why some social workers choose SFBT. Instead, SFBT focuses on developing solutions with clients by imagining a preferred future. The goal of SFBT is to uncover alternatives to the problem rather than to identify and solve it.

Fast, Less number of sessions, Monetary savings with efficiency: SFBT is designed to help people change their lives in the fastest way with effectively possible. By finding and amplifying exceptions, change is efficient and effective. Treatment usually lasts less than six sessions, and it can work in about two sessions. Its brevity and its flexibility have made SFBT the choice of intervention for many health care settings. Interventions in a medical setting many times need to be brief. Agencies also choose SFBT because its efficiency translates into monetary savings.

Assumptions of solution focused therapy

The following main assumptions underpin SFT and give key principles that guide the counseling model's practice and strategies.

- Clients have strengths, resources, and coping abilities that help them to change while maintaining optimism and hope.
- It is rarely essential to have a lot of information about a problem in order to solve it to change.
- Clients' solutions aren't always clearly relevant to the issue at hand.Either the client or the therapist can initiate this process.
- 9) Exceptions (situations in which an issue could have occurred but did not) Because exceptions are a part of life, they are frequently undervalued in relation to the stated problem. Solution-building talks delve into these aspects of solution behavior, a great deal of information.
- Rather than focusing on past issues or current conflicts, the therapy focus should be on the client's desired future.
- Patients are the foremost authorities in their own life. The role of the therapist is to

encourage and amplify the client's efforts and this knowledge.

- Change is unavoidable, persistent, and contagious. Conversations that lead to solutions. Change behaviour should be identified, elaborated on, and reinforced.
- Even little increments of change add up to enormous increments.
- Presuppositional language emphasises the likelihood of change that occur, instilling a sense of "when," rather than "if."

Problem-free talk

Judgment Free: Solution-focused therapists strive to establish a judgment-free environment for their clients, where they can discuss what is going well and what areas of their lives are free of problems.

Relaxed way of gathering information: Problem-free talking can be beneficial for revealing hidden resources, assisting the individual in relaxing, or assisting the person in becoming more naturally pro-active, for example. Solution-focused therapists may discuss seemingly unrelated life events such as leisure activities, social gatherings, relaxation, and conflict resolution.

Knowing client's inner mental activities: Client values, beliefs, and strengths are frequently revealed in this way. The therapist can use these strengths and resources to move the therapy forward as a result of this talk.

Transferring client's behaviors from one incident to the other For example, if a client wants to be more forceful, it's possible that they are assertive in some settings. This strength can then be transferred-generalized to another area where new behavior is sought. A client may be having difficulties with their abusive child and the therapist with the knowledge of client's life incidents of his patience shown towards his office assistant can be transferred in to this situation. So knowledge of client's previous behavioral incidents and mental conditions can be used in the present problem behaviors of his hostility towards his child. By transferring his behavior with his office assistant how compassion, patience, and consistency were crucial to the good conduct.

Clients values, beliefs and strengths: This method is widely used to expose a client's values, beliefs, and strengths. As a result of this conversation, the therapist can use these abilities and resources to drive the therapy ahead. For example, if a client wishes to be more aggressive, they might act assertive in particular situations. This ability can then be generalized or transferred to another area in which novel behavior is desired.

Applications of SFBT

SFBT is very adaptable to many settings because it helps the clients create custom-made interventions for themselves, and the client is always considered to be the expert.

Language Usage: Even the practitioner's language is taken from the words the client uses to

describe their life and preferred future. The result is that SFBT provides interventions that are perfectly matched with the clients' way of understanding and acting.

Techniques such as the **miracle question** can be adapted to make them more culturally relevant and come across in ways more empathetic and supportive based on the culture and needs of the population being served. It is no surprise that SFBT can be and has been used in a wide variety of settings, populations, and problems.

Schools and Education: SFBT has been applied to many settings, including education and business settings. It works in schools as well as with college students.

Children and Families: SFBT is effective with children and families and can be used in a variety of family scenarios. Adolescents, pregnant and postpartum women, couples, and parents benefit from it. SFBT has been proven to be successful for families in the child welfare system,, in social welfare case management,, financial counseling,, and therapy groups.

Jail prisoners, Addicts, Inpatients with mental illness: It has been utilised successfully with people in jails, inpatient drug recovery programmes, inpatient psychiatric hospitals, and a variety of other medical settings.

Families of chronic health problems: It has proven to be beneficial in the treatment of family members of patients with life-threatening illnesses.

Other Country people and with different culture people: SFBT works with people from a variety of countries and cultures, including Turkey, Chile, Iran and China. It was found to be beneficial with Latinos in a systematic review.

Other Traumatic Conditions and Disorders: SFBT helps persons who have been through a traumatic situation. It has been proposed that it be used with suicidal or crisis patients, families dealing with suicide, and individuals suffering from eating disorders, substance use disorders, and obesity. It was also indicated as a promising remedy for those who had suffered a brain injury and that it was beneficial to people with intellectual disabilities. It's even been proven to work with a patient who was in the midst of a psychotic episode.

Young People: It has been demonstrated to help teenagers and youngsters improve their self-esteem, hope, and good behavior.

Professional: In a qualitative research, child protective services workers said that SFBT

training and supervision helped them work in a more cooperative and strengths-based manner, and that it enhanced the general tone and ambiance of their encounters.

Because SFBT alone cannot be used for child protective services and a more authoritative approach is required, there are models for child protection services that incorporate features of SFBT.

Coaching

Example solution-focused coaching prompts include:

What are grounds for optimism?

0–10, what would be different at +1 on your scale?

What would others notice at +1?

When does your perfect future happen, even a little bit?

How did you make that happen?

Where in your life have you overcome similar problems?

Who believes you could do this?

What other resources do you have that can help?

Suppose the problem went away overnight: How would you know?

What would you notice was different?

Describe concrete observable behaviors – from different points of view: boss, colleagues, friends, computer?

What else? What else? What else?

What would you like to happen?

How will you know you've achieved it?

What was the best you ever did (at this thing)?

What will be the first signs that you're getting better?

What would your family, your partner, your friends and strangers notice is different about you?

What will be different since your last catch up with me?

Counseling

A solution-focused short therapy model is solution-focused counseling: Solution-focused counseling refers to a number of related but distinct paradigms. In the 1990s, for example, Jeffrey Guterman created a solution-focused counseling method. This model combines solution-focused concepts and tactics with postmodern theories and a strategic eclecticism approach. In his book, Mastering the Art of Solution-Focused Counseling, Guterman explores the idea and practice of solution-focused counseling. Guterman's counseling model was evaluated in the Journal of Marital and Family Therapy, which stated that he "clearly displays and emphasizes the adaptability of this model as well as its value for the client and therapist."

Consulting

Solution-focused consulting is a method of managing organizational change based on the concepts and practices of solution-focused treatment. While counseling is for individuals and families, solution-focused consulting is being used by organizations of all sizes, from small teams to huge business units, as a change process.

Hypnotherapy

The hypnotherapy of Milton H Erickson, the hypnotherapist who influenced Steve de Shazer and Insoo Kim Berg, has elements that are similar to solution-focused short treatment.

Solution-focused hypnotherapy (SFH) incorporates the best of solution-focused brief therapy (SFBT), cognitive behavioral therapy (CBT), neuron-linguistic programming (NLP), and direct hypnosis into practical, current tactics.

Techniques of Solution Focused Therapy:

The abbreviation MECSTAT, which stands for Miracle questions, Exception questions, coping questions, Scaling questions, Time-out, Accolades, and Task, is one way of defining the practise of SFBT.

Solution-focused therapy is a type of counselling that focuses on a client's ability to solve problems rather than the problem's source or origin. After Steve de Shazer and Insoo Kim Berg and their colleagues studied therapists in a mental health institution in Wisconsin, they developed it over time. Practitioners of Solution Focused Therapy (SFT), like positive

psychologists, use goal-oriented inquiry to assist clients in moving toward a more positive future.

Solution-focused therapy has been successfully applied to a wide spectrum of client challenges due to its versatility. It's also been employed with a diverse variety of clients. In order for this method to function, clients must have some notion of what will improve their lives.

The following areas have utilized SFT with varying success:

- depression
- relationship difficulties
- drug and alcohol abuse
- eating disorders
- anger management
- communication difficulties
- crisis intervention

Incarceration recidivism reduction

Regardless of the issue that a client brings to therapy, Solution Focused Therapy follows the same process. It uses **numerous questions** to guide the discourse toward establishing and fulfilling the client's vision of solutions, as questions are the foundation of solution-focused therapy. The signature questions in solution-focused interviews are designed to initiate a therapeutic process in which practitioners listen for and absorb clients' words and meanings (relating to what is important to clients, what they want, and related successes), then formulate and ask the next question by connecting to clients' key words and phrases. Therapists continue to listen and absorb as clients respond from their own frames of reference, and the therapist formulates and asks the next question by connecting to the client's comments in the same way.

Practitioners and clients collaborate to co-create new and altered meanings that lead to solutions through this ongoing process of listening, absorbing, connecting, and client response.

SFBT Questions

Miracle Vision

"I'm going to ask you an odd question [pause]," says the therapist. This is the unusual question: [pause] After our conversation, you will return to your work (home, school) and complete whatever tasks you need to complete for the remainder of the day, such as caring

for the children, cooking dinner, watching TV, bathing the children, and so on. It will soon be time to retire to your bed. Everyone in your home is calm, and you are able to sleep soundly. A miracle occurs in the middle of the night, and the problem that caused you to contact me today is resolved!

However, because this occurs while you are sleeping, you have no way of knowing that the problem was healed by an overnight miracle. [pause] So, what minor change might you notice when you wake up tomorrow morning that will make you think, "Wow, something must have happened—the problem is gone!"?

While the miracle question is simple to pose, it takes tremendous expertise to ask successfully. To ensure that the pace fits the person's ability to follow the inquiry, the question must be asked slowly while paying particular attention to nonverbal communication. The phrase "I don't know" is frequently used as an initial answer. To pose the question properly, polite silence should be followed by a period of time for the person to thoroughly absorb the inquiry.

After thoroughly exploring the miracle day, the worker can use scales to answer questions such as: Where are you now? on a scale of 0 to 10, with 0 being the worst things that have ever happened and 10 representing the miraculous day. What would it take for you to realise you didn't need to see me any longer? What will be the first signs that you have improved by one point? In this regard, the miracle question is more of a sequence of questions than a single query.

Depending on the situation and the client, there are many distinct versions of the miraculous inquiry. The counsellor may inquire in a specific circumstance.

"What would you view differently if you woke up tomorrow and a miracle had occurred, allowing you to no longer lose your temper so easily?" "What would be the first indications that a miracle had occurred?"

In this case, the client (a child) might answer by stating.

"I wouldn't be offended if someone called me a name."

To ensure success, the counsellor encourages the client to set positive goals, or what they will do rather than what they will not do. "What would you do instead when someone calls you names?" the counsellor might ask the client.

Problem-Free Talk

Unrelated to the problem: Though most of the solution focused sessions comprises of problem free talk, the therapist usually at the beginning of a session engages the client in a discussion, completely unrelated to the problem. Solution focused therapists talk about seemingly irrelevant life experiences of the client such as leisure activities, meeting with friends, relaxing

and managing conflict. The therapist also gathers information on the client's values and beliefs and their strengths.

Transfer of Strength: Dan Jones, in his Becoming a Brief Therapist book writes: '...it is in the problem free areas you find most of the resources to help the client. Problem free talk conveys the message that there is more to a person than the problems and also reveals potentially transferable strategies, beliefs, values and skills. For example; if a client wants to be more assertive it may be that under certain life situations he/she may be assertive. This strength from one part of their life can then be transferred to the area with the current problem.

Ideas to use for treatment: It also relaxes them and helps build rapport, and it can give ideas to use for treatment...Everybody has natural resources that can be utilised. These might be events...or talk about friends or family...The idea behind accessing resources is that it gives you something to work with that you can use to help the client to achieve their goal...Even negative beliefs and opinions can be utilised as resources'

Pre-Session Change

Constructive Thought: There is a core solution-focused belief that clients are engaged in constructive action when they seek help. Some of these actions are helpful and others prevent the situation from getting worse. Therefore at the beginning or early in the first therapy session, solution focused therapist typically asks, "What changes have you noticed that have happened or started to happen since you called to make the appointment for this session?" This question might have three possible answers.

Good Idea: First, Solution Focused Therapy the client may say that nothing has happened. In this case, the therapist may simply begin the session by asking something like: "How can I be helpful to you today," or "What would need to happen today to make this a really useful session?" or "What needs to be different in your life after this session for you to be able to say that it was a good idea you came in and talked with me?"

Questioning of possibilities: The second possible response may be that things have started to change or get better. In this case, the therapist asks many questions about the changes that have started, requesting a lot of detail. This starts the process of "solution-talk," emphasising the client's strengths and resiliencies from the beginning, and allows the therapist to ask, "So, if these changes were to continue in this direction, would this be what you would like?" thus offering the beginning of a concrete and positive goal.

Question of solutions: The third possible answer may be that things are about the same. The therapist might be able to ask something like, “Is this unusual, that things have not gotten worse?” or “How have you managed to keep things from getting worse?” These questions may lead to information about previous solutions and exceptions, and may lead the client into a solution-talk mode.

Client as agent of Change: Overall by acknowledging pre-session change, the therapist underlines that the client and not the therapist, is the agent for change.

Presupposing change questions : A practitioner of solution-focused therapy asks questions in an approach derived way. Here are a few examples of presupposing change questions. “What stopped complete disaster from occurring?”, “How did you avoid falling apart.”, “What kept you from unravelling?”

Exception Questions

Exception-seeking questions: SFBT supporters argue that there are always occasions when the identified problem is less severe or not present for customers. The counsellor wants to help the client to recognise these instances and make them as frequent as possible. What happened this time that was unique? What did you do differently this time? The goal is for customers to build confidence in taking more and more "small steps" toward their dream scenes by repeating what has worked in the past. Milton Erickson impacted this notion and practice.

Exception questions include the following:

1. Tell me about times when you haven't been furious.

2. Tell me about your happiest moments.

3. Can you recall the last time you felt you had a better day?

4. Has there ever been a point in your relationship when you felt happy?

5. What did you notice about that day that made it better?

6. Can you recall a period when the issue did not exist in your life?

The positive concept of thinking in this therapy is if the client feels or felt happy, when he felt? What happened that time?There are always exceptions waiting to be found. If the clients experienced difficulties 40 percent of the time it means remaining 60 per cent was problem free. What happened during those times? What they did that was helpful? How did they do it? Could they do it again?

Self Assessment Questions

1) Are there times now that a little piece of the miracle happens?

2) Tell me about these times. How do you get that to happen?

Therapeutic Interventions with Children

3) What will you do to make that happen again?

4) What will your husband (for example) say you need to do to increase

the likelihood of that (exception) happening more often?

5) What is different about the times when the problem does not happen, or

when it is less severe or less frequent?

Present- and Future-Focused Questions Vs. Past-Oriented

Focus

The questions that are asked by SF therapists are almost always focused on the present or on the future, and the focus is almost exclusively on what the client wants to have happen in their life. This reflects the basic belief that problems are best solved by focusing on what is already working and how clients would like their lives to be, rather than focusing on the past and the origin of problems.

Questioning and back ground ideas of the therapist (insight of SFT)

Questions and compliments.: The solution-focused approach's core tools are **questions and compliments.** SF therapists and counsellors avoid forming interpretations on purpose, and they rarely **confront their clients**. Instead, **they concentrate on defining the client's objectives and creating a thorough description of what life will be like once the objective has been met and the problem has been resolved satisfactorily.**

"exceptions,": To create effective solutions, they comb through the client's life experiences for "exceptions," such as occasions when **some component of the client's aim was already occurring to some degree**, and use these to co-create uniquely relevant and effective solutions.

In SFT, compliments are commonly utilised to assist the client focus on what is working rather than what isn't. Recognizing that a client has an impact on progress toward a goal enables for hope to emerge. Once a client's hope and perspective have shifted, they can

pick what daily steps they want to take to achieve their goal.

Higher levels of hope and optimism can predict the following desired outcomes:

1. **SFBT is future-oriented and goal-oriented.** Interviewing technique that helps clients "build solutions." Elliot Connie defines solution building as **"a collaborative language process between the client(s) and the therapist that develops a detailed description of the client(s)' preferred future/goals and identifies exceptions and past successes".** By doing so, SFBT focuses on clients' strengths and resilience.
2. achievement in all sorts of areas
3. freedom from anxiety and depression
4. improved social relationships
5. improved physical well being

Desired future:

SFBT therapists help clients discover times in their lives when events were more closely aligned with their ideal future.

The parallels and contrasts between the two occurrences are contrasted and examined. When the problem isn't there or isn't as severe, therapists can assist clients in achieving their goals and achieving their desired outcomes by highlighting small successes and encouraging them to repeat good choices and behaviours. SFBT inquiries are used to get a client to talk about their desired future.

They must describe how the problem will alter once it has been addressed or controlled.

Ideal Future

. "What would you observe that signals the problem that brought you to see me has been resolved?" for example. According to SFBT, change occurs when people focus on and flesh out the characteristics of their ideal future. SFBT practitioners employ the "miracle question" as a tool to assist clients define their ideal future. In this inquiry, the client is asked to imagine that the problem was miraculously solved without their knowledge. "What are some of the first signs that your problem has been solved?" it continues.

Furthermore, the therapist will inquire about previous solutions or "exceptions" to the problem. In SFBT, "exceptions" are times when the problem is smaller or dealt with more successfully, and SFBT claims that they occur in every case. Finding exceptions helps with solution creation by assisting in the finding of what is working in the client's life. They look at what is already working and guide the client to do more of it by identifying and emphasizing minor exceptions to the problem.

When looking for exceptions, the practitioner does not try to persuade the client that they are significant. That would be in direct opposition to the SFBT ideology, which regards the

client as the expert in their own life. Instead, the therapist assumes a genuine, inquiring demeanor and asks the client to explain their understanding of the exception's importance. The therapist must maintain an unknowing condition, which can be challenging for inexperienced SFBT practitioners.

SFBT practitioners employ one strategy to assist find exceptions: starting sessions (other than the first) with the question "What's been better since we last talked?" This inquiry directs the client's attention to areas where things are going well, or exceptions.

Another approach employed by practitioners is "scaling inquiries." The effectiveness of the cues is measured using a scale. Then they're asked what they've discovered that makes them rank oneself so high instead of lower. They're also asked for information regarding when things aren't as bad. Then there's the "how do you do it?" or "how did you do it?" query. Because exceptions might take the shape of coping, an SFBT practitioner can search for them by asking "coping questions." "It sounds like you've got a lot on your plate... how are you handling it?" for example. When a customer discovers a behaviour that benefits them, they are urged to maintain it. Time is running out for them to achieve their aim.

The SFBT session is fairly structured. There are certain interviewing strategies as well as a specific way to conduct a session.

On the other side, practitioners argue that adhering to the idea is more important than adhering to the procedures. An SFBT practitioner needs bring multiple assumptions into the session to truly engage in actual SFBT practice.

One of the most fundamental SFBT assumptions is that clients are experts in their own lives and know what is best for them and how to attain their objectives. This is the fundamental premise that underpins SFBT.

The therapist's knowledge is restricted to the questions that will elicit the process of change. Clients are assumed to have all they need to design a solution in SFBT, and the therapist does not need to teach them skills or tell them what to do. In actual SFBT practice, resistance is rare or non-existent. A state of curiosity and not knowing is essential for SFBT.

Although SFBT appears to be quite basic and straightforward to apply, mastering it is rather challenging.

Because SFBT requires an organized approach, many practitioners opt to use SFBT components rather than practicing pure SFBT. Because transitioning from a problem-focused to a solution-focused perspective can be difficult for a practitioner, this is routinely done. Many new SFBT trainees, on the other hand, struggle with being overly cheerful and failing to truly validate their clients' pain. This could be because the concentration necessary to use their newly gained SFBT skills and processes takes them away from being 'with' the

client. Authentic SFBT requires the therapist to pay close attention to the client's verbal and nonverbal communication, as well as the therapist to change the questions to meet and better understand the client's perspective.

Compliments

Another important component of solution-focused short treatment is compliments. It validates any progress that clients make; it encourages clients by reminding them of their personal power over their well-being; it emphasises strengths and abilities; it sets the expectation that past success is an excellent indicator of future possibilities; it fosters confidence; and it facilitates relationship building and maintains rapport.

SF therapists usually start the therapeutic process by collaborating with the client's skills. SF therapists/counselors ask the client to picture their ideal future by describing what their life will be like when the problem is either gone or dealt with successfully to the point that it no longer constitutes a problem as early in the session as respectfully possible. The therapist and the client then pay close attention to any behaviours on the client's part that contribute to progress toward the client's objective, whether little steps or greater changes.

To support this approach, detailed questions are asked about how the client achieved or maintained current levels of progress, any recent positive changes, and how the client developed new and existing strengths, resources, and positive traits; and, in particular, any exceptions to client-perceived problems.

Personal transformation, according to solution-focused therapists, is already constant. SFBT therapists assist clients in constructing a concrete vision of a preferred future for themselves by assisting them in identifying positive paths for change in their lives and attending to changes now in motion that they wish to continue.

Compliments are frequently given in solution oriented therapy in the form of appreciatively toned questions such "How did you do that?" that enable the client to self-compliment by answering the inquiry.

Compliments Solution-Focused Therapy (SFT) is a type of therapy

1) How did you accomplish this?

2) How did you know that trying it was a good idea?

3) What made you think it was a good time to do it?

4) Where did you begin?

5) How did you keep going like that?

Miracle Questions

It's a useful tool for guiding clients toward a solution-oriented mindset. This inquiry allows clients to take tiny efforts toward solving the challenges they're facing. It's asked in a certain way, as detailed later in this article.

Here's an illustration of how to ask the miraculous inquiry. It should be delivered with intention. When this is done, the client is able to visualise the miracle taking place.

"Now, I'd like to ask you a peculiar question." Assume that a miracle occurs while you are sleeping tonight and the entire home is silent. The miracle is that the issue that led you here has been resolved. However, you are unaware that the miracle has occurred since you are sleeping. So, what will be different when you wake up tomorrow morning that will tell you that a miracle has occurred and the situation that led you here has been resolved?"

The basic premise underlying SFBT is that the procedures are positive and solution-focused, allowing the client to be in treatment for a short period of time. Overall, boosting each client's quality of life by putting them at the heart of their development and driving it. The average number of sessions in SFBT is 5-8.

Goals are set during the sessions. Specific experimental actions are investigated and implemented in the client's day-to-day activities. A client can better track his or her progress by keeping track of what works and where revisions are needed.

The Miracle Method was created as a result of the Miracle Question. The steps are outlined below (Miller & Berg, 1996). It was created to tackle problem drinking, but it may be applied to any area of change.

1. Express your desire for anything different in your life.

2. Visualize a miracle occurring, and your life will be transformed.

3. Determine how essential the miracle is to you.

4. Make the miracle as modest as possible.

5. Use language that is positive, explicit, and behavioural to define the change.

6. Instead of stating how you will conclude your adventure, state how you will begin it.

7. Make sure you know who, where, and when, but not why.

The miracle question, also known as the "problem is gone" inquiry, is used by a coach, therapist, or counsellor to ask the client to picture and describe in detail how the future would be different when the problem is no longer present.

The following is a classic rendition of the miracle question:

"I'm going to ask you an odd question [pause]," says the narrator. This is the unusual question: [pause] After our conversation, you will return to your work (home, school) and complete whatever tasks you need to complete for the remainder of the day, such as caring for the children, cooking dinner, watching TV, bathing the children, and so on. It will soon be time to retire to your bed. Everyone in your home is calm, and you are able to sleep soundly. A miracle occurs in the middle of the night, and the problem that caused you to contact me today is resolved! However, because this occurs while you are sleeping, you have no way of knowing that the problem was healed by an overnight miracle. [pause] So, when you wake up tomorrow morning, what minor alteration might make you think to yourself, "Wow, something has changed."

In solution-focused therapy, the miraculous question is a key intervention. Posing the miraculous question signifies the start of solution discourse after meeting with therapeutic patients and gaining a brief explanation of presenting problems. It's a method to ask for a customer's goal in a way that expresses respect for the problem's enormity while also encouraging the client to set smaller, more doable goals. Many clients use it as a means to undertake a "virtual rehearsal" of their desired future.

The exact phrasing of the intervention may vary, but the main idea is: "I'm going to ask you a question that's not like any other question you've ever heard." It will necessitate some acting on your part. Assume that after our meeting tonight, you go home, to bed, and fall asleep. A miracle occurs while you are asleep, and the miracle is that the situation that led you here is resolved. However, because you are sleeping, you are unaware that a miracle has occurred.

What will be the first thing you notice when you get up tomorrow morning that will tell you the miracle has occurred?"

The inquiry elicits a variety of responses from clients. They may appear perplexed. They may claim that they "don't know" or that they don't grasp the question. They might even smile.

When given enough time to think about it and enough perseverance from the therapist, they usually start to think of some things that would be different if their problem was remedied. This, as well as all other relevant questions, enable patients to create a vision of the future, which is usually the therapy's goal.

Clients can frequently more easily develop enriched meanings about exceptions and prior solution behaviours that could be valuable in realising their desired futures when they have a thorough description of how they want their lives to be.

Miracle Questions: Variations on a Theme

Consider the possibility that a miracle occurs while you are sleeping tonight. You wake up the next day with the feeling that you're on your way to making a decision.

What will you do differently this time to let you know you're on the right track?

Imagine yourself six months from now, having successfully solved the challenge that brought you here today. What will be different in your life to indicate that the issue has been resolved?

Pretend that the problem has been handled with the help of children. What are the things you're doing differently this time?

What will I observe if I follow you around with a video camera after you've solved this problem, and what will I see that will tell me this?

What will be the first indication that part of the miracle is taking place?

• Who will be the first to recognise that something is going on?

• What will others notice about you that will alert them to the fact that this is taking place?

Scaling Questions

These are questions that allow a customer to give a rating to their whole experience. They also allow a customer to assess their desire to modify their situation. Scaling questions allow a practitioner to include a positive follow-up inquiry as well.

"On a scale of 1-10, with 10 being the best and one representing the worst, where would you say you are today?" is an example of a scaling question.

A follow-up question is as follows:

"What's the difference between a four and a five?"

These types of questions encourage the client to consider the positive aspects of their situation as well as their willingness to make the necessary changes.

In a non-threatening manner, scaling inquiries allow clients to use monitoring and tracking of their own experience. Scaling and measuring are helpful methods for identifying client variances. Subjective assessment and scaling are frequently used to promote objectives and progress toward goals.

SFBT is known for encouraging clients to get very explicit about subjective measuring and scaling, such as by asking questions that encourage clients to construct their own polarity and then assessing their progress—forwards and backwards—towards the more desirable pole. SFBT came up with a new phrase to make this call for additional internal rigour feel natural to clients: What is the "worst problem that has ever existed?"

(either 0 or 1) What do you mean by "the best things that might possibly be?" (ten). On a scale of one to ten, the client is asked to rate their current situation. "What's stopping you from slipping one point further down the scale?" is an example of a question used to extract useful specifics about behaviour to measure by, resources, and support. Clients are then asked to carefully assess their own progress (for example, "on a day when you are one point higher on the scale, what informs you this is a 'one point higher' day?"). Preferred futures can also be explored in light of the client's own scale (for example, "where on the scale would be good enough? What would a day at that point on the scale feel like; what would you do differently?").

Scaling inquiries are a critical next step in SFBT, whether the client provides precise goals directly or via the miraculous question. Scaling questions are important for concretizing and defining hazy client perceptions. They assess the severity of an issue, progress toward a goal, confidence, and dedication to a goal.

Normally the therapist uses a scale of 0 to 10, where 0 means the” worst the problem has ever been” or perhaps how the client felt before contacting the therapist and 10 representing “the best things could ever possibly be”. Asking a patient to “scale” items transforms a description of something important into an accessible and measurable entity. This then becomes a starting point from which future progress is assessed.

The therapist typically uses a scale of 0 to 10, with 0 representing "the worst the situation has ever been" or perhaps how the client felt before approaching the therapist and 10 representing "the greatest things could ever possibly be." When you ask a patient to "scale" items, you're turning a description of something significant into a quantitative entity. This serves as a benchmark against which future progress can be measured.

"How will you know when you reach 2.5?" a therapist might ask if a patient rates a problem on a scale of 1 to 2. In order to answer this question, the patient must determine the next step and begin fixing the problem. "How did you manage to come in today?" if confidence is at one, enables a patient to recognise that action is achievable even with low confidence. If your confidence is at a 3, a question like "What do you need to do to get your confidence to 3.5?" can urge you to think about the tactics you'll need to maintain and enhance your confidence. When clients are having problems thinking in terms of forward progress, a question like, "What do you need to do to keep your progress at 3?" allows both patients and therapists to recognise that treading water can be a feat in and of itself.

Some questions as examples of Scaling Questions

1) On a scale of one to ten, where ten represents a solved problem and one represents the worst situation imaginable, where is the problem today?

2) On a scale of one to ten, with ten being the most confident, how confident are you in this?

Where are you, with an issue that can be addressed and a confidence level of 1?

3) If a score of 10 indicates that you are willing to go to any length to find a solution, and a score of 0 indicates that you are not,

How would you evaluate yourself today if you were prepared to accomplish nothing?

4) What will you need to do to improve from a 3 to a 3.5, for example?

Coping Questions

These kinds of questions reflect a client's toughness. In their own life, clients are experts. They can grow from a strong position if they can recognise what works.

"How have things been going so far?" and "How have you managed to stay afloat?" "How are things going?"

Coping questions are used to learn about a client's resources that they may have overlooked. Even in the worst-case situation, there are instances of how to cope: "I understand how difficult things have been for you, but I'm struck by how you get up every morning and do everything you can to get the kids to school."

"How do you go about achieving that?" says the narrator. Genuine admiration and curiosity may help to attract attention to strengths while not appearing to contradict the client's point of

view. The first summary, which they claim is factual and verifies their storey, adds, "I can see how things have been really horrible for you." "You manage to wake up each morning, etc." is a truism in the second section, yet it works against the problem-centered narrative. They clearly cope, and coping questions begin to challenge the problem-centered narrative in a gentle and helpful way.

Coping Questions aid in the elicitation of information regarding client resources that they employ in times of overwhelming difficulty but are unaware of. Even in the middle of despair, many clients are able to accomplish a number of tasks that demand significant effort. Therapists look for instances of coping strategies, such as:

"I can understand how difficult things have been for you, but I'm struck by the fact that you still manage to get up every morning and do everything necessary to get the kids off to school." "How do you go about doing that?"

The therapist's genuine curiosity and respect helps to emphasise strengths without appearing to contradict the client's perception of reality. "I can tell that things have been incredibly difficult for you," the first summary says, validating the client's feelings about their troubles. The second half, "you manage to get up each morning, etc.," is likewise true, but it goes against the problem-focused narrative and opens up a new perspective on the client's resiliency and determination. Coping questions begin to gently and supportively challenge the problem-focused narrative, laying the groundwork for solutions.

Examples of Coping Questions

1) How did you get yourself out of bed this morning?

2) What steps are you taking to keep things from going worse?

3) That sounds nearly impossible. How do you deal with it?

4) I recognise how difficult this is for you. What route did you take to get there? today's office?

Take a Break and Reconvening

SFT encourages therapists to take a break near the end of a session. Taking a break helps both the clients and the therapist to think on the discussions that had ended the session. The therapist takes use of this time to compose a message to the clients in the form of feedback. In some situations, the therapist will leave the room for a few minutes to do this, but if this is not

possible, the therapist will need to examine his or her notes and create a brief message for the client.

The following is a list of the feedback:

• a brief summary of what the client is already doing that is useful; • praise on how the client participated in the session and the therapist's views about it;

• a declaration that connects the client's behaviour to the stated goal or goals

Homework Assignments: Therapists in SFT commonly conclude sessions by providing a suitable homework task for the client to try between sessions if they so desire. The following generic tasks are usually given as part of a course homework:

• Consider when an exception arises and make a note of the differences; • make more exceptions and pay attention to the repercussions; • look for positive developments.

• act as if you're working on a small part of the miracle picture;

• act as if you already know how to solve the problem and test it out; and

• Finally, consider what you're doing to keep the situation from getting worse. when working with children

So, what is better, even a little bit, since last time we meet? At the start of each session after the first session, the therapist usually asks about progress, about what has been better during the interval. Clients who report that there have been some noticeable improvements, the therapist help the client to describe these changes in as much detail as possible.

Clients who report that things have stayed the same or have gotten worse, on the other hand, have therapists look at how they have kept things from becoming worse; or, if things have gotten worse, what did the client do to keep things from being much worse. Whatever the client did to keep things from getting worse becomes the focal point, a source of praise, and possibly an experiment, because whatever the client did, he or she should keep doing.

Experimenting - Experience – Positive outlook- Solution focused Therapy

Another approach therapists lead clients towards solution orientation is to invite them to try something new. Clients immediately focus on the positive when they are invited to build on what is currently working. This permits the client's mind to broaden and build from that viewpoint, according to positive psychology.

Using what has worked in the past assists the customer to figure out what works and what

doesn't when it comes to tackling the problem at hand. Many SFT therapists take a break in the second half of a client consultation to reflect on what they've learnt in the first half of the session.

During consultation breaks and invites for more information from clients, both the therapist and the client can consider what might have been missed during the early conversations. Following this pause, clients are applauded and given a therapeutic message concerning the current issue. The message is frequently conveyed in a cheerful tone so that clients leave with a positive outlook on their goals.

SFT – Positive Approach – Positive Psychology

Mind mapping is powerful tools that can help people feel more hopeful and optimistic. In life counselling, this intervention is frequently employed. A study of solution-focused life coaching found that this sort of intervention boosts goal-setting and hope, as well as overall happiness.

Though life coaching is not the same as therapy, this study demonstrates the effectiveness of solution-focused inquiry in enhancing positive behaviour.

Mind mapping is a visual thinking tool that aids in the organisation of data. It aids consumers in better analysing, comprehending, and generating new ideas in areas that they could not have come up with on their own. Having it written down gives them a point of reference for future goal-setting.

In the administration of SFBT, empathy is essential. For any forward movement to occur, the client must feel heard and held by the practitioner. It is recommended that the practitioner leans in to ensure that the client understands that the practitioner is actively listening.

SFT interventions include speaking to strengths and linking those strengths with goal-setting. Strengths are validated by recognizing and acknowledging what is already working for the customer. Self-awareness of these assets boosts self-esteem, which facilitates forward progress.

The inquiries answered in Solution-Focused Therapy are aimed positively and with a goal in mind. The goal is to encourage a shift in viewpoint by pointing clients in the direction of hope and optimism, which will take them along a path of good change. Focusing on the changes that must be done in order to achieve goals and improve well-being yields results and progress.

Solution-focused (brief) therapy (SFBT) is a collaborative goal-directed method to psychotherapy change based on direct observation of clients' responses to a sequence of carefully designed questions. SFBT is based on social constructionist thinking and Wittgensteinian philosophy, and it focuses on achieving what clients desire without delving into the problem's history and origins (s). SF therapy sessions are often focused on the present and future, with the past being discussed only to the extent necessary to communicate empathy and a thorough knowledge of the client's difficulties.

Solution-Focused Brief Therapy - Activities & Exercises

1. **Solution-focused art therapy/ letter writing**

   The important and powerful in-session task is to request a client to draw or write about one of the following, as part of **Art Therapy:**
   A picture of their miracle
   Something the client does well
   A day when everything went well. What was different about that day?
   A special person in their life

2. Strengths Finders

The Solution focused Therapy does activities for client to focus up on. Focus a client's attention on a time when they felt their best. Inquire about the strengths they displayed when things were going well. This can be an eye-opening practise that assists clients in focusing on the abilities they currently possess.

A client can ask others who are important in their lives to tell them how they see the client's strengths as a variation of this activity. Collecting strengths from the perspective of another person can be highly enlightening and beneficial in moving a client into a strength mind-set.

1. **Solution Mind Mapping**

Mind mapping is a technique that helps client to work more efficiently with both sides of your brain. But with a mind map, the client has a real overview just like his therapist, which helps him to find the relationships between things easily. A creative way to guide a client into a brainstorm of solutions is by mind mapping. Have the miracle at the center of the mind map. From the center, have a client create branches of solutions to make that miracle happen. By exploring solution options, a client will self-generate and be more connected to the outcome.

2. **Experiment Journals**

The client may see and feel cause and effect while experimenting. Encourage customers to conduct experiments in real-life contexts to solve the problem at hand. Keep track of what

works in terms of approach with the client. Assuage the client's fears by reassuring them that a range of experiments is a ideal effort.

Objective Type Questions:

1. Solution-Focused Therapy is a therapeutic technique that encourages clients to believe in their own skills to solve difficulties in their lives. **True**/False
2. The solution-focused brief therapy approach grew from the work of American social workers Steve de Shazer, Insoo Kim Berg. **True** / False
3. In Solution-Focused Therapy, the questions are addressed positively and with a goal in mind. The goal is to encourage a shift in viewpoint by pointing clients in the direction of hope and optimism, which will take them along a path of good change. **TRUE** / False
4. 1. Miracle Question, 2. Presupposing change questions, 3. Exception Questions, 4. Scaling Questions, 5. Coping Questions are 5 types question types used in SFT method. **TRUE** / False
5. SFBT questions encourage clients to think about their problems in a solution-oriented manner. They give fresh significance to their experiences, finding change potential where it was previously unnoticed. **TRUE** / FALSE

Lesson 14:-Grief counseling – II

The learning objectives:

By the end of this unit, student should be able to:

1. Define loss, bereavement, grieving and mourning.
2. Outline the process of grieving.
3. Explain the role of culture in bereavement.
4. Identify strategies that one can use to help children and youth who have suffered the loss of loved ones.
5. To be able to describe current models of grief.
6. To be able to consider interventions, including counseling, for people experiencing bereavement and loss
7. Grief Counseling and Grief Therapy: What's the Difference?
8. The Benefits of Grief Counseling
9. Grief Counseling for Adults
10. Grief Counseling in the Workplace
11. Grief Counseling for Children and Elementary Students.
12. How to Provide Grief Counseling in Hospice Care
13. Coping with Miscarriage
14. Grief Counseling and Therapy for Pet Loss
15. Group Grief Counseling and Retreats

Introduction - Define loss, bereavement, grieving and mourning.

Grief is the emotional response to loss, specifically the death of a person or living thing with whom one had built a link or affection. Grief comprises physical, cognitive, behavioural, social, cultural, spiritual, and philosophical elements, in addition to the emotional response to loss. While the phrases are commonly used interchangeably, bereavement refers to the state of being bereaved, whereas sorrow is the emotional response to that bereavement.

Grief is the intense pain that comes with a loss. It might feel all-encompassing since it is a mirror of what we love. Grief is not limited to the death of people, but it can be complicated by emotions of guilt and confusion, especially if the connection was strained.

APA Dictionary of Psychology
The anguish experienced after significant loss, usually the death of a beloved person. Grief is

often distinguished from bereavement and mourning. Not all bereavements result in a strong grief response, and not all grief is given public expression (see disenfranchised grief). Grief often includes physiological distress, separation anxiety, confusion, yearning, obsessive dwelling on the past, and apprehension about the future. Intense grief can become life-threatening through disruption of the immune system, self-neglect, and suicidal thoughts. Grief may also take the form of regret for something lost, remorse for something done, or sorrow for a mishap to oneself.

Grief, sometimes known as acute grief, is a short-term event for certain people, yet the anguish may resurface at any time. Others, however, may experience months or years of persistent grieving, often known as difficult grief. Such grief can develop to isolation and chronic loneliness if it is not met with care+ and support.

Is there a distinction between grief and depression?

Many of the symptoms of bereavement and depression are similar. There is depression, as well as a loss of pleasure capacity, insomnia, and a lack of interest in eating or caring for oneself. Symptoms of grief, on the other hand, tend to fade over time, though they may resurface on anniversaries or other occasions when a loss is remembered. While negative sentiments like "life is unjust" and "I'll never get over this" are common during the grieving process, it's critical to keep them from directing the behaviour.

Loss : The term "loss" is frequently used to describe the end of a relationship. a connection that provided affection and stability, such as one with a member of ones family or a close friend There are, however, numerous forms of losses.

Grief – Counseling by Psychologist – APA Dictionary

The provision of counsel, information, and psychological support to those whose capacity to function has been harmed by the death of someone they love or a friend. It involves counselling for the grieving process as well as practical help on funeral and burial arrangements for the loved one. Grief counselling is occasionally provided by specialised services (e.g., hospices), or it may be provided as part of a larger counselling session.

Grief Work – APA Dictionary

Theoretical process through which bereaved persons gradually lessen or modify their emotional attachment to the person who has died, allowing them to refocus on their own lives. Grief work has recently centred around the notion of a continuing relationship, which was first proposed by Sigmund Freud in his 1917 essay "Mourning and Melancholia" as a process in which the successful result is the bereaved's emotional detachment from the departed. That is, instead of severing all emotional ties with the departed, the bereaved symbolically turns the relationship into a continuous bond that offers a feeling of meaning

and value conducive to the formation of new relationships.

Bereaved – APA Dictionary

The state of having experienced the death of a loved one. Individual sorrow and mourning reactions differ. The bereaved person may experience emotional anguish and distress, and may or may not express this distress to others. Bereavement can sometimes indicate a shift in social standing (e.g., from wife to widow). —bereaved adj. —bereaved adj. —bereaved adj

Bereavement has a similar connotation to loss, although it is more usually used to refer to the death of a loved one.

Traumatic grief – APA Dictionary

A severe form of separation sadness that occurs when a loved one dies suddenly and unexpectedly. Although the entire illness encompasses many other painful and dysfunctional responses, numbness and shock are typically accompanied by a sense of futility and the meaninglessness of existence.

Grief is the natural human reaction to loss. When someone we love dies, we experience a deep human sense of sorrow and sadness.

Mourning Accepting our loss, making it a part of our memories, and moving on with our lives are all part of the grief process. We mourn because of the tremendous sadness of losing a loved one to death. When we grieve inside, we express our anguish via sorrow. Mourning is the expressing of grief in public.

Its purpose is to expose the reader to grieving and bereavement work, with the understanding that bereavement can often be a source of mental health problems, and that persons who are experiencing mental health problems will also feel bereavement. Limited interventions performed by health care practitioners (particularly mental health practitioners) are now recognised as having value in improving outcomes for the bereaved.Starting with early ideas based on Freud's writings on melancholia and going on to attachment and more contemporary developments toward the idea of “continuing relationships and' re-membering.'

A section on interventions will look at several ways to deal with grief. Even while this notion is explored in great detail in this chapter, the issue of grieving, particularly in light of recent moves away from pathologizing some elements of grief, marks this as a subject that invites a holistic approach.

Bereavement and grief are not illnesses –

Grief and bereavement are not illnesses; they are part of the human experience.

• Bereavement can be challenging and lead to mental health issues, and bereavement can be even more difficult for persons who already have mental health issues.
• There are various methods to mourning, and more modern models have shifted away from the concept of'moving on' and toward the concept of preserving a link with the deceased.
• The majority of bereaved persons do not require or benefit from counselling.
• Providing support to persons who have been bereaved necessitates basic counselling skills as well as an understanding of the grieving process.

Terminology relate to grief

Bereavement: The loss of a loved one, usually by death.
Grief: A deep feeling of sorrow and sadness that comes from the loss of someone or something that has been important in one's life.
Loss: Being deprived of a person or thing that was important in one's life.
Mourning: An expression of deep sorrow following a death or other significant loss.
Rituals: Actions based on religion or traditional beliefs which help to commemorate and give meaning to a person's death.

What do the terms 'bereavement' and 'grief' mean

Before diving into bereavement in detail, it's important to grasp what grief and bereavement mean. The English word bereavement comes from an ancient **Germanic root word that means 'to deprive of, take away, seize, rob,' while the word grief comes from a Middle English version of the Old French grief, which comes from grever, 'to burden,' which comes from the Latin gravare, 'to cause grief, make heavy.**' Another term that comes up frequently in this context is **mourn, which comes from the Old English murnan, which means "to sorrow, bemoan, yearn after."**

The modern definition of bereavement is the loss of a loved one, usually a human or an animal, generally through death. Grief is a common reaction to loss, which includes feelings of sorrow, burden, and heaviness, and mourning the loss is linked to feelings of longing for the person. We've all suffered loss of some kind, but how we react to it is in part determined by our attachment to the thing that has been taken away. Most of our strongest bonds are with other people, particularly family and close friends.
Often, our first reaction to a loss is panic, with us believing that it cannot be true, that something must be wrong. This is sometimes followed by looking for the lost object, gradually recognising that the object may never be discovered, possibly feeling angry or upset about the loss, and, finally, accepting that the object may never be found.

We might replace the object with something different depending on what it was, but if it had sentimental worth, the emotional part of the item can never be replaced. Many approaches to mourning and bereavement identify comparable processes to those described above in explaining responses to the loss of a loved one, and as the chapter unfolds, you'll be able to connect your personal experiences to the theoretical principles and examine how you may use them in practise.

Outline the process of grieving. (Stages, Types, Process of Grief, Grief cycle – theories,

Stages of Grief:

Although Kübler-Ross initially proposed that everyone moves through each of the five stages once and only once, she later acknowledged that some people may only experience two stages and that some people may revisit stages later in life (Mastrangelo & Wood, 2016).

Because of the ongoing effect of (psychiatrist Elisabeth Kubler-Ross' grief and acceptance, in that sequence. However, studies have shown that many people, if not the majority, will not complete these stages. While some people go through the stages of grief and eventually come to grips with their loss, sorrow is now understood to be very individual and unexpected.

Because grief takes many forms, experts advise that those who want to help a grieving friend or loved one follow their lead and refrain from casting judgement on whether they look to be insufficiently sad or have been grieving for too long. Inviting people to seek "closure" is also detrimental. Providing physical aid and acknowledging a loss are examples of positive actions. Many grieving persons want others to listen, ask questions, and share memories with them, validating the depth and authenticity of their emotions and aiding them in their healing.

The five Stages of Grieving, developed by Dr. Elizabeth Kübler-Ross, is the most well recognised and mentioned loss model. It states that people who experience grief go through a cycle of these five stages:

Denial - Develops as a result of an individual's shock, and might take the shape of numbness, nonchalance, or avoidance. This is a mental survival mechanism that helps people cope with the emotional burden of loss.

Anger - After the reality of the person's death has sunk in, anger sets in as well, as people begin to blame others or themselves. They may also have doubts about their faith.

Bargaining - At this point, people may start asking a lot of "If Only" and "What If" questions, envisioning what would have happened if the circumstances had been different.

Depression - This stage is marked by melancholy and a sense of hopelessness as one comes to terms with the fact that death is unavoidable. The emptiness felt as a result of the vacuum left when a loved one died becomes obvious, and the bereaved person wonders if he or she would be able to live a happy life without the departed. "Is there truly a point in living?" is a common query at this time. It's crucial to stress, however, that depression in this context does not refer to a mental illness, but rather to intense feelings of grief and helplessness.

Acceptance - After some time, the individual might adjust to life without the deceased. At this point, the individual might make the conclusion that this is a reality that he/she would have to manage, and make an effort to engage in new hobbies, activities, or create new memories with other friends and family members who are good emotional support to the grieving person.

Theories of Grievance

Bowlby's attachment theory was greatly influenced by Sigmund **Freud's writings** on people's relationships with idealised things and real figures, and attachment theory impacted other bereavement authors, including William Worden and Colin Murray Parkes. Bowlby defined sorrow as having **three stages: 1. shock and numbness, 2. yearning and searching, and 3. despair and disorder. Parkes later added a fourth to the list: 4. restructuring.**

Bowlby agreed with Parkes and accepted the concept of four stages that did not **have to be experienced in order**, but might occur at different times.

- **Shock and numbness are the stage**. There's a sense that the loss isn't real and that it's difficult to comprehend at this point. During this phase, there may be bodily distress, which may manifest as physical symptoms.

- **Yearning and searching for answers**. The person is conscious of the void left in their life by the loss, as well as the loss of an imagined future that included them. At this point, the person may look preoccupied with the deceased in an attempt to fill the emptiness.
- **Disorganization and despondency**. Here, the grieving individual is able to accept that life has changed and that things will never be the same again. Hopelessness, despair, wrath, and questioning are some of the feelings linked with this stage.

- **Recovery and reorganisation**. In this stage, the person begins to reconstruct their life and live on without their loved one.

Bowlby and Parkes had a big impact on Elizabeth Kübler-Ross, and her well-known grieving

model debuted in her book On Death and Dying, which defines five stages of grief: denial, anger, bargaining, depression, and acceptance. The acronym 'DABDA' is commonly used to remember these stages. These stages are not necessarily experienced in the same order as the preceding model. Grieving persons are unable or unable to recognise the reality of their loss during the denial stage.

They may believe they are having a bad dream, that the loss is unreal, and that they will 'wake up' as though from a dream, expecting everything to return to normal. After acknowledging the reality of the loss, the individual may get enraged at the loss and its unfairness.
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They may get enraged at the individual who has gone missing or at others, such as friends, relatives, or carers. The following phase, bargaining, involves the person pleading with a higher force to erase the loss, maybe by promising to change if the person is returned to them.
The person then enters a depressive stage, in which they confront the truth of their loss and their own powerlessness to change it. According to Kübler-Ross, when a person has processed their early grief reactions, accepted the loss, and begun to move on and plan for a future without the loved one, they will enter a stage of acceptance.

Worden proposed a similar model to these earlier approaches, with his chores of grieving following a similar series of stages, however instead of the idea of ‘moving on,' he inserted the thought that the bereaved can establish an enduring connection with the dead person in the current edition.

• **Task I**:
Acceptance of the loss's reality. When someone dies, there is often a sensation of disbelief, as if it couldn't possibly be true. This is frequently referred to as denial, and part of the initial responsibility is to come to terms with the fact that the person is gone and will not return, both logically and emotionally. Funerals, for example, are beneficial to clients because they represent the reality of the situation and the death.
• **Task II**:

To deal with grief's anguish. Clients will sometimes want to avoid the excruciating agony of losing a loved one. Society provides us with a plethora of ways to divert our attention, and it encourages us to do so because of subliminal messages about not displaying grief and a general aversion to grieving. Processing the sorrow of loss and grief, on the other hand, is vital and can help people avoid dragging the anguish into the future, where it may be more difficult to deal with.

• Task III:

To acclimate to life without the deceased. The bereaved must make exterior, internal, and spiritual adjustments after losing a loved one. External adjustments may include having to assume positions previously held by the deceased individual, as well as carrying out daily tasks and activities in their absence. Internal modifications are needed to build a new sense of identity without the individual; 'Who am I now?' Spiritual adjustments concern the broader meaning of bereavement and a new engagement with the world, which may include a reconsideration of spiritual views.

• Task IV:

In the midst of starting a new life, find a lasting connection with the deceased. In this job, the clients may examine how to maintain an emotional connection with the departed without stopping them from going on with their lives. It is not a case of the client forgetting about the deceased, but rather of the client reconnecting with and enjoying their life while recalling memories, thoughts, and sentiments about the loved one. Worden points out that there is no specific time for these duties to be finished, however it is likely that they will take months or years to complete. While it is critical to handle these duties in order to assist adjust and integrate to loss, he also recognises that no two people will experience loss or its intensity in the same manner.

Models of grief and bereavement

Bereavement affects everyone, and until recently, grief was often treated as if it were an illness, with models based on Freud's writings on mourning and melancholia, which conceptualised loss as a state requiring a path to'recovery,' often identifying various stages of grief (for example, Worden's four tasks of mourning or KüblerRoss's five stages of grief), before a resolution culminating in with the deceased. They keep the potential of remaining in love with a deceased lover open, as well as the opportunity of continuing to retain and mould that person's identity.

This is in sharp contrast to assistance aimed at assisting the grieving individual in recognising and accepting their feelings of loss and sadness, as well as accepting the truth of death and moving on emotionally to a life without the deceased person.

More modern bereavement theorists, such as Klass et al., have questioned this approach, **instead assuming that grieving people maintain a relationship with the deceased.** Some social constructionist narrative therapists, notably White and Hedtke and Winslade, have questioned **traditional techniques to treating with death and bereavement, instead focusing on ways for the grieving person to retain a relationship.**

When considering the concept of the craft of caring, it is clear that bereaved people's experiences can be viewed through two lenses**: one that views aspects of grief (particularly those that may be perceived as denying the reality of the loss) as abnormal or even pathological, and another that views these experiences holistically and considers them normal, even if they are nothing more than a way to maintain the deceased's relationship or bond.**

Although there are many unique theories and models of grieving with different stages and processes, generally all models agree that the following symptoms are common, whichever order they appear in:

Shock and disbelief, feeling numb, even denial that the loss occurred, Sadness, despair, loneliness, feeling empty, Guilt, regret, shame, Anger, feeling resentful

Anxiety, helplessness, insecurity, fear, Physical symptoms like fatigue, nausea, sickness, weight loss or gain, aches and pains, night sweats, heart palpitations, feeling faint or lightheaded, insomnia (It’s normal to experience these symptoms, but if you are experiencing them very intensely or for a long period of time after suffering the loss, client may want to look into grief counseling or grief therapy.

Unresolved and Complicated Grief

Everyone grieves in their own unique way, and everyone's reaction to grieving differs. However, certain warning signals may indicate that people, particularly children, aren't

dealing with their grief well. To process well and to study situation, client needs or require additional assistance and attention.
When life difficulties go unspoken or unacknowledged, they become a burden.
Within the child, the youngster is either locked or frozen. Feelings are suppressed. This is grief.The child is prevented from going through the natural grieving process.
For a variety of causes, grief might go unresolved, including:
• Not having enough time to grieve due to a lack of time, Dealing with one sadness at a time, then the other.• There is a lack of information. If youngsters are not informed about the dangers, They make decisions based on the facts regarding death, loss, or separation. They make stuff up in their heads and act on it. Not being permitted to participate in funeral rites.
The mourning of the family and community; exclusion from the burial or
comparable settings that allow and accept painful expression of feelings. Children may be cut off from their senses as a result of such exclusions. They think of themselves as ordinary folks. Lack of assistance during the grief process as a result of Isolation due to unskilled friends, a lack of a supporting adult by peers, caregiver preoccupation, or, for the young, pressure to be "powerful" as an adult, Lack of a safe environment in which to express feelings and act out stress, which can subsequently erupt in violence.

Types of Grief
There are various types of grief that individuals might go through.

Anticipatory Grief

Sometimes we can know that something is going to happen. Anticipatory grief refers to a sense of loss before the actual occurrence of loss. This can occur when a loved one has a terminal illness, or one is personally being diagnosed with a chronic illness, or when one faces the imminent loss of some human function.

Normal Grief

Normal grief is the natural experience of loss and emotions accompanies the death of a loved one, and usually subsides in intensity over time. It is generally we can see around us happening.

Complicated Grief

Some sufferer due to various reasons. Grief that is long time, prolonged and resultant in severe behavioral concerns such as suicidal ideation, depression due to any reason, addictions, risk-taking behavior, or displaying symptoms of mental health concerns. In these situations, more in-depth counseling and psychotherapy would be important in helping the individual recover from the traumatic loss.so the grief is linked to some mental health problems also.

Disenfranchised Grief

Sometimes grief cannot be informed to all kith and kin. Disenfranchised grief is grief that is not made (Call attention) known to others, such as in the case of a young mother who aborts her child without the knowledge of her parents or others. Another example can be in the case of an extramarital lover (secret friend) whose lover passed on. In these cases, the grieving process is compromised as they are unable to process through this grief with others and receive the social support they need to overcome their grief.

The Grieving Process

It is critical to understand that each person's grieving and mourning sentiments are different. The grief stages we'll go over are just that: a guide. A person's natural tendency is to cycle back and forth between these stages, moving in and out at their own pace. Grief might take weeks, months, or even years for some people. Grief should be recognised as a process with no set time limit, regardless of how long it takes. Even after a person has passed through the earliest stages of mourning, certain situations might trigger feelings of loss and grief. For example, the child may grieve again on the anniversary of a loved one's death, albeit the sentiments will likely be less intense than the initial loss.

Stage	**Possible Feelings**	**Possible Behaviour**
Denial/avoidance	Shock, numbness, feelings of disbelief (“This is not true”)	Unconcerned or unknowing attitude. May be inactive or overactive or fall ill
Disorganisation	Anger, guilt, shame, longing, anxiety, fear	Regression to earlier behaviours, exaggerated fears, temper tantrums, physical symptoms, lack of concentration, mood swings
Transition	Hopelessness, helplessness, despair	Withdrawal, aggression, giving up in school, depression

Reorganisation	Painful acceptance of reality	Shows interest in life, forms other attachments, better able to concentrate, has energy and motivation to move on

The Grief Cycle: Theories

In 1999, Joanne Jozefowski published The Phoenix Phenomenon: The five steps of rebuilding a broken life are summarised in Rising from the Ashes of Grief.

Shock, denial, worry, dread, and panic are common reactions.

Chaos: befuddlement, disbelief, out-of-control actions, irrational thoughts and feelings, despair, helplessness, desperate searching, losing track of time, sleeping and eating difficulties, obsessive focus on the loved one and their belongings, agony from imagining their physical harm, shattered beliefs

Adapting: restoring order to daily life while grieving: attend to basic needs (personal grooming, shopping, cooking, cleaning, and paying bills), learn to live without the loved one, accept help, focus on helping children cope, connect with other grieving families for mutual support, take control of grieving so that grief does not control you, and gradually accept the new reality.

Equilibrium: Re-establishing stability and routines: enjoy pleasant activities with family members and nice times with friends, work productively, choose a positive new course in life while honouring the past, and learn how to deal with others who ask questions about what you've been through.

Transformation: reconsidering your life's purpose and identity; seeking meaning in tragic, senseless loss; and enabling yourself to have both

Allowing yourself to discover that your struggle has led to the development of a stronger, better version of yourself than you expected to exist; learning how to talk with others about one's heroic healing journey without exposing them to your pain; becoming supportive of others dealing with their losses.

Complicated grief	
A. Stressor	Loss of a significant other
B. Intrusion	1. Occurrence of distressing, intrusive images, ideas, memories, recurrent dreams, or nightmares; the mind is flooded with emotions without a sense of reduction in intensity.

	2. Illusions or pseudo hallucinations. The mind is 'haunted' by a sense of presence of the deceased without a sense of reduction in intensity
C. Denial	1. Maladaptive reduction in or avoidance of contemplation in thought, communication or actions on some important topics related to the loss.
	2. Having an implicit relationship for more than 6 months with the deceased as if alive; keeping the belongings of the deceased exactly or completely as before.
D. Failure to adapt	1. Inability to resume work or responsibilities at home beyond 1 month after the loss.
	2. Barriers to forming new relationships beyond 13 months after the loss.
	3. Exhaustion, excessive fatigue or somatic symptoms having a direct temporal relation to the loss event and persisting beyond 1 month after the loss.

Grief therapy is a type of psychotherapy used to treat severe or complicated traumatic grief reactions, which are frequently triggered by the death or separation of a close person, or by a societal calamity. The purpose of grieving counselling is to identify and address the psychological and emotional issues that have arisen as a result of the loss.

They can manifest as behavioural or bodily changes, psychosomatic difficulties, delayed or intense mourning, conflictual issues, or unexpected and sudden mourning. Grief counselling can be done individually or in a group setting. Parents of cancer patients are one group to whom grief treatment has been widely applied.

Grief counselling

Grief counselling is a type of psychotherapy that tries to assist people in dealing with their physical, emotional, social, spiritual, and cognitive reactions to loss. These feelings are typically associated with the death of a loved one, but they can also be moulded by any substantial life-altering loss (e.g., divorce, home foreclosure, or job loss).

Grief counsellors think that everyone grieves in their own unique way, shaped by their family's history, culture, life experiences, personal values, and core beliefs. They believe it is usual for people to retreat from their friends and family and feel helpless; some people may be angry

and desire to act. Some people may laugh, while others may feel sorrow or guilt. Both crying and not crying can be considered suitable expressions of grief.

Grief counsellors are aware that grief is accompanied by a wide range of emotions and behaviours. Some counsellors feel that the mourning individual benefits from the assistance of others in almost all countries and cultures. Furthermore, grief counsellors feel that in the absence of such support, counselling may give a path to a healthy conclusion. Grief counsellors also believe that if the grieving process is interrupted, such as by the grieving person having to deal with practical survival issues at the same time or by them having to be the strong one trying to keep their family together, grief can remain unresolved and later resurface as a counselling issue.

Grief Therapy

There is a distinction between grief counseling and grief therapy.

Counseling entails assisting people in moving from a state of uncomplicated, or normal, grieving to a state of health and resolution. For painful or complicated grief reactions, grief counselling requires the use of therapeutic methods. This might happen when a mourning reaction is persistent or shows as a physiological or behavioural manifestation, or when a grief response falls outside of the spectrum of cultural or psychiatrically determined normality.

Grief Counseling and Grief Therapy:

Grief Counseling and Grief Therapy

In most cases, the distinction between counseling and therapy is purely conceptual. Counseling and therapy both rely on dialogue between the client and the mental health professional to assist the client in addressing emotional, mental, or behavioural issues and resolving problems. The phrases "counseling" and "therapy" are, nevertheless, occasionally used interchangeably.

"counselling" is more commonly used to refer to sessions aimed at assisting clients who are dealing with everyday stressors and seeking ways to cope with common issues and problems. "grief counselling" can refer to any type of counselling that a person might receive after the death of a loved one. If a widow is having trouble coping with her husband's death, she may benefit from grief counseling. Counseling is the process by which a	Therapy is more commonly used to describe sessions in which clients are facing more difficult, pervasive, and/or chronic problems, such as depression, anxiety, or addiction, it is also used to describe sessions in which clients are battling more difficult, pervasive, and/or chronic difficulties. While "grief therapy" is more likely to refer to sessions in which a client participates while their grief is causing them to experience challenges that are outside of their regular range of responses.

counselor helps an individual understand and solve problems to help him or her cope with mental or emotional stressors. For example, counseling generally works to find solutions and relief to specific immediate problems such as learning how to positively communicate in family, work place etc in relationships with others.	If she has lost her appetite and has been having difficulties sleeping for weeks, she may need to seek bereavement Therapy. Therapy usually involves talking about our situation in order to gain more understanding about issues such as mood, feelings, behavior, and ways of thinking. For example, therapy can help you learn how to find meaning in Grief experience of the client.

Thus, grief counseling and grief therapy are basically the same thing. The terms "counseling" and "therapy" have different meanings, but are often used to describe the same activity. Both counseling and therapy involve talking with a trained professional -- many are also licensed by the state in which they work.

INTERVENTIONS AND COUNSELLING

Unfortunately, grief is an unavoidable part of life. How Does Grief Counseling Work? The grief can be said as "The process of adapting to a tragic loss may range dramatically from one individual to another, depending on his or her background, beliefs, relationship to the thing that was lost, and other conditions."

The therapist is the one who can pay attention to what the client says and understand the situation and support with suitable methods of counseling. The Cognitive behavior therapy, Narrative Therapy, the action oriented therapy, family therapy, group therapy, Community therapy, exigency counseling, adolescent counseling, child counseling, old age counseling etc are few of the counseling methods to mention.

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Grief Counseling - Application to Various Counseling Situations of Grief:

Grief counseling is commonly recommended for individuals who experience difficulties dealing with a personally significant loss. Grief counseling facilitates expression of emotion and thought about the loss, including their feeling sad, anxious, angry, lonely, guilty, relieved, isolated, confused, or numb.

Grief therapy aids the individual in coming to terms with the loss he or she has suffered, as well as processing the natural evolution of feelings that may accompany different stages of coping with the loss. In order to cope better with sadness, grief therapy sessions also include parts on boosting an individual's personal and social resources.

It's important to remember that the majority of bereaved or grieving people don't require or benefit from counseling, and some therapies may even be harmful to some people experiencing normal grief, according to Wimpenny's study of the data. Intervening too soon can prevent the bereaved from experiencing emotional grieving, which is a natural, healthy, and necessary response to loss. Grief is a natural part of life for humans.

According to the findings, health, education, and social care personnel need a basic comprehension and awareness of mourning feelings in order to provide the attention that many people believe they require. Basic counselling skills, as well as an awareness of the mourning process, such as that proposed by Worden, are essential in order to provide appropriate support to bereaved people.

While the goal isn't to learn specific counselling techniques, any engagement with a grieving person should be guided by Rogers' essential values of warmth, empathy, and sincerity. According to Worden, the overall goal of grief counselling is to "help the survivor in adapting to the death of a loved one and being able to acclimate to a new reality without him or her." The counselling process is then linked to the four grieving duties. It's important to note that in rare cases, medicine may be required to treat depression or anxiety brought on by protracted grieving.

Medicine, on the other hand, is rarely useful in easing the grief that comes with mourning; it is preferable for the bereaved person to suffer through the anguish of loss in order to move on and recover. Increasing the reality of the loss It's vital to support the grieving individual in

talking about their loss at this time. Asking probing questions about the death can help with this. For example, discussing the death or grief issue details, who was present, and what was said about the deceased person, or discussing the funeral: who was present, and what was said about the deceased person. Visits to the cemetery or the site where the ashes were scattered can also help to bring the reality of the loss home.

The grieving person may be deliberately discouraged from talking about their feelings in most social and family situations, but careful and attentive listening can enable the bereaved person to discuss and absorb the truth of the loss. One important guideline while counselling a bereaved individual in mourning is to avoid using understatements like "passing away" or "sleeping in peace." When speaking to a grieving person, using the words 'dead' or 'death' is simple and emphasises the gravity of the loss. Assisting the client in resolving emotional and behavioural problems People who have been bereaved often desire to avoid the pain they are experiencing and may seek medical assistance.

It is vital to assist the person in comprehending and moving through their sorrow, which may include feelings of rage, guilt, fear, helplessness, and loneliness. A bereaved or grieving individual may get outraged - at the person who died, at themselves, or at others who cared for the deceased, such as family members or professionals. At times, this wrath may be directed at the counselor. Allowing the person to know that their sentiments are normal and providing a safe space for them to express them can be quite beneficial. It could be helpful to gently encourage the person to find counter-arguments to their anger, such as feelings of forgiveness and acceptance, though this should be done with caution and sensitivity so as not to appear to be dismissing the person's feelings.

Assisting the client, in overcoming a variety of obstacles to readjustment after the loss. The purpose of these interventions is to assist the bereaved person in adjusting to their loss by making it easier for them to live without the deceased and make independent decisions. Worden proposes that the counsellor use a problem-solving approach, delving into the survivor's individual concerns and how they might be remedied. It's crucial to realize that the person who died could have served as a friend, companion, sexual partner, financial organiser, cook, or decision-maker in the bereaved individual's life. In these responsibilities, the mourning partner may feel disoriented, and aid in developing practical, financial, or decision-making abilities may be valuable.

Advice on social activities might help a bereaved person build social networks that supply them with company and companionship. Issues surrounding the death of a sexual partner must be handled with caution, particularly because some grieving individuals will not feel ready to engage in intimate relationships for a long time, if at all, after their spouse's death. assisting the grieving person in maintaining a relationship with the deceased while also feeling at ease

reinvesting in life Using the previously described narrative therapy concept of 're-membering' can be extremely beneficial in assisting the grieving person in maintaining a relationship with the departed person, with the goal of keeping the deceased person's voice as a resource.

The ability to freely converse about a deceased person may provide a person with renewed strength. You could want to question about the person's relationship with the deceased as well as their current feelings about the client. This type of conversation has the power to instill a new sense of worth in people and to hint that their deceased loved one's memories may be valuable in the future. Gunzburg uses a systemic approach to counselling and gives a useful process of affirmation, deconstruction, and rebuilding for those who are grieving from a more systemic, constructionist perspective during therapy or counselling. This approach comprises defining the problem, looking into the conditions, and weighing future solutions.

• **Identifying the issue**: Therapists get an insight of how clients create their ideas of the context within which those feelings developed by encouraging clients to articulate their emotions associated to unresolved sorrow.(Cognitive Therapy, Cognitive Emotive therapy)

• **Getting a sense of the situation**: When a client's problem is related to loss, the therapist's responsibility is to validate the client's perspective, highlight their strengths, and use creative methods to express unresolved grief. Some clients, on the other hand, may attribute their problem to anything other than loss, which commonly involves blame and linear thinking. The therapist's job is to deconstruct the client's perspective and provide a new perspective on the problem. The therapists can then. W. Worden presented the "Four Tasks of Mourning" as a way for humanity to heal:

1.Acceptance of the truth of the loss, 2. Ability to work through the anguish of bereavement/grief, 3. Adjusting to life without the individual who has died, or cause of grief, loss of something, 4. Maintaining a connection to the departed while going on with one's life. Affirm the client's changes and offer creative methods to communicate unresolved sadness. (Social Skill Training) Developing skills for living without lost objects, or persons by developing spiritual thoughts and laws of nature.

• **Future possibilities include:** Therapists and clients collaborate to develop a framework that provides them with greater autonomy, options, emotional freedom, creative and holistic thinking, and a new path toward a more meaningful life and a more acceptable relationship. (Re-scheduling)

The discussion and dealing with different Grief situations make us understand that, counseling differs from situation to situation, age of the grieving person, type of loss, depth of loss felt by the grieving person, importance of the counseling in that particular period as felt by the kith and kin of the grieving person, and he himself.

Children, adolescents, adults, old age people have their age related situations for the grieving. The maturity of thought process, understanding the importance of maintaining mental health is very necessary. The psychological and physical health are interdependent, and in the case of grief, immediate steps to strengthen mental health is prioritized as prolonged grief is more dangerous than any other psychological problems.

So we take up different age groups, different grief situations as part of this lesson.

Identify strategies that one can use to help children and youth who have suffered the loss of loved ones.

Grief in Children: What Can You Do to Help a Child from Birth to Two Years

When a parent dies, a very young child requires a consistent, close individual to act as a parent or caregiver. This will make it easier for the child to cope with the loss of a parent and the changes in his or her life.

his or her life It's critical that the caregiver remains the same.

When there are no major changes in their environment, young children adjust more easily.

If at all possible, the youngster should be kept in the same setting or routine

in the company of his or her brothers and sisters

This is what can be done to help the child:

• Make sure the substitute caregiver is nearby and reliable.

• The caregiver should make a lot of physical touch with the child.

• The routine of the child (for example, feeding time and bed time) ought should be the same.

• The child's surroundings should not change.

• If the youngster has a sibling, he or she should not be separated from them.

How Can we Help a Child from age 2 to 6

What can we do to help a youngster aged two to six years who has lost a parent? It's critical to have a reliable substitute caregiver once more. The youngster must be addressed in his or her own language.

He/she is aware of the situation. Soft words, hugs, and hand-holding must be used often to calm and encourage the youngster. In addition, the following may be beneficial:

• Allow the youngster to express his or her grief and share his or her anxieties and concerns.

• Be straightforward and honest while answering inquiries.

• Assist the youngster in recognising and naming emotions.

"It sounds like you're worried (mad, upset, etc.)...", for example.

• Allow time for children to play. Toys and other play materials are important aids for young

children who are grieving.

• When it comes to behaviours like thumbsucking or bedwetting, be tolerant.

• Maintain a close and constant relationship.

• Spend time with the youngster, express interest in him or her, and engage in playtime with him or her. Make a lot of physical touch and show a lot of affection.

• The child's routine and environment should not change (as far as is possible).

• The child's siblings and sisters should not be separated from him or her.

• Share with the child happy memories and anecdotes about the deceased parent, as well as photos of the parent and child together.

• Assure the child that the future will be bright.

• Encourage the kid to engage in cooperative play.

• Assure the youngster that he or she did not cause the parent's death and that many people still love him or her.

Age 6 to 9

When speaking with youngsters of this age group, it is important to discuss death honestly. "Mommy is sleeping," for example, should not be said. "Your mother has died," say simply and truthfully. Children who are told that their mother is sleeping may be terrified to sleep for fear of dying as well.

At this age, children are curious about what will happen to their parent once he or she has been buried. It is the caregiver's responsibility to convey to the kid the family's culture and religion's notions of heaven, ancestors, and reincarnation. During this stage, the kid may begin to grasp abstract notions such as changing forms of existence (becoming an angel or "going to be with Jesus").

It is critical for the adult to be confident in his or her own convictions before describing where the parent has gone to the youngster. Spiritual, religious, and cultural beliefs are critical for a child's well-being. Children who have a spiritual or cultural belief system have been demonstrated to cope better than those who have not. It is the caregiver's responsibility to reinforce the child's beliefs in a way that is respectful of the child's family's beliefs.

After a death, allowing children to participate in religious and cultural rites (for example, attending a funeral) might help them grasp what has happened. Children's ability to cope improves when they grasp what has happened.

Explaining the Concept of Death

This practise can be used to explain death to a kid. Remove a single strand of hair off the child's head. Explain that because it is alive, it hurts when it is pulled. Allow the youngster to thoroughly remove the hair.

Explain that once the hair is removed from the body, it dies and we no longer have access to it.
It is no longer felt. Explain that it's the same with people: when they were young,
They could feel agony via their bodies while alive, but not now that they are dead.
Their bodies have ceased to function, and they are no longer in pain.
To summarise, here are some suggestions for assisting youngsters in this age group coping with their loss:

• Be patient and sensitive to the needs of children.
• Make you feel at ease.
• Stick to a daily schedule.
• Assure them that the death was not their fault. They should be reassured repeatedly and taught that their parents' deaths have nothing to do with their actions.
That it is not their fault if their parents or someone close to them has died.

Love has passed away.
• Share happy recollections and anecdotes about the person who has passed away.
visit the grave, and look at photos of the deceased individual together

Have remembrance periods Tell the youngster stories of what the parent did when you were a child if you are a family member.
He or she was the same age as the child. Children adore this stage.
I enjoy hearing stories.
• Explain religious practises to the youngster and encourage him or her to participate.
• Allow the youngsters to assist, but do not overburden them with responsibility.
• Encourage kids to talk about how they feel about death.

9 to 12 years age
Children are able to understand things more clearly by the time they reach this age. They begin attending school with a desire to study.
Counseling for caregivers and instructors is critical during this time because they will be spending more time with the youngsters. Friendships and group activities teach children how to socialise and learn. The child comprehends the causes of death but is unable to comprehend the consequences of death. Although children may employ magical themes on occasion, they are generally aware of the distinction between imagination and reality. This age group's children go through a grief process that is similar to that of adults. Some children, on the other hand, may be unable to accept the death of a parent. Others may

look for a reason for the parent's death. They may believe God or their ancestors have betrayed them. Children in this age group may withdraw from adults in response to grief.

• Become melancholy and depressed. • Take risks and engage in self-destructive behaviour. • Inability to focus and pay attention. • Pretend to be normal and hide their feelings in order to appear mature. • Be concerned about their own lives and fear that they may perish. • Demonstrate a strong concern for others. • Pose death-related questions. • Revert to your youthful behaviour. • Act out forcefully by throwing temper tantrums or becoming a school bully.

• Providing consistent and close care.
• Providing solace and encouragement.
• Instilling basic abilities in the child, such as assertiveness.
• Encouraging the child to attend classes.
• If at all possible, do not separate the youngster from his or her parents.
brothers and sisters of his/hers
• Encouraging the child to interact with other kids, particularly those his or her own age.
• Investing time in the child and demonstrating an interest in him or her
and having a good time together.
• Paying attention to what the child is saying and attempting to comprehend how the child is experiencing.
• Encouraging youngsters to express their emotions (children)convey feelings in a variety of ways (as we'll see).
• Sharing happy recollections and anecdotes about the person who has passed away with the youngster.

• Instructing the kid on how to communicate with the departed parent by "relocating" the parent's memory to a "location"
If the youngster can quickly recall the parent
• Finding the right time to talk about death and disease.
• Discussing HIV/AIDS concerns, particularly transmission prevention.
• Assigning minor duties and chores to the child.
• Talking about their loss should be honest and factual.
• Accept that they will have emotional swings and physical symptoms

Grief among - Adolescent Children from 13 to 18 Years of Age

Teenagers may show characteristics of withdrawal and turn their sentiments internally in response to bereavement.

• Prefer to spend time with friends rather than family.

Guilty sentiments might be triggered by family.

• Act as if they are unaffected by the death or as if they are unable to express their sentiments. This can be demonstrated by: • Failing in school. • Getting into squabbles. • Control temper tantrums. • Being impolite. • Attempting to flee from one's home. • Being untrustworthy. • Getting into legal difficulties. • Using drugs and consuming alcoholic beverages. • Getting involved with prostitution. • Discussing or displaying suicidal tendencies. • Having a mature/quiet demeanour. • The act of withdrawing.

This is a time when spend a lot of time thinking about self, feelings, and how one see the rest of the world. When it comes to death, teenagers recognise that it is a reality and spend a lot of time considering how it will effect them and those around them. They even fantasise about dying and wonder aloud, "Who will be there?" Young teenagers may still believe that death will never happen to anyone they care about. They believe that no one, especially grownups, understands them. As a result, they have a closer relationship with their peers. They may be terrified of death since they are aware that it is something they cannot predict or control. They may be terrified of viewing the deceased's body because of the way it will appear. They may also experience remorse for things they did or did not do in response to the person's actions.

• Respect and privacy for children of this age group to grieve in their own way. • To have their feelings taken into account. • To be a part of the planning process as well as family discussions and decisions. • Encouragement to express their sadness in other ways, such as through sports, writing, music, theatre, and art. • To know that the departed person loved them, even if things at home were not always going well. • Not be interrogated about their emotions. • To be in the company of their peers. • Confidence in their future.

Some Techniques for Assisting Children -Talk about Grief

As a caregiver, you'll need to know how to enable children to talk about their sadness and emotions in a variety of ways. A few of them have already been discussed.

1. Artwork/Drawing

Drawing is a common way for children to express themselves. They have the ability to sketch. photos to express their feelings, to bid farewell to the deceased, as well as to resurrect positive recollections of the deceased.

Do not explain the picture for the children; instead, ask them to tell you about it.

2. Telling a story

Encourage your youngster to tell (or write) a tale about the deceased individual.
As well as memories of things they used to do together. Allow the child to tell the narrative, with the help of others.

3. Composing

Allow any recollections to be written down by children who are able to write.
sentiments, and what they wish they could have said or done in the person's place has been supposed to die, but hasn't. All of these are options for bidding farewell, Possess them. Make a memory book about a vacation or a happy/sad memory, their entire lives. Use a scrapbook, a photo album, or pages that are taped together.
combined in a pleasing manner to create a book that the youngster can keep.
As a book, it can include narrative, photography, or images ripped from magazines, a method of preserving a special memory.
You may have the kids build a Loss Timeline, filling it in with the persons they've lost in the order that they died. They might also make a family tree using a circle to represent those in their family who are still alive and a square to represent those who have passed away.
This can let them see that there are still others who can help them them.

4. Imagination and drama

To communicate emotions, use dolls and puppets or act out plays. Organize the
Younger children's games include acting out a funeral or reminiscing over the deceased. (imagine a person who has died).
5. Listen to music: Music and singing are popular ways for children to express themselves. Encourage them to go ahead and do so. They might wish to pound the drums harder, for example. To get the wrath and despair out, for example.

6. Physical Activity/Sports

Encourage children to express their feelings through physical activity.
Football, jumping, hitting a ball, and running are all great ways for kids to let off steam. Emotions and pent-up energy – relaxation results.

Children frequently use play to communicate their emotions. When a child is playing, there are a few things one can look out for as a teacher, parent or care taker, as instructed by the grief counselor:

• Anxiety over being alone for an extended period of time. • Pretending to be much younger for an extended period of time. • Excessive mimicking of the deceased, constant declarations of regret wishing to be a part of the deceased.
• Anxiety about being separated. • Isolation from friends. • Emotional ups and downs. •

Aggressive new forms of playing, such as pushing, shoving, or pretending to kill someone. • Persistent feelings of hopelessness and depression.

• Suicidal ideation. • When kids chat or play, they express their concerns. • Issues at school

Let's take a look at the most prevalent indications of abnormal sorrow and how we might help kids and teens cope.

Sleep Disturbance – the counselor would considered the following options for counseling.

• She could be too exhausted to sleep.

• She could be starving

• She might not want to sleep alone herself.

She might be terrified of having nightmares.

• She might have a fear of the dark.

• She might be scared that her caretaker sister will die., as did their parents.

What are one be able to accomplish to assist?

• Figure out why he or she refuses to go to bed. Act in accordance with this.

• If at all possible, make sure she has a calm area to sleep.

• Make her feel at ease in bed and assure her that you will be there when she awakens.

• Inform her that her other siblings would be joining her in bed soon. Have a bedtime routine, such as a prayer or a brief tale, that you follow every night. Leave the light on or light a candle if she is terrified of the dark. Be patient with her and don't yell or threaten her; instead, be firm and insist on her going to bed. When she begs you to let her stay up, don't give up. If she begins to cry, console her briefly before leaving her alone in bed. Although this may appear harsh, she will quickly learn to relax and fall asleep when it is time for bed.

Eating Disturbance

Following a loss, it's common for a child to refuse to eat much.

Big variations in the child's typical feeding routine, on the other hand, are cause for alarm.

If a youngster is having difficulty coping with loss, he or she requires special attention and assistance:

• The child refuses to eat anything, even a favourite food.

• The child eats constantly, to the point where he or she becomes ill. What can you do to assist?

• Give the child extra time to express his or her feelings.

• Involve the youngster in physical, enjoyable activities like sports. which will aid in the improvement of his or her appetite

Disturbance in Eating

Following a loss, it's common for a child to refuse to eat much.However, if the child's typical feeding pattern undergoes significant modifications,It's a source of concern.

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assistance:

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Deep Fears Of Future Or Past Experience

As we've seen, everyone is afraid at some point in their lives. Following the death of a loved one, a kid may be afraid of the changes that are about to occur, of being alone, or of death itself.

• She has developed strong phobias, including those of her grandma.

• She might be so terrified that she gets nightmares. A caregiver, on advise of counselor should pay attention to how the youngster expresses his or her fear.

The child will tell you everything needs to know.

• Use terms like, to demonstrate an awareness of feelings and worries.

"I have faith in you." What you're going through and how you're feeling are both important. are genuine."

• Discuss these anxieties openly and gently, because what may appear foolish to an adult is very genuine to a youngster. "Don't be ridiculous," they sayisn't persuasive, and it doesn't benefit the child. • Keep in mind that fear is real.

School Problems

If a child's grades suddenly decline, he or she isn't coping with sadness and needs extra attention. • The child picks battles with other children.

• The child's work has recently deteriorated and is now illegible.

• The child has developed a dislike towards teachers.

She could be acting the way she is because of the following reasons: • Her siblings have been separated from her, • Her mother has died, and she holds herself responsible, • She might feel alone, • She may hold herself responsible for her expulsion.

Specialized Care

Grief can cause strong emotions in certain youngsters. Extreme feelings or other over-reactions to mourning may persist rather than diminish as time passes.

Keep an eye out for indicators of unresolved or unusual sadness. If you believe that, because the child's reaction is so extreme, he or she will almost certainly require more specialized assistance than normal counselor can provide.

Specific techniques and strategies one can use, including:

1. Some bereaved people feel compelled to learn everything they can about their loved one's illness and/or death circumstances, especially soon after the loss, and they may wish to check medical records. This is normal, and it's especially common in the case of a sudden death.
2. Encourage the use of symbols and "transitional items" such as photos, audio or video tapes, clothing or jewellery, or a collection of the deceased's personal belongings.
3. Encourage the deceased or God to write a letter expressing his or her thoughts and feelings.
4. Encourage people to keep a sadness journal with personal reflections, poetry, and remembrances.

   Reading about grief can assist them to feel less alone in their sadness. Grief resources can be found in bookstores, libraries, hospices, and on the Internet.
5. Family members might create a memory book with stories about family events, photos, poems, and drawings, among other things. They could also build a memory box, which would contain some particular objects that could be shared or saved as a remembrance.
6. Encourage them to express their grief via art.
7. According to one grief therapist, the grieving person should try to resolve any "unfinished business" from the deceased's relationship in his or her mind. It can be beneficial to concentrate on what the survivor was able to accomplish for the departed rather than what they should have done.
8. Another helpful method for "unfinished business" is the "empty chair" technique, in which the bereaved person imagines the departed and is encouraged to communicate anything they need to say.
9. Role-playing can be beneficial when the bereaved are confronted with situations that they are afraid of or are uncomfortable with, such as beginning a new relationship. Role play can help you develop better coping skills.
10. While supporting persons in hospice care who are grieving the loss of a loved one has its unique set of issues, it is generally comparable to any other type of grief therapy or counselling in that the most essential thing is to provide them with support, encouragement, and care.

Grief Counseling for Adults

If a person decides to seek grief therapy, this section explains what to expect throughout their sessions.

The major purpose of most grief counselling is to assist the client in integrating the reality of their loss into their future lives while also assisting them in maintaining a healthy link with

the loved one they have lost (Neimeyer, 2013). There are two critical first stages for working with a new client grieving from their loss,

The Death's Event Story is Being Processed

When working with a bereaved client, clinicians will initially encourage them to engage in a therapeutic re-telling of their loss. When it comes time to help the client rewrite the storey of their loss, the clinician must provide a safe space for them to open up and build trust so that they can communicate effectively with the therapist.

Getting to Know the Relationship's Background

The clinician will learn about the client's relationship with the loved one they lost in addition to hearing about the loss event itself. "Death may end a life, but not necessarily a connection," . Rather than losing their link with their loved one, the clinician will assist the client in learning how to rebuild it.

Spirituality and Law of Nature

The spiritual acceptance of any type of loss, and understanding how the nature is functioning helps the grieving person to be strenghty. The exapmles of k

Real life incidents give an understanding the client that he is part of the universe and it is not the first time happening.

Stroebe and Schut's Dual Process Model

According to Stroebe and Schut's concept, the bereaved respond to stressors by alternating between two types of coping mechanisms known as "loss-orientation" and "restoration-orientation."

Loss-orientation describes how the bereaved cope with issues directly related to the loss (for example, feeling lonely or sad), whereas restoration-orientation describes how the bereaved cope with and adjust to challenges relating to secondary changes brought about by the loss (for example, dealing with financial matters). Loss-oriented coping behaviours, such as sobbing and talking about feelings, might help people manage their emotions, according to Stroebe and Schut. Quite the opposite,

Restoration-oriented coping behaviours, such as learning new skills like financial management, may assist the grieving individual in adjusting to their new life by diverting their attention away from the 'loss.' According to this dual process theory, grieving people alternate between confronting and escaping their stressors. According to Stroebe and Schut, people's attention will shift between these two processes at different periods, with some people being more focused on coping with the loss itself, while others being more focused on transitioning to a new existence.

Continuing Bonds -

Some social constructionist**, narrative therapists** (for example, Michael White and Hedtke and Winslade) propose therapy approaches aimed at allowing the bereaved person to preserve a relationship with the departed person.
The term 'continuing bonds' was as an alternative to the traditional concept of mourning, which demands the bereaved to 'let go' of the departed. They said that the bereaved maintain a connection with the deceased, resulting in the formation of a new relationship.

This bond develops and evolves over time, usually offering comfort and solace to the bereaved or grieved. Talking to the deceased, locating them (often in heaven), experiencing them in dreams, visiting the grave, feeling the deceased's presence, and participating in mourning rituals are among the ways that the bereaved person can build a 'new' relationship with the deceased. In a study that conflates dreaming with yearning, found that those who looked for their departed partner in a crowd also tended to dream of them still being alive, while Fraley and Shaver argued that some forms of continuing relationships may be 'healthier' than others.

They came to the conclusion that this could indicate a conscious yearning for the deceased to come back to life, a process reflected in and occurring in tandem with the deceased's dreams, and could indicate a refusal to accept their spouse's death. Incorporating the concept of continuous ties into the traditional paradigm appears to allow a lot of potential for pathology, especially if the dominant discourse is materialistic. Instead of debating whether or not experiences of communication with the deceased person are imagined or genuine, simply considering them as a way to retain the tie with the departed person may prove to be valuable.

Narrative Therapy: 'Saying Hullo Again' And 'Re-Membering'

White proposed an alternative to the prevalent'saying goodbye' metaphor characterised by'letting go' in traditional approaches to bereavement in a short article titled'Saying hullo again,' and Hedtke and Winslade describe a focus of're-membering,' a process that redirects the focus of grieving toward maintaining an ongoing relationship with the deceased person.

The grieving can take comfort in the fact that the departed was a member of their own "membership club" of life. They employ the subjunctive to create new possibilities and ways of understanding situations, such as shifting from talking about the deceased in the past (she or he was a regular reader of Hello!) to methods of including the departed in the present (she or he would enjoy this edition of Hello!). Nell, who was motivated by White's studies, found a number of ways to say hullo again, including writing letters to the deceased, visiting the grave, and sharing memories with others, but she also recognised the

value of utilising dreams to say hullo again.

According to Nell, dreams of the deceased have a vast, but mostly unexplored potential for assisting clients in dealing with their grief. In therapy, such dreams can effectively launch a saying hallo process, which can subsequently be supported with numerous strategies to assist the client reintegrate the lost link into his or her life. Ignoring such dreams would deprive the client of a vital link with the deceased, as well as a valuable healing opportunity.

Following are some of the changes that children and adults may experience as their grief is resolved:

1. They will be able to relate to individuals and the community more effectively; they will be able to listen to and appreciate other perspectives; and they will have a greater awareness of both the world and themselves.
2. They will begin to place a higher emphasis on their own life.
3. They will strengthen their personal bonds.
4. They will be enthusiastic about new activities.
5. People who were withdrawn will begin to socialise with their peers.
6. They will be better at giving, learning, and listening.
7. They'll be pleasant company for others.
8. They will gain a greater sense of self-worth.

Grief, contrary to popular belief, can result in good improvements.

Controversies - Efficacy and pathogenesis

In the academic literature, the relative usefulness and potential harm of grief treatment are now being debated. In the absence of complicated (or abnormal) mourning behaviours, researchers believe that people may seek grief treatment, and that in such cases, grief counselling may cause a normal bereavement and grief response to become pathological. Others suggest that mourning counselling is extremely beneficial for people who have experienced unusually protracted and intense bereavement or grief reactions.

Some mental health professionals have questioned whether or not complicated grief exists. There have been some new diagnostic criteria proposed for "complex sorrow." Because "complex grieving" isn't a different mental disorder, others argue that it shouldn't be labelled. Depression, posttraumatic stress disorder, and personality disorders all have a symbiotic link.

In empirical studies, attempts have been made to establish the incremental validity of complicated grief. Studies to support, supports the incremental validity of complicated sorrow. The study advises that "how intricate bereavement symptoms might be arranged diagnostically is still very much subject to debate." Because this is a hot topic in the field, new research on it is expected to appear in the scientific literature.

Trauma counseling

To the extent that anyone can, each person has unique emotional experiences and ways of coping, grieving, and reacting or not reacting to the impact of loss or trauma, both during and after the events of loss or trauma. When a loss or trauma hits suddenly, brutally, or unexpectedly, coping becomes even more difficult. When a community is hit by a disaster, both the cost and the amount of support are frequently increased.

The emotions of weeping, agonising anguish, indignation, shock, guilt, helplessness, and outrage are all common. These are particularly trying times for children who have had little experience dealing with strong emotions inside themselves or within their families. These feelings are all part of a natural healing process that relies on the resilience of the individual, family, and community.

With the comfort and support of understanding loved ones and occasionally strangers who come to their aid, people heal in their own time and in their own way. Resilience is more common than spectacular, according to study. The majority of people who have been through a loss or a disaster do not get PTSD. Some folks are still in a state of shock.

People heal at their own pace and in their own way, with the comfort and support of sympathetic family members and, on occasion, strangers who come to their aid. Resilience is more common than spectacular, according to studies. The majority of people who have been through a traumatic event or loss do not get PTSD. Some folks are still in a state of anxiety.

The post-trauma self is a person who has been through a traumatic event.

Because trauma, PTSD, human development, resiliency, and self-integration are all linked, counselling for the complex traumatic aftermath of a violent death in the family, for example, requires an integrative approach that employs a variety of skills and techniques to best suit the presentation of the problem. It's likely that post-traumatic self isn't the same person were before the trauma.

This can lead to shame, more shocks, and grief for the lost unmodified self, all of which have ramifications for family and employment. Whatever therapeutic technique is used, the goal of counselling in these settings is to improve safety, trauma processing, and reintegration.

Although you may be most familiar with melancholy as a response to the death of a loved one, the definition given below is more general: "... a reaction to any form of loss" . As a result, sorrow can be experienced in a variety of situations, including as the death of a loved one or a pet, the end of a marriage, estrangement from a family member, or any other significant loss.

Grief counselling is intended to help the client grieve in a healthy way, understand and cope with their emotions, and finally find a way to go forward (Therapy Tribe, n.d.). This can be addressed by existential therapy, individual treatment, group therapy, and/or family therapy (Mastrangelo & Wood, 2016).

Techniques used in Grief Counseling

The following are three of the most important things a skilled grief counsellor can do for their client:

1. **Let them talk about the departed;** inquire about the person, and give them a secure place to talk about their lost loved one.
2. **Differentiate between grief and trauma;** if the client can't get an image out of their brain or has flashbacks to the time they learned of their loved one's death, they are suffering from trauma, which can prevent them from working through their grief.
3. **Address any guilt the client** is experiencing and assist them in organizing their sorrow; the client may feel guilty about what they did or didn't do while their loved one was living, or they may feel terrible about not being "sad enough" or moving on now that their loved one is gone. Encourage them to let go of their guilt and make a commitment to living a life that honours the deceased, even if that means temporarily forgetting about them.

Interventions and Strategies in Grief Therapy

Apart from the three key tactics mentioned above, there are numerous more more specific interventions and modified procedures that can be employed to assist a client in grieving counselling.

Companioning Model of Bereavement Caregiving:

The Companioning Model of Bereavement Caregiving, for example, was established by Dr. Alan D. Wolfelt, in which the counsellor or therapist works as the client's companion and aid. He is present for his client and observes their experience; nevertheless, "observe" in this sense means "bearing witness to" and "looking out for" them, not just "watching."
Companioning entails...paying attention to the spirit rather than the intellect. Curiosity, not expertise, is what motivates us, not to teach, but to walk alongside, rather than leading. Rather than, it's better to be still. It's not about putting words to every bad situation; it's about recognising the treasures of sacred quiet.
Respecting chaos and ambiguity rather than imposing order and rationale Going into the wilderness of the soul with another person, not thinking you're in charge of finding your

way out, Listening with the heart instead of the head Rather than leading people, I like to observe their challenges. Rather than erasing another person's grief, being there with it. Rather of imposing order and logic, we should respect chaos and uncertainty. Going into the soul's wilderness with someone else and not thinking you're in charge of figuring out how to get out.

Dr. Kenneth Doka urges **clients to establish rituals in order to maintain contact with their loved ones and to move on despite their loss.** The following four types of rituals could be beneficial:

Continuity Rituals – These rituals demonstrate that the client's deceased loved one is still present in his or her life and that their bond is still strong.
Transitional Rituals — This type of ritual marks a significant change in the grieving process, such as emptying out the deceased's room or handing over their belongings.
Affirmation Rituals – The client expresses regret by writing a letter or poetry to the deceased, thanking them for their love and support.
Intensification Rituals — These rituals bring people together and solidify their shared identity; for example, a military unit would meet on a regular basis to mourn deceased colleagues, or survivors of a violent act might return to the scene to leave flowers or construct a memorial to those who died.
Few more Activity Based Grief counseling Techniques:

1. **Commemorative rituals**, such as lighting a candle and remembering the loved one, watching home videos or looking through old photos of the loved one,
2. **Travelling** to a place the loved one always wanted to visit, or visiting the burial site and leaving a tribute or symbolic item, such as flowers or a balloon, can provide comfort to those grieving a loss.
3. There are a million various ways to grieve, and mental health practitioners don't necessarily promote or implement all healthy grieving methods equally.
4. The **Intuitive Griever** is expressive about their sadness and has strong sentiments about it (e.g., crying, lamenting their loss). They can cope with their loss more effectively if they can make their experience easier and express their feelings.
5. Long periods of confusion, difficulty to concentrate, disorganization, and disorientation, as well as physical tiredness and/or concern, may be experienced by some.
6. On the other side, the **Instrumental Griever** is more prone to grief-related thoughts than sadness-related feelings, and is generally unwilling to express their emotions. They place a premium on self-awareness and mastery of their surroundings, as well as problem-solving abilities. They may have brief spells of cognitive impairment, such as bewilderment, forgetfulness, or obsessiveness, as well as an increase in energy.

7.

Tips for Coping with Grief

Grief counselling and therapy can help client cope with the loss of a loved one.

Counselors will most likely give the following three grief tips in addition to the approaches and strategies outlined above.

1. Do not be alone in your grief.

It's vital to stay in touch with others at this period. Family, friends, religious leaders, a grief support group, and/or a certified mental health professional may be part of grievers support system to help you cope. Client can get help from the support system in the following ways:

Make funeral arrangements or assist the client with new commitments. To find peace and consolation, turn to faith's mourning traditions. Share sorrows with others who can empathize. Work out difficult feelings in a safe atmosphere.

2. Make sure you're taking care of yourself.

It's easy to forget about our own needs when we're mourning, yet neglecting ourselves won't help us deal with grief effectively.

Keep in mind to:

3.Construct a graphic depiction of your feelings (e.g., write something, paint, put together a scrapbook, or play a musical instrument). To avoid adding physical tiredness to your emotional exhaustion, eat, sleep, and exercise. Allow yourself to feel whatever feelings are coming up for you and be patient with yourself. Recognize what's causing your sadness and plan ahead (for example, take a day or two off work, notify your friends and family that you'll need extra help,

4. Seek grief counseling from a specialist.

While not everyone needs the help of a counsellor or therapist during their mourning process, for those who do, it can be quite useful. A skilled expert can help you understand the mourning process and give you the tools you need to manage your emotions .

Workplace Counseling for Bereavement or Grief - Following suggestions are provided by experts to address grief in the workplace:

It can be difficult to cope with the death of a coworker, whether it occurs at work or outside of it. It's critical that business leaders deal with bereavement in a healthy way, or they risk losing morale, productivity, and a general unfavourable attitude toward leadership.

Before You Do Anything Else: Stop the Action

The very first thing that should be done after a death is to put an end to normal company operations. Leaders should pause and postpone any non-essential activities to give staff time to comprehend what has transpired.

This may entail closing the firm for the day or assembling all employees for a few hours to inform them of the situation and handle any issues that arise (e.g., safety concerns). Leaders should make certain that all employees are informed of the issue and have proper information before they leave.

Focus on Feeling/Talking/Sharing

Make time for employees to congregate and share their feelings after the initial meeting to discuss what happened and make sure everyone is up to date. After a loss, it's critical to offer employees an opportunity to process their emotions and connect with their teammates. One might want to enlist the help of an outside facilitator to guide a group discussion.This may need to be broken down into numerous smaller groups in larger firms; the crucial point is that each employee gets an opportunity to share in a secure setting.

After every employee has had an opportunity to speak, the company might organise a larger ceremony or commemoration that includes everyone.

Use a Variety of Formats

Every person grieves in their own unique way, and it's crucial to avoid forcing anyone to grieve in a certain way. Provide bereavement therapy or support in as many different modalities as feasible. Some folks may not feel comfortable discussing in front of a group and might benefit from one-on-one conversations.

Others may find ceremonies and rituals soothing, while others may find them excessively sombre or overbearing. Make an effort to provide support for a variety of coping techniques and strategies.

Create Ceremony/Rituals

Even if some people dislike them, most people find some solace in ceremonies and rituals. It could be as easy as having everyone sign a card to the deceased's family, or it could be as elaborate as organising a company-wide memorial service for the departed.

Periodic remembrances may also be beneficial if the loss was very significant to the workplace.

Provide Many Opportunities

Before reaching out, some people require time to process their emotions, while others may be in shock or denial for a while. Instead of picking a single day or week to grieve, make sure you give yourself multiple chances over a longer period of time. Allow employees as much time as they need to process their feelings.

Allow them to say their final goodbyes during a memorial service. It will help understand how much the deceased was treasured and essential to others, as well as that grieving is

normal. If they refuse to attend the service, assist them in creating their own service or ritual to say their goodbyes.

How to Provide Grief Counseling in Hospice Care

Hospice care is one of the most emotionally exhausting fields to work in, as we are dealing with grief and loss every day. While there are some aspects of an expected loss that make it easier to cope with, that certainly doesn't mean it's easy.

Disaster related Grief

In Grief counseling therapist Listen to the client's issues in a supportive manner. Assist disaster survivors in realizing that their emotional reactions are, for the most part, natural, normal, and expected. Organize and prioritise day-to-day and recovery-related responsibilities to help survivors manage with added stress.

Assist people in recognizing and comprehending a variety of trauma reactions, including numbness, annoyance, befuddlement, fury, concern, grief, and helplessness. Individuals should be assisted in recognizing their own strengths and developing healthy coping methods so that they can progressively return to their pre-disaster (or pre-loss) level of functioning. Therapist or trained counselor may help folks grieve in their own unique ways by being attentive and sympathetic. Make systematic use of a variety of recovery services to locate appropriate referrals.

Coping with Miscarriage grief counseling

Regardless of how common miscarriages are, they can leave pregnant parents destitute and heartbroken (and others heavily invested in the pregnancy, such as grandparents of the child lost).

It is totally natural to experience loss after a miscarriage, regardless of when it occurs throughout the pregnancy; however, current research suggests that roughly 15% of women who miscarry have more severe grief-related symptoms, necessitating the assistance of a skilled mental health professional.

You should seek counselling or treatment for your loss if you've been experiencing the symptoms indicated below for a long time or to the point that you can't function normally.

Following a miscarriage, the victim may experience: Depression, Numbness and skepticism, Anger, Guilt, Sadness, Concentration problems, Fatigue, Sleeping Problems, Appetite loss.

Crying episodes that occur frequently, Relationships with family or friends are broken or suffering. Attempts or acts of self-harm/suicide, (American Pregnancy Association, n.d.)

Shock or denial that one had a miscarriage. May show Anger, shame, and/or melancholy; a sense of injustice, or the question "Why me?" feeling.

Acceptance of the miscarriage's truth.

Getting to stage three doesn't mean you've stopped grieving, but it does mean you've accepted your situation and have a better grasp of what you're up against; things can only get better from here.

Therapists suggest to keep the following in mind as you go through your grieving process: Seek out your loved ones for understanding, support, and comfort.

If you need counselling, seek it out, and encourage your spouse to seek it out as well if he or she requires it; clients are not alone. Allow yourself the time, space, and permission to mourn and reflect on your losses. Set attainable goals for yourself and concentrate on one task at a time. Allow yourself to experience both pain and joy; savouring minor pleasures will not make your loss disappear (American Pregnancy Association, n.d.).

It's all too easy to get caught up in your own misery while grieving a loss and forget about your partner's pain. This is detrimental to the health of a relationship and should be avoided at all costs.

Make sure do the following to help relationship get through the grief process:

If you need counselling, seek it out, and encourage your spouse to seek it out as well if he or she requires it; clients are not alone. Allow yourself the time, space, and permission to mourn and reflect on your losses. Set attainable goals for yourself and concentrate on one task at a time. Allow yourself to experience both pain and joy; savouring minor pleasures will not make your loss disappear (American Pregnancy Association, n.d.).

Grief Counseling and Therapy for Pet Loss:

The death of a four-legged, furry loved one can also be devastating. In today's society, pets are frequently viewed as family members, and losing one may be almost as devastating as losing a human family member.

Counseling is offered to help people cope with the loss of a pet, while some clients may find that internet counselling and support groups are more appropriate than appointments with a mental health professional.

If a person is grieving the loss of a pet, internet counselling is now available. It provides forums, chat rooms, suggestions and guidance to individuals grieving the loss of a pet, as well as an opportunity to remember the pet and information on how to help others, particularly youngsters, cope with the loss. The Association for Pet Loss and Bereavement also provides a variety of services to assist people cope with the loss of a pet, such as access to professionals, information on how to become a pet bereavement counsellor, chat rooms and forums, and monuments for lost pets.

Remember that there is no shame in grieving the loss of a pet—they may truly become members of the family, and losing a family member is never easy. If you believe one of your family members is having more difficulty than usual, he should not be embarrassed to seek

the assistance of a skilled mental health expert to help you through the grieving process.

Group Grief Counseling And Therapy Counseling Retreats

A client who has been grieving for a long time can benefit from something more rigorous and sociable than individual counselling. Group counselling and retreats may be exactly what you need to go through a long period of mourning. Under the supervision of a competent mental health professional, group counselling, also known as group therapy, for bereavement can help clients recover quickly and find solace in sharing their experiences with others. Typically, these groups are closed and limited to a specific number of participants who remain in the group until the end. They can take a variety of forms and focus on various types of losses. The Grief Group therapy offers the following group therapy options:

"Art in Grief" Therapy: Parent Loss, Suicide Loss, Spouse / Partner Loss

Trauma Information Group, (Family Therapy can also can be done)

Grief support groups provide participants with emotional support and understanding as they cope with the loss of a loved one. They may be found in most major cities and villages around the world, and there are many different types of support groups focusing on various topics. Some support groups, for example, qualify as group counselling and are conducted by a mental health professional, but others are more informal and are led by a peer.

Support groups can differ in a variety of ways, including attitude and culture, structure, and attendance (good vs. spotty), Groups that stay the same vs. groups that change, Focused on individual loss against general loss; advocacy and action vs sorrow experience.

Clients must choose a group therapy or support group that is a good fit for them in order to gain the benefits of group counselling or support groups.

Some of the following benefits can be used for withstanding Grief:

1. Instillation of hope by seeing those farther along in the grieving process who are functioning and coping well.
2. The universality of grief in a support group reminds the client that he is not alone there are many others who experience grief as well.
3. Information and insight sharing can help client get helpful suggestions, good advice, and general understanding.
4. The opportunity to practice and receive altruism, which is healing in and of itself.
5. The group cohesiveness can help client feel that he belong, that you are accepted, and that clients experience is valid.

However, grief support groups are not for everyone, and there are some pitfalls and disadvantages as well, including:

1. It can be overwhelming, especially when client are feeling vulnerable.

It can be discouraging to see others in the midst of their grief and leaves client feeling

hopeless.

2. They will likely not provide client with a therapy experience, especially if a peer is leading the group.
3. Client might get bad information or bad advice from others in the group.
4. Client may experience judgment from others, along with negativity and insensitivity.
5. There may be difficult people in the group who derail healing.
6. The culture of the group may be unhealthy or client may feel pressure to adopt beliefs client don't necessarily agree with .
7. If group therapy and support groups aren't intensive enough for client, he may want to try a grief retreat. These retreats offer clients the opportunity to work through client's grief over a long period of time, from a couple of days to a week or two. Some have schedules all attendees are expected to follow, while others are more self-directed, but they all give attendees a chance to connect with others who are grieving and talk with an expert in loss and grief.

Some activities for Relief from Grief

The Goodbye Letter – This is a worksheet designed for kids. It will assist them in saying their goodbyes to the deceased in a productive manner if they complete it.

Grief Sentence Completion – The Grief Sentence Completion worksheet encourages kids and teens to think about and communicate their feelings about loss.

The Grieving Process Handout – The reader will be guided through the regular grieving process as well as the more abnormal grieving process in this handout.

The Stages of Grief – This isn't the only model out there, but it's a popular one that refers to a variety of stages or feelings that bereaved people go through. These steps are outlined in this handout.

My Stages of Grief – Although Kübler-Ross' five-stage model of mourning is no longer regarded the canonical model of grief, some clients may find it beneficial to fill out this worksheet on their grieving progress.

Interventions for Prolonged Grief – This guide provides solution-focused tactics and strategies for assisting your client in coping with their loss and learning to function again.

Grieving is also a natural and even inescapable component of life. You may never be able to "get over" your loss, but you may learn to manage and cope with it so that you can continue living your life.

Objective Type questions

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1. Grief is individualistic in Nature. True/ False
2. Grief counseling don't apply to children. True / False

3. Although ---------- initially proposed that everyone moves through each of the five stages once and only once, she later acknowledged that some people may only experience two stages and that some people may revisit stages later in life. (**Kübler-Ross – answer)**
4. Who proposed that humans must undergo the “Four Tasks of Mourning” to heal: To accept the reality of the loss, To work through the pain of grief, To adjust to life without the deceased, to maintain a connection to the deceased while moving on with life. (**answer - W. Worden**)
5. Grief counseling done to many families during Covid-19 Pandemic situation. But many sufferers not aware of its value. Since virus is spreading grief counseling can be provided through …. So that people in remote areas also can benefit from it. (answer - Cell Phone)

Lesson 15:-Addiction counseling – III

Learning Objectives:

After completing the lesson, the student will be able to understand

1. What is history of Addiction
2. What definition of Addiction and related terminology.
3. What are different types of substances cause addiction?
4. Types of therapies applied to addiction.
5. Group therapy and its importance in helping addicted people.
6. How cognitive behavior therapy helps in helping addictive patients
7. What are associated health issues with addiction
8. What is difference between substance abuse and addiction
9. How yoga, meditation and pranayama helps in recovery for addictive patients.

What is Addiction?

The oldest definition of addiction, according to psychologists, is when a person loses control over something that has a gratifying effect and keeps them going back. The addicted person wishes to abstain, but they are unable to do so. Some addicts believe they have lost control over their activities. Internal conflict may arise between the impulse to fuel the addiction and the wish to abstain and recover control.

History of Addiction:

Sigmund Freud and William Halsted - Experiments

The term "addiction" dates back to the seventeenth century. The use of addictive substances including alcohol, opioids, cocaine, and cannabis may be traced back to Syria's, China's, and South America's ancient history.
Addiction was defined at the time as being forced to engage in any number of harmful practises.
Eaters: Narcotics abusers were dubbed "eaters" of opium and morphine. **Drunkard:** Alcohol abusers were referred to as drunkards.
Bad Habits: Dipsomania or alcoholism were the terms used in medical textbooks to describe these **"bad habits."**

On Coca: The diagnosis of addiction was not initially printed in medical literature until the nineteenth century. Sigmund Freud and William Halsted began testing with cocaine users in the 1880s. Sigmund Freud, in particular, believed that cocaine may be the solution to a

variety of mental and physical issues, and wrote a paper titled "On Coca" on its virtues. Freud began to recommend the drug as a way to cure morphine addictions, despite the fact that he was unaware of the substance's powerful addictive properties. Inadvertently, Freud and Halsted became guinea pigs in their own research over time, and their contributions to psychology and medicine revolutionised the world as a result. Freud openly supported cocaine and its purposes, even suggesting that it may be used as an anaesthetic. This theory was later proven to be correct. Most of his other claims regarding cocaine, on the other hand, were proven to be untrue, as was his support for the drug.

Pain Relief: Cocaine took over Freud's life while he was working at the Vienna General Hospital in Austria, where he discovered that the substance helped him with his migraines. When the effects of cocaine faded, Freud increased his cocaine consumption. Physicians began prescribing cocaine to their patients who needed pain treatment after learning about its pain-relieving effects.

W.H. Bentley, an American physician, was performing his own cocaine studies, unaware of Freud and Halsted's work. His essay in the Index Medicus described how he effectively treated individuals addicted to opium and alcohol with cocaine. It wasn't long before it was apparent that cocaine was significantly more addictive than previously thought, and that cocaine overdose was causing a significant number of deaths.

Cocaine use as a recreational drug spread like a worldwide pandemic in the late 1800s.

Addictive personality: As the use of cocaine became more widespread, doctors began seeking for new techniques to treat patients who were addicted to opiates, cocaine, or alcohol. Physicians contested the existence of the term "addictive personality," but they agreed that the features Freud possessed (bold risk-taking, emotional scar tissue, and mental turbulence) were characteristics that aided in the development of the "addictive personality."

Important Contributors

Psychoanalysis –Sigmund Freud

According to Freud, people are endowed with three levels of awareness: conscious, preconscious, and unconscious, where conscious level refers to what we are fully appreciative of, preconscious is what people could be aware of if they became more attentive, and unconscious level includes facts that humans cannot be aware of. The aim of the therapy is to turn unconscious into conscious.

Dream interpretation and **psychoanalysis** (also known as **talk therapy**) are two of his well-known contributions. Psychoanalysis is used to treat a multitude of conditions including addictions. As one of the most influential thinkers in the 20th century, he altered the way we perceive ourselves and communicate about our perceptions as a number of his theories have been popularized and terms he created have entered into general language.

William Halsted received his degree in medicine in 1877 conducted experiments with the drug cocaine. While their research was in process they became guinea pigs for their own experiments when they became addicted to cocaine. In 1884 he became the first to describe how cocaine could be utilized as a localized anesthetic when injecting into the

trunk of a sensory nerve, and how the localized ischemia prolonged the anesthetic properties of the drug.[

G. Alan Marlatt was a pioneer in the field of addiction psychology he spent his professional career as an addiction psychologist, researcher, and director of the University of Washington's Addictive Behaviors Research Center and professor in the Department of Psychology. Marlatt adopted the theory of harm reduction, and developed and scientifically tested ways to prevent an addict's slip from becoming a relapse. He understood that expecting immediate and complete abstinence from addicts often deterred addicts from seeking the help they needed and deserved.

Thomas McLellan was born in 1949 in Staten Island, New York. He is a professor at the University of Pennsylvania School of Medicine at the Center for Studies of Addiction. McLellan has conducted decades of research for the efficacy of treatment for substance abuse patients, and is recognized both at the national and international level as an addiction psychologist. He is also known for the development of the Addiction Severity Index or ASI

Arnold Washton has specialized in addiction since 1975 and is an addiction psychologist known for his work in the development of therapeutic approaches to the treatment of drug and alcohol abuse. He is the author of many books and professional journal articles on treatment and addiction. He is a lecturer, clinician, researcher, and has served on the advisory committee for the US Food and Drug Administration.

William L. White is a Senior Research Consultant at Chestnut Health Systems, an addiction counselor, researcher and writer in the field of addiction for over 45 years. He wrote over 400 papers and 18 books. He received awards from the National Association of Addiction Treatment Providers.

Terminology in Addiction:

Addiction and dependence glossary

- **addiction –** a biopsychosocial disorder marked by the continued use of drugs (including alcohol) in the face of significant harm and negative consequences
- **addictive drug –** Because of the drug's effect on brain reward circuits, psychoactive substances are linked to dramatically greater incidence of substance use disorders with repeated use.
- **dependence –** When recurrent exposure to a stimulus is stopped, an adapted state is accompanied with a withdrawal syndrome (e.g., drug intake)
- **drug sensitization or reverse tolerance -** - the drug's rising effect as a result of repeated administration at the same dose
- **drug withdrawal** – Symptoms that appear when you stop using a medicine after a long period of time.
- **physical dependence** – Chronic physical–somatic withdrawal symptoms are a sign of dependence (e.g., fatigue and delirium tremens)
- **psychological dependence –** Emotional–motivational withdrawal symptoms are a symptom of dependence (e.g., dysphoria and anhedonia)

- **reinforcing stimuli –** Pairing them with triggers that increase the likelihood of repeating behaviours
- **rewarding stimuli –** stimuli that the brain understands as innately pleasant and desirable, or as something to strive for
- **sensitization –** a response to a stimulus that has been magnified as a result of repeated exposure to it
- **substance use disorder –** a disorder in which substance abuse causes considerable clinical and functional damage or suffering

tolerance – the impact of a medicine lessening as a result of repeated administration at a given dose

An addiction is a chronic dysfunction of the brain system that involves reward, motivation, and memory. It's about the way your body craves a substance or behavior, especially if it causes a compulsive or obsessive pursuit of "reward" and lack of concern over consequences.

When considering only their chemical makeup, there are six main classifications of drugs: alcohol, opioids, benzodiazepines, cannabinoids, barbiturates, and hallucinogens. Out of all the thousands of drugs that are out there, both prescription and illegal, each one can be categorized under one of these six headings.

Definition of addiction

An addiction is a chronic dysfunction of the brain system that involves reward, motivation, and memory. It's about the way addicts body craves a substance or behavior, especially if it causes a compulsive or obsessive pursuit of "reward" .

Someone experiencing an addiction will: Be unable stay away from the substance or stop the addictive behavior, display a lack of self-control, have an increased desire for the substance or behavior, dismiss how their behavior may be causing problems, lack an emotional response.

Over time, addictions can seriously interfere with daily life. People experiencing addiction are also prone to cycles of relapse and remission. This means they may cycle between intense and mild use. Despite these cycles, addictions will typically worsen over time. They can lead to permanent health complications and serious consequences like bankruptcy.

The most common drug addictions are: nicotine, found in tobacco,THC, found in marijuana,opioid (narcotics), or pain relievers,cocaine,Substances or behaviors that can trigger addiction. The most well-known and serious addiction is to drugs and alcohol

Besides nicotine, drugs, and alcohol, other common addictions include:

Coffee or caffeine, gambling, anger, as a coping strategy , food, technology,sex, work. (Technology, sex, and work addictions are not recognized as addictions by the American Psychiatric Association in their most recent edition of the Diagnostic and Statistical Manual of Mental Disorders).

Most signs of addiction relate to a person's impaired ability to maintain self-control. This includes changes that are:

Social: such as seeking out situations that encourage a substance or behavior

Behavioral: such increased secrecy

Health related: such as insomnia or memory loss

Related to personality: Someone with an addition won't stop their behavior, even if they recognize the problems the addiction is causing. In some cases, they'll also display a lack of control, like using more than intended.

Withdrawal: Some habits or social behaviors look like addiction. But in the case of an addiction, a person will typically react negatively when they don't get their "reward." For example, someone addicted to coffee can experience physical and psychological withdrawal symptoms such as severe headaches and irritability.

Some behavior and emotional changes associated with addiction include:

1. Unrealistic or poor assessment of the pros and cons associated with using substances or behaviors
2. Blaming other factors or people for their problems
3. Increased levels of anxiety, depression, and sadness
4. Increased sensitivity and more severe reactions to stress
5. Trouble identifying feelings
6. Trouble telling the difference between feelings and the physical sensations of one's emotions
7. Learn to recognize the signs of addiction

The stages of addiction will often play out in stages. Human brain and body's reactions at early stages of addiction are different from reactions during the later stages.

The four stages of addiction are:

Experimentation: uses or engages out of curiosity.

social or regular: uses or engages in social situations or for social reasons

Problem or risk: uses or engages in an extreme way with disregard for consequences

Dependency: uses or engages in a behavior on a daily basis, or several times per day, despite possible negative consequences.

Pleasurable “high”

Addictive substances and behaviors can create a pleasurable “high” that’s physical and psychological. One typically use more of certain substances or engage in behaviors longer to achieve the same high again. Over time, the addiction becomes difficult to stop.

Bio psychosocial disorder

Addiction is a bio psychosocial disorder characterized by compulsive engagement in rewarding stimuli despite adverse consequences. A variety of complex neurobiological and psychosocial factors are implicated in the development of addiction, with the predominant paradigm among researchers in the United States being the Brain Disease model, though debate exists within the field over relative contribution of any given factor.

Impaired control

Classic hallmarks of addiction include impaired control over substances or behavior, preoccupation with substance or behavior, and continued use despite consequences.

Immediate Gratification:

Habits and patterns associated with addiction are typically characterized by immediate gratification (short-term reward), coupled with delayed deleterious effects (long-term costs).

Some Addictions:

Examples of drug and behavioral addictions include alcoholism, marijuana addiction, amphetamine addiction, cocaine addiction, nicotine addiction, opioid addiction, food addiction, chocolate addiction, video game addiction, gambling addiction, and sexual addiction. The only behavioral addiction recognized by the DSM-5 and the ICD-10 is gambling addiction. With the introduction of the ICD-11 gaming addiction was appended.

Drug Addiction and Dependence:

The term "addiction" is frequently misused when referring to other compulsive behaviors or disorders, particularly dependence, in news media. An important distinction between drug addiction and dependence is that drug dependence is a disorder in which cessation of drug use results in an unpleasant state of withdrawal, which can lead to further drug use.

Addiction is the compulsive use of a substance or performance of a behavior that is independent of withdrawal. Addiction can occur in the absence of dependence, and dependence can occur in the absence of addiction, although the two often occur together.

According to the National Institute on Drug Abuse, addiction differs from substance abuse in that it is a chronic disease that is incredibly difficult to control. Abuse of certain substances,

such as alcohol or prescription drugs, can cause chemical changes in the brain that lead to addiction. These changes compel someone to keep using the substance that they are addicted to, no matter what the negative effects may be. “Drug addiction has a more severe presentation than drug abuse,” “With the physical symptoms [of addiction] comes the psychological element of feelings of helplessness and hopelessness in having control over addiction behaviors,”

Common Symptoms of drug addiction Include:

- Developing a tolerance to the drug
- Experiencing withdrawal symptoms when you try to stop using
- Being unable to stop, even when you want to
- Constantly thinking about the drug, how to get it, and how it makes you feel
- Inability to complete daily tasks
- Relationship problems with friends, family, and co-workers
- Sleeping too little or too much
- Changes in appetite
- Changes in appearance including bloodshot eyes, weight gain or loss, tremors, and shakes
- Lack of personal hygiene
- Mixing drugs and alcohol
- Stealing or borrowing money to pay for drugs
- Abusing prescriptions to get more of certain drugs
- Irritability, agitation, and changes in motivation

The brain – Frontal Lobe:

Some people may try a substance or behavior and never approach it again, while others become addicted. This is partially due to the brain’s frontal lobes. The frontal lobe allows a person to delay feelings of reward or gratification. In addition, the frontal lobe malfunctions and gratification is immediate.

Additional areas of the brain may also play a role in addiction. The anterior cingulate cortex and the nucleus accumbens, which is associated with pleasurable sensations, can increase a person’s response when exposed to addictive substances and behaviors.

Brain – Chemical Imbalance:

Other possible causes of addiction include chemical imbalances in the brain and mental disorders such as schizophrenia or bipolar disorder. These disorders can lead to coping strategies that become addictions.

Early exposure - Family

Experts believe that repeated and early exposure to addictive substances and behaviors play a significant role. Genetics also increase the likelihood of an addiction by about 50 percent,

according to the American Society of Addiction Medicine. But just because addiction runs in the family does not necessarily mean a person will develop one.

Environment and Culture:

Environment and culture also play a role in how a person responds to a substance or behavior. A lack or disruption in a person's social support system can lead to substance or behavioral addiction. Traumatic experiences that affect coping abilities can also lead to addictive behaviors.

Addiction that's left untreated can lead to long-term consequences. These consequences can be:

physical, such as heart disease, HIV/AIDS, and neurological damage
psychological and emotional, such as anxiety, stress, and depression
social, such as jail and damaged relationships
economic, such as bankruptcy and debt
Different substances and behaviors have different effects on a person's health. Serious complications can cause health concerns or social situations to result in the end of a life.

All types of addiction are treatable. The best plans are comprehensive, as addiction often affects many areas of life. Treatments will focus on helping any or the person we know stop seeking and engaging in their addiction.

Therapy often decreases in frequency and duration as a person learns to cope with the causes of his or her addiction and to handle life's stressors. However, many experts believe a person never fully recovers from addiction. People who experience a traumatic event or increased stress should turn to therapy to decrease the chances of relapse.

Therapy isn't a one-size-fits-all process. Different approaches are more appropriate and effective for different people, depending on their age, type of addiction and the factors that contributed to their addiction.

13 principles of effective drug addiction treatment

These 13 principles of effective drug addiction treatment were developed based on three decades of scientific research. Research shows that treatment can help drug-addicted individuals stop drug use, avoid relapse and successfully recover their lives.

1. Addiction is a complex, but treatable, disease that affects brain function and behavior.
2. No single treatment is appropriate for everyone.
3. Treatment needs to be readily available.
4. Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.
5. Remaining in treatment for an adequate period of time is critical.

6. Counseling— individual and/or group —and other behavioral therapies are the most commonly used forms of drug abuse treatment.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure it meets his or her changing needs.
9. Many drug-addicted individuals also have other mental disorders.
10. Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.
11. Treatment does not need to be voluntary to be effective.
12. Drug use during treatment must be monitored continuously, as lapses during treatment do occur.
13. Treatment programs should assess patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, as well as provide targeted risk-reduction counseling to help patients modify or change behaviors that place them at risk of contracting or spreading infectious diseases.

Source: National Institute on Drug Abuse. These principles are detailed in NIDA's *Principles of Drug Addiction Treatment: A Research-Based Guide*.

According to the National Institute on Drug Abuse, people begin taking drugs for a variety of reasons, including:

to feel good — feeling of pleasure, "high" or "intoxication"
to feel better — relieve stress, forget problems, or feel numb
to do better — improve performance or thinking
curiosity and peer pressure or experimenting

People can develop an addiction to:

Alcohol
Marijuana
PCP, LSD and other hallucinogens
Inhalants, such as, paint thinners and glue
Opioid pain killers, such as codeine and oxycodone, heroin
Sedatives, hypnotics and anxiolytics (medicines for anxiety such as tranquilizers)
Cocaine, methamphetamine and other stimulants
Tobacco

Common therapies include:

Usually the medications, to help treat serious complications of addiction, like withdrawal during detox, the addiction case manager can help in any de addiction center, to help coordinate and check ongoing treatment, inpatient addiction treatment, self-help and support groups. There will be some probles associated with addiction in some cases. The problems can be mental disorders such as depression or schizophrenia, suicidal tendencies

etc. so psychotherapy, including behavioral, talk, and group therapies, medical services are applied based on the clients requirement.

Now a days medical facilities, therapeutic interventions, psychological therapies, de addiction centers are available. So the needy can visit primary care doctor for an evaluation. The type of treatment a doctor recommends depends on the severity and stage of the addiction. With early stages of addiction, a doctor may recommend medication and therapy. Later stages may benefit from inpatient addiction treatment in a controlled setting.

Now a days in India, in every city and especially Andhra Pradesh, in every government hospital we can see de-addiction centers. Overcoming addiction is a long journey. Support can go a long way in making the recovery process more successful. Many organizations can help, depending on the type of addiction.

Local community groups, online forums, addiction information and experts, treatment plans and a strong social support system is important during recovery. Letting the addicts friends, family, and those closest to the addict know about treatment plan can help keep on track and avoid triggers.

If anyone is aware of or someone one know has an addiction, confidentially we can refer that case to de-addiction centers run by government and seek free treatment. It should be done immediately if addict has suicidal thoughts or actions.

Anyone suffering from a drug or alcohol addiction knows how powerful and devastating this disease can be. Sometimes a person abusing substances believes they are managing addiction on their own, when in reality their addiction is managing them. A licensed addiction counselor can help a person abusing substances at any stage of readiness to achieve and maintain sobriety.

Counselors are an important part of addiction therapy, and their role and involvement in the treatment process is instrumental to recovery.

Addiction counselors can help support you throughout the treatment process and create an individualized plan for recovery, relapse prevention, and after-care. There are various types of therapy available while in treatment that will provide an array of benefits and allow you to sustain your sobriety while in recovery.

In India now the services are offered by National health centers, national mental health centers free of cost and with residential facilities. The NIMHANS – Bangalore is world famous and the research continuously going on in the NIMHANS for bringing change in the lives of addicts, in the form of not only providing medical treatment, but psychotherapies, rehabilitating the persons, offering family and couple therapies for addicted families also.

The Addiction counselors Role :

Addicts and their families can work with an addiction counsellor to explore what led them to use drugs or alcohol, share and process feelings, increase awareness of negative thought and behaviour patterns, learn healthy coping skills, identify potential triggers, and develop a long-term plan to stay sober. Addiction counselling is used widely in both inpatient and outpatient treatment programmes, and it can be done individually or in groups.

An addiction counselor's responsibilities also include conducting substance misuse examinations and general assessments, providing unbiased emotional support for patients during a treatment programme, and assisting with the implementation of treatment plans. To get to the base of the addiction, conduct one-on-one, couple, and family therapy sessions. Psychoeducation should be provided. Assist in the facilitation of process groups and group exercises. Administer drug and alcohol tests on a regular basis. Develop a specific treatment plan based on the client's requirements and goals, and assist the client in developing an aftercare plan based on the services available in his or her location.

Group Therapy: Addiction counselors will also conduct group therapy sessions that often incorporate family members or other patients in addiction treatment. Group therapy can lead to discussions about family dynamics and how unhealthy relationships can create or feed into addictive behaviors. Once these dysfunctions are identified, the patient can begin making important post-treatment plans.

Process of counseling:

In both individual and group therapy, an addiction counsellor works with patients to assess their circumstances and set goals in order to create a personalised treatment plan. The counsellor should be an excellent listener and have a compassionate demeanour generally. The goal of the initial therapy sessions is to build the groundwork for mutual trust, which is essential for a good conclusion.

Counselors give a safe place for the user to openly talk by empathising (many are former addicts themselves) and being patient. This will aid the counsellor in determining the underlying issues that are causing the addicted behaviour. Long-term recovery is less possible without pinpointing the underlying issue, which is why this portion of therapy is so important.

Any co-occurring mental health disorders will be diagnosed and treated by a qualified therapist. The desire and commitment to help their patients proceed through the phases of change with the ultimate goal of obtaining long-term abstinence is the most critical attribute in a successful addiction counsellor.

Symptoms of substance use disorder are grouped into four categories:
Impaired control: a craving or strong urge to use the substance; desire or failed attempts to cut down or control substance use
Social problems: substance use causes failure to complete major tasks at work, **school or home;** social, work or leisure activities are given up or cut back because of substance use
Risky use: substance is used in risky settings; continued use despite known problems
Drug effects: tolerance (need for larger amounts to get the same effect); withdrawal symptoms (different for each substance)
Need for Counseling

Substance abuse is more than just a physical addiction to drugs or alcohol. Even after detox, when the body is no longer dependant, relapse is a real possibility. Certain psychological and social circumstances, particularly in the context of relapse, can be significant triggers. Stress, particularly unexpected life challenges, can be debilitating. Environmental cues, such as visiting a neighbourhood, Social networking sites, as well as spending time with friends who continue to use, can all lead to a strong desire to use again. Counseling can help you overcome cravings and learn to cope with life's challenges without the use of drugs or alcohol.

Several counseling therapies treat substance use disorders. No one method is known to be better than another. Likewise, no one approach works for everyone with opiate addiction. The right treatment plan will be tailored to addiction and individual needs.

A person's recovery plan is unique to the person's specific needs and may include strategies outside of formal treatment. These may include:
Hospitalization for medical withdrawal management (detoxification)
Therapeutic communities (highly controlled, drug-free environments) or sober houses
Outpatient medication management and psychotherapy
Intensive outpatient programs
Residential treatment ("rehab")
Many people find mutual-aid groups helpful (Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery)
Self-help groups that include family members (Al-Anon or Nar-Anon Family Groups)
The Therapies available and found to be good for addiction are:

Biofeedback and Neuro-feedback:

These therapies use real-time displays of brain activity to monitor levels of muscle tension, blood pressure, and heart rate. This trains the patient on how to manipulate brain function in order to gain some control over their physiological processes.

Behavioral therapy

Cognitive behavioural therapy (e.g., relapse prevention and contingency management), motivational interviewing, and a community reinforcement approach were found to be effective interventions with moderate effect sizes in a meta-analytic review of the efficacy of various behavioural therapies for treating drug and behavioural addictions.

According to the 2014 National Survey of Substance Abuse Treatment Services, behavioural therapies are used more than any other therapeutic practise in addiction treatment centres. Behavioral therapies assist patients in comprehending the causes of high-risk behaviour and developing strategies for avoiding or dealing with high-risk circumstances.

Cognitive -Behavioral Therapy (CBT).

Because it focuses on the relationship between ideas and the behaviours and choices that follow, CBT is useful in treating addiction and mental health disorders. A counsellor can utilise CBT to help patients identify triggers that lead to drug or alcohol abuse and then replace unhealthy responses with healthier ones.

CBT, or cognitive behavioural treatment, teaches people learn to detect the moods, ideas, and events that make them crave drugs. You'll learn how to avoid these triggers with the help of a therapist. One learns to replace bad ideas and sensations with healthy ones that will help them maintain their clean status.

This is a highly effective therapy approach. However, not all therapists have received training in cognitive behavioural therapy.

The goal of cognitive behavioural therapy is to learn how to lessen the negative behaviours that come with substance dependence. Anticipating risky situations and using coping skills such as avoidance or self-control to prevent relapse is a central element in CBT.

Counselors utilise CBT to treat a range of addictions, and it is one of the most prominent therapy in addiction medicine. Marijuana, cocaine, methamphetamine, nicotine, and a variety of other substances are among them.

Using a number of techniques, patients learn to detect and modify dangerous behaviour during CBT. They discover the root reasons of harmful behaviour so that they can address the issue at its source. They're able to identify urges or triggers and devise techniques to deal with them. Patients who gain skills during CBT are able to apply them in real-world circumstances later in life, according to research.

Dialectical Behavior Therapy (DBT).

DBT is a treatment for people who have a dual diagnosis, and one of the main goals is to help patients acquire confidence and coping skills so they can deal with stressful events in a healthy way. DBT can help patients with diseases including Borderline Personality Disorder and eating problems by improving communication skills and self-image.

DBT (dialectical behaviour therapy) is a type of treatment that focuses on acceptance and change. DBT was developed in the 1970s to treat suicidal people, but it has now been adopted for other purposes, including substance use problems. The focus of treatment for substance use disorders is on reducing substance use and the behaviours that lead to it, as well as promoting healthy behaviours (such as the formation of strong relationships) that assist the person avoid using.

Patients who struggle to regulate their emotions and have suicidal or self-harming ideas benefit from dialectical behaviour therapy. Acceptance of unfavourable thoughts, feelings, or behaviours is emphasised in this therapy in order for patients to overcome them.

Relaxation practises, such as yoga, are used in DBT to assist patients become more conscious of their thoughts and feelings. Tolerating self-destructive ideas or cravings requires skills such as controlled breathing and muscle relaxation. The goal is to reduce self-harming behavior's frequency and severity while also encouraging positive change.

DBT has been shown to help people with a variety of problems, including mood disorders, personality disorders, eating disorders, and self-destructive conduct.

Eye Movement Desensitization and Reprocessing

Eye movement desensitization and reprocessing therapy alleviates distress associated with traumatic memories and symptoms of post-traumatic stress disorder, which commonly cause or worsen substance use disorders.

EMDR therapy helps the patient reprocess the memory of a traumatic event so it is less painful. The patient performs external eye movements while thinking of the traumatic event. The process teaches the brain to associate the memory with less upsetting feelings so it can heal.

Studies indicate EMDR can relieve symptoms of PTSD after three 90-minute sessions. Patients with severe PTSD symptoms, such as combat veterans, usually require more sessions than individuals with less severe symptoms.

Holistic Therapies.

Meditation, Hypnotherapy, Guided Imagery, and Mindfulness.

Identifying triggers, managing stress responses, and adopting deep relaxation techniques are all part of these types of therapies. The goal of this sort of treatment is to put a person in a relaxed state of mind so that they may use healthy coping methods to deal with cravings, emotions, and stress. Aromatherapy is a great way to supplement these types of treatments.

Holistic therapy, in addition to established therapeutic modalities, assists patients in practising introspection and learning good coping skills. It also allows patients who are hesitant to open up in traditional therapy sessions a non-threatening approach to express their deepest worries and issues. Yoga, art therapy, music therapy, and equine therapy are examples of holistic therapies that might be beneficial in the treatment of addictions.

In order to treat the full person, quality addiction treatment centres also offer nutrition and wellness, as well as a range of other sorts of therapies, with the ultimate goal of leading the patient toward a permanent recovery.

It takes a lot of effort to break a habit of prescription drugs, illicit drugs, or alcohol — or any other substance use disorder. You have a lot to be proud of, but there is still work to be done. Detox is merely the first step in a long process of learning to control cravings and avoid relapse.

For many people, counselling is an important part of their recovery from substance abuse. You can stay clean through cognitive behavioural therapy, family counselling, and other sorts of therapy. Other mental health disorders that frequently play a role in substance misuse can be treated with psychotherapy.

Yoga

Yoga is an exercise that emphasizes controlled breathing and body postures to promote physical strength, concentration and serenity. Clinical trials involving yoga and mindfulness found the therapies were effective complements to preventing and treating addiction, according to a study published in Complementary Therapies in Medicine.A meta-analysis of studies on meditation published in Alcoholism Treatment Quarterly found that the technique can reduce stress, anxiety, tobacco smoking, and alcohol and drug abuse. Additionally, a clinical trial on mindfulness therapy published in the Journal of Consulting and Clinical Psychology found yoga was a feasible and effective treatment for opioid abuse and chronic pain.

Animal Therapy

Several therapies for addiction involve animals. During equine therapy, one of the most popular animal-assisted therapies, patients interact with horses. The horses give feedback through nonverbal cues. The patients learn to understand their own emotions and overcome negative emotions such as frustration and fear.
Other therapies involve people in recovery voluntarily helping animals at shelters or having animals during traditional therapy sessions. Research indicates animal- or pet-assisted therapy can improve a patient's participation in treatment and willingness to talk about any history of trauma or substance abuse. Animal assisted therapy can also reduce stress, fear and anxiety.

Contingency Management Therapy

This strategy provides you with positive reinforcement for being clean. Vouchers for products and services are widespread, as are privileges in a more rigorous treatment context.

Positive conduct is reinforced with tangible rewards in contingency management and motivational incentive methods to therapy. The therapies are used in conjunction with other types of therapy to help people stay abstinent during counselling.

The Matrix Model

The Matrix model gives individuals in recovery from stimulant addiction a framework for maintaining abstinence. It's primarily used in patients recovering from methamphetamine or cocaine addiction.
Therapy using the Matrix model involves a variety of evidence-based therapies that promote relapse prevention and encourage family therapy, education and support-group participation. Therapy sessions usually include detailed worksheets or manuals for the patient to reference.
The therapist is a teacher and coach, developing a positive relationship with the patient and promoting behavioral change. The therapist promotes dignity and self-worth in the patient who avoids confrontational communication. However, the Matrix model does involve drug testing.

Motivational Interviewing

Using this strategy, therapists attempt to motivate and assist in maintaining drug or alcohol sobriety. If the addict is motivated by a desire to be with his or her family or to return to work, these difficulties may become the focus of therapy.

Motivational therapies are the second-most-used therapy in drug rehabilitation centres. Patients might use the therapies to assist them develop internal motivation to start or maintain treatment. They are frequently used in conjunction with behavioural therapy to create incentives for sustaining sobriety.

Motivational enhancement treatment is a sort of motivational interviewing that is specifically designed for substance dependence. It alleviates patients' fears or apprehensions about starting treatment or ending their drug use. Instead than teaching patients how to change, the idea is to encourage them to do it.

An examination precedes two to four individual counselling sessions in the MET programme. The therapist starts by getting motivational remarks from the client. He or she encourages the patient's initiative, and the two talk about how to deal with potentially dangerous situations. The next sessions will focus on tracking progress, evaluating strategy, and maintaining internal drive.

Other types of therapy, such as CBT, are frequently used in conjunction with MET. It's a good way to bring individuals into therapy, but it shouldn't be the only treatment option.

Acupuncture

Acupuncture therapists insert fine needles into the body to stimulate healing. Acupuncture is a complementary treatment option at several rehab facilities, and people in self-help programs also report benefits from acupuncture.

A study of patients in recovery from cocaine addiction published in the Archives of Internal Medicine found patients assigned to acupuncture therapy were more likely to abstain from cocaine use. Another study published in the American Journal of Public Health found acupuncture significantly improved tobacco smoking cessation rates.

Family or couples therapy

Addiction has a profound impact on the lives of addicts and their families. When you have solid relationships with your family and friends, you are more likely to have a successful therapy. Spouses and other family members are used in a variety of therapeutic strategies.

In life, family members can be a tremendous force for change. They may be more likely to stay in therapy if they are included. They can start to repair the harm that addiction has done to their lives. According to studies, family therapy reduces relapse rates, increases family satisfaction, and aids children of addicted parents in coping with their condition.

Multisystemic family therapy is most commonly used to treat severe antisocial behaviour in children and adolescents who are addicted to drugs or alcohol. MST has a number of objectives: Improve family discipline, teach dispute resolution skills, eliminate parental drug usage, improve school attendance and performance, and eliminate drug prevalence in the environment.

Treatment takes place in natural settings like the home, school, or neighbourhood, and it has been shown to reduce incarceration and substance misuse rates.

Multidimensional Family Therapy

Outpatient treatment for drug-abusing teenagers is multidimensional family therapy. To eliminate harmful behaviour and increase good behaviour, it focuses on individual, family, peer, and community networks.

MDT takes place in clinics, family courts, schools, and private residences. Individual and family sessions are typically used to teach the adolescent decision-making and problem-solving abilities. Parents explore their parenting approach and learn to positively and successfully impact healthy behaviour during family sessions.

Brief Strategic Family Therapy

Brief strategic family therapy is used by therapists to prevent family relationships that support or intensify juvenile drug use or problematic conduct. Problems at school, delinquency, involvement with anti-social peers, aggressive tendencies, and high-risk sexual behaviour are examples of such behaviour.

BSFT is based on the idea that each family member's actions have an impact on the entire family. The therapist is responsible for identifying and correcting problematic family interactions. The method can be applied in a variety of contexts, including mental health facilities, rehab clinics, residences, and more.

Functional Family Therapy

The theory behind functional family therapy is that dysfunctional family relationships cause and support problematic behaviour. FFT aims to increase communication, problem-solving abilities, and parenting abilities. The adolescent and one or more family members attend each therapy session.

To enhance motivation for change, FFT involves families in the therapy process. Contingency management strategies and other sorts of behavioural treatment are also included.

Adolescent Community Reinforcement Approach

Adolescent community reinforcement is comparable to adult community reinforcement, but it includes structured methods for better communication, problem solving, and stress management. The use of role-playing and behavioural rehearsal techniques is an important part of the therapy.

Assertive Continuing Care

Weekly home visits during the three-month period following a teenager's discharge from a drug rehab facility are part of assertive continuing care. Teens and their caregivers are taught problem-solving skills, communication strategies, and other tools to help them heal.

Maintenance Therapy

Addiction is a long-term disease. It is very likely that those who have it will relapse.

Once you've completed detox, you'll almost certainly require lifelong therapy, which may involve counselling and potentially medication. Currently, the FDA has approved three medications to treat opioid addiction and three drugs to treat alcohol addiction.

Horticultural Therapy

Horticultural therapy involves gardening and other plant-based activities led by a trained therapist. Studies indicate horticultural therapy, also referred to as garden therapy and therapeutic gardening, can enhance critical thinking, improve attention span, decrease stress, reduce anxiety and improve social integration.

Effective substance abuse treatment requires patients to address all underlying causes of addiction. Most patients undergo multiple therapies to address all of the causes. Counseling and therapy are essential tools in the recovery process and have been proved to help individuals in recovery.

Music Therapy

Music therapy techniques include lyric analysis, songwriting, musical games and ad-libbing music based on emotions. During music therapy, patients engage emotions, motivations and barriers to treatment through lyrics and melody.

Research on music therapy has found songwriting can promote healthy change, drumming can promote relaxation and dancing can reduce stress, anxiety and symptoms of depression. A study published in the Drug and Alcohol Review found music therapy was positively associated with a patient’s willingness to participate in treatment

Exercise:

Consistent aerobic exercise, particularly endurance exercise (e.g., marathon running), appears to prevent the development of certain drug addictions and is an effective adjunct treatment for drug addiction in general, and psychostimulant addiction in particular, according to clinical and preclinical evidence.

Consistent aerobic exercise reduces drug addiction risk in a magnitude-dependent manner (i.e., by time and intensity), which appears to occur through the reversal of drug-induced addiction-related neuroplasticity.

According to one study, exercise can help people from becoming addicted to drugs by modifying immunoreactivity in the striatum and other regions of the reward system.

Aerobic exercise reduces drug self-administration, lowers the risk of relapse, and has the opposite effect on striatal dopamine receptor D2 (DRD2) signalling (increased DRD2 density) than addiction to a variety of drugs (decreased DRD2 density). As a result, when employed as an additional treatment for drug addiction, persistent aerobic exercise may contribute to better treatment success.

Art Therapy

Patients express themselves by drawing, painting, sculpting or creating art journals during art therapy. Art therapy techniques also include stress painting, in which patients paint during periods of high stress, and the creation of incident drawings: illustrations of events that transpired during substance abuse.

Some therapists emphasize interpretation and contemplation as therapeutic techniques during art therapy. Studies on art therapy indicate it can decrease denial, treatment avoidance and shame It can also be used to facilitate group discussions and motivate change.

Individual vs. Group Therapy

While any counselling therapy for drug abuse treatment is preferable to none, group therapy is often chosen over individual therapy for drug abuse treatment. It is more likely to be challenged and supported by peers who are also going through treatment in group therapy.

Individual counselling can help if you have depression, bipolar disorder, or any serious mental health problem that needs to be treated apart from your substance abuse problem.

Outpatient vs. Residential Treatment

In fact, going from a controlled, inpatient environment to home, where it's easy to start using again, may increase your chances of relapse. Furthermore, residential treatment programmes are costly.

The most common environment for drug and alcohol misuse therapy is outpatient treatment programmes.

Objective Type Questions:

mark the correct answer

1.Emotional–motivational withdrawal symptoms are a symptom of dependence are known as	**A**	Psychological Dependence
	B	Physical dependence
	C	Substance use disorder
	D	Resistance

2. CBT – is	**A**	Cognitive Behaviour Therapy
	B	Communication behavior therapy
	C	Cognitive based treatment
	D	Controlled behavior therapy

3. NIMHANS is located in	A	Bangalore - India
	B	Chennai - India
	C	London - UK
	D	Delhi - India

Fill up the blank:

4. The frontal lobe allows a person to delay feelings of reward or gratification. In addition, the frontal lobe malfunctions and gratification is ---------- . (ans - immediate)

Mark True/false

5. Dream interpretation and psychoanalysis (also known as talk therapy) are two of his well-known contributions. Psychoanalysis is used to treat a multitude of conditions including addictions