NETAJI SUBHAS OPEN UNIVERSITY

School of Vocational Studies

Self Learning Materials

Advance Diploma in Psychological Counselling

PAPER-3

Counselling and Psychotherapies Basic

(Theory)

Writer:
Dr. Rajkumari Basu
Associate Professor, Loreto College (Rtd.)
Ms. Barnali Dutta
Teacher & Special Educator, Founder of MindCloak,

➢ UNIT-1 COUNSELLING BASICS / MENTAL HEALTH

STRUCTURE:

OBJECTIVES:

After studying this unit, we will be able to understand

- The basic concept of counselling and mental health
- Counselling and guidance
- Essential skills of a counsellor
- Methods and techniques applied in counselling
- How to apply counselling in medicine and psychiatry
- Different areas of counselling
- Legal and ethical factors involved in counselling

COUNSELLING

INTRODUCTION:

In our busy world we are instantly struck by its complexities, and the most importantly this state of affair is man's own making. Man has not only adopted himself to the world and its conditions but to a large extent successfully modified the environment to suit his needs.

A significant result of this interaction between man and environment is the series of material changes brought about in the world. Technological changes have made major impact upon people's lives and work. Industrialization has resulted in social and vocational mobility. In order to cope up with the rapidly changing world around him man start the guidance movement and this movement later led to the growth of counselling psychology in the first decade of the 20th century, based on man's concern for his fellow men and their wellbeing.

Counselling must have existed in one form or another since the very beginning of human civilization. Man must have sort comfort, help and solace from family and close associates. However, it is only in the recent past that counselling emerged as a distinct branch of psychology. Modern psychology is a product of the educational system which has its deep roots in the concern for an individual's rights, dignity and worth as a human being.

DEFINITIONS:

A popular definition is, "Counselling is an interactive process conjoining the counselee who needs assistance and the counsellor who is trained and educated to give this assistance" (Parez. 1965).

According to the American Counselling Association (ACA), counselling is defined as "Counselling is a professional relationship that empowers diverse individuals, families and groups to accomplish mental health, wellness, and education and career goals."

Counselling also has been defined as "a process which takes place in a one-to-one relationship between an individual beset by problems with which he cannot cope alone and a professional worker whose training and

experience have qualified him to help others reach solutions to various types of personal difficulties" (Hahn and MacLean,1955)

In simple words, counselling is building up a therapeutical relationship between a therapist and one or more clients where the former employs certain skills based on systematic knowledge of the human personality in attempting to bring about a voluntary change in the client. It is directed to self-realization and self-direction. It is essentially a learning process.

GOALS:

The purpose of counselling is to help individuals overcome their immediate problems and also to equip them to meet future problems.

Goals of counselling are immediate, long range and intermediate/process. The immediate goal, however, is to obtain relief for the client and the long-range goal is to make him a "fully functioning person". Both the immediate and long-term goals are secured through what are known as mediate or process goals.

Some of the major goals of counselling:

1) SELF ESTEEM IMPROVEMENT-Self-esteem is the core of our personality. If the core is imbalanced the whole personality is affected. For achievement of ultimate goal of "Relative positive mental health", achievement of balanced self-view with positive self-esteem is necessary.

2) AUTONOMY/SELF DEPENDENCE- The counselee should be able to achieve through counselling, optimum autonomy of thoughts, emotions and actions with self-sufficiency, minimum dependence on his physical and social environment especially other persons around him.

3) TRUST AND FAITH IN SELF POTENTIAL FOR GROWTH- Through counselling, the counselee learns to trust himself, his self-worth, self-confidence, self- directiveness, and decision making and judgement, not as impulsive but well- judged.

4) AWARENESS- One of main objective of counselling is 'Increased awareness' a sense of 'activeness and responsiveness', his/her capacity to appreciate his environment with a fresh look and a deeper environment.

5) SPONTANEITY- Being spontaneous in thoughts, feelings and actions means a person shows reduction in rigidity and defensiveness, cultivating openness, for change, novelty, and variety of experiences of others and own.

6) AUTHENCITY/GENUINENESS- Being 'genuine self 'means not keeping a 'façade' not having 'hypocrisy", or double- standard in relation to others. A genuine person, thus, more involved in life experiences, and never faces alienation or 'meaninglessness' of life.

7) BEING 'FULLY FUNCTIONING PERSON'- To reach this goal, even to some extent, a person has to learn to 'Life here and now' which means an increasing tendency to live life fully, not being apprehensive or using 'readymade' methods for working on future problems of life.

8) SELF-ACTUALIZATION-A major goal of not only counselling process, but of everyone 'LIFE' itself, is self-actualization (Maslow). An actualizing person is conscious of his abilities and expectations to match each life stage development. Jahoda has developed, six key criteria for mental health for effective coping up problems and situations in life. These are: a) A person's attitude toward himself as balanced self-view. b) Awareness of self-actualization potential. c) Integrated personality. d) Autonomy and self-reliance. e) Reality orientation. f) Accepting life as it comes and environmental mastery.

PURPOSE OF COUNSELLING:

With all sorts of unexpected challenges, stressors, and problems in life, one must understand that counselling goes beyond severe mental health concerns and disorders. It's a valuable process to deal with and manage everyday life challenges we all face. Whether it's dealing with exam stress, figuring out career paths,

overcoming procrastination, or struggling with marital adjustment, counselling provides support and guidance in all aspects of life.
It's there to help boost confidence, beat stage fright, navigate concerns arriving from bullying, and deal with trauma arising from physical or sexual abuse. Additionally, it's a lifeline for teenagers grappled with adolescence-related concerns and adults facing job stress. From managing general anxiety to overcoming feelings of depression, counselling offers a safe space to explore and grow.

As childhood lays foundation for our emotional and psychological well-being, children might experience mental health challenges stemming from family, friends, or school.

Psychological concerns in children and adolescents may include shyness, lack of confidence, low self-esteem, fears, excessive worries etc.
Behavioural concerns comprise of general disobedience, stubborn behaviour or rigidity, aggression, use of abusive language, physical fights, bullying others, unable to form friendships or socialize, use of cigarettes and alcohol consumption, truancy etc.
Academic concerns such as hesitation in clarifying doubts or answering questions when asked (even if they know the answer), below-average performance in academics, lack of productivity, difficulty in time-management, inability to complete exam papers within time-limit, difficulty copying from board and maintaining writing speed, lack of participation in extracurricular etc. can worsen their difficulties.

Experiences like trauma, bullying, and abuse (verbal, physical, sexual abuse) may present itself in the form of unusual changes in behaviour, restlessness, extreme worries or fears, fatigue and psycho-somatic symptoms such as stomach-ache, headache and so on. Additionally, other concerns may arise from various factors including parental disputes, separation or divorce, neglected parenting, and excessive use of electronic devices. All this can significantly impact the mental health of children and adolescents.

While counselling deals with a wide range of emotional, psychological, and behavioural concerns, it plays a crucial role in addressing severe mental disorders as well. Individuals grappled with mental disorders rely on the support, guidance and therapy provided by mental health professionals (counsellors and psychologists).

These disorders significantly impact individuals' daily functioning and overall well-being. Among them are Anxiety Disorders, marked by heightened levels of worry and fear, and Depressive Disorders, which manifest as feelings of profound sadness, hopelessness, and disinterest in activities. Additionally, Obsessive-Compulsive Disorder (OCD) entails persistent, intrusive thoughts and behaviours that disrupt daily functioning. Eating disorders like anorexia nervosa, bulimia nervosa, and binge eating disorder involve unhealthy relationships with food and body image, posing serious threats to individuals' physical and mental health.
While the list of disorders is endless, it also includes Personality Disorders, and other psychotic disorders involving delusions, hallucinations, self-harm etc.
Neurodevelopmental Disorders like Intellectual Disability (ID), Specific Learning Disability (SLD), autism spectrum disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD), and Down syndrome (DS) show impact on different areas of development of a child such as cognitive, physical, motor, social, emotional, and speech & language development.

These disorders present unique limitations for individuals, impacting their learning, communication, and social interactions. Assessment and different modes of therapy serve an essential purpose in addressing the complexities of these mental disorders. By offering personalized assistance, counsellors / psychologists aid individuals in managing the difficulties associated with neurodevelopmental conditions.

Early and effective intervention is crucial in giving the best possible management.
Acknowledging the need for professional assistance and finding the right counsellor, psychologist or therapist is the initial step towards improved mental health. With appropriate support and therapeutic guidance, many individuals can overcome or effectively manage their mental health, leading to improved quality of life.
Overall, the purpose of counselling is to provide a supportive, non-judgmental environment where individuals can explore their concerns, develop coping skills, and improve their overall well-being.

Definition of Guidance

Guidance is a kind of advice or help given to the individual's especially students, on matters like choosing a course of study or career, work or preparing for vocation, from a person who is superior in the respective field or an expert. It is the process of guiding, supervising or directing a person for a particular course of action.
The process aims at making students or individuals aware of the rightness or wrongness of their choices and importance of their decision, on which their future depends. It is a service that assists students in selecting the most appropriate course for them, to discover and develop their psychological and educational abilities and ambitions. Guidance results in self-development and helps a person to plan his present and future wisely.

Definition of Counselling

The term counselling is defined as a talking therapy, in which a person (client) discusses freely his/her problems and share feelings, with the counsellor, who advises or helps the client in dealing with the problems. It aims at discussing those problems which are related to personal or socio- psychological issues, causing emotional pain or mental instability that makes you feel uneasy. The counsellor listens the problems of the client with empathy and discusses it, in a confidential environment. It is not a one day process, but there are many sessions.
Counselling is not just giving advice or making a judgement, but helping the client to see clearly the root of problems and identify the potential solutions to the issues. The counsellor also changes the viewpoint of the client, to help him take the right decision or choose a course of action. It will also help the client to remain intuitive and positive in the future.

Difference between Guidance and Counselling

Comparison Chart

BASIS FOR COMPARISON	GUIDANCE	COUNSELING
Meaning	Guidance refers to an advice or a relevant piece of information provided by a superior, to resolve a problem or overcome from difficulty.	Counselling refers to a professional advice given by a counsellor to an individual to help him in overcoming from personal or psychological problems.
Nature	Preventive	Remedial and Curative
Approach	Comprehensive and Extroverted	In-depth and Introverted
What it does?	It assists the person in choosing the best alternative.	It tends to change the perspective, to help him get the solution by himself or herself.
Deals with	Education and career related issues.	Personal and socio-psychological issues.
Provided by	Any person superior or expert	A person who possesses high level of skill and professional training.
Privacy	Open and less private.	Confidential
Mode	One to one or one to many	One to one
Decision making	By guide.	By the client.

Key Differences between Guidance and Counselling

The significant differences between guidance and counselling are given in the following points:

1. Advice or a relevant piece of information given by a superior, to resolve a problem or overcome from difficulty, is known as guidance. Counselling refers to a professional advice given by a counsellor to an individual to help him in overcoming from personal or psychological problems.
2. Guidance is preventive in nature, whereas counselling tends to be healing, curative or remedial.
3. Guidance assists the person in choosing the best alternative. But counselling, tends to change the perspective, to help him get the solution by himself or herself.
4. Guidance is a comprehensive process; that has an external approach. On the other hand, counselling focuses on the in-depth and inward analysis of the problem, until client understands and overcome it completely.
5. Guidance is taken on education and career related issues whereas counselling is taken when the problem is related to personal and socio-psychological issues.
6. Guidance is given by a guide who can be any person superior or an expert in a particular field. As opposed to counselling, which is provided by counsellors, who possess a high level of skill and undergone through professional training.
7. Guidance can be open and so the level of privacy is less. Unlike counselling, wherein complete secrecy is maintained.
8. Guidance can be given to an individual or group of individuals at a time. On the contrary, counselling is always one to one.
9. In the guidance, the guide takes the decision for the client. In contrast to counselling, where the counsellor empowers the client to take decisions on his own.

CONCLUSION:

Therefore, after reviewing the above-given points, it is clear that guidance and counselling are two different terms. The guidance aims at giving solutions while counselling aims at finding problems, working over it and then resolving it. However, both the process attempts to solve the problems of the client whereby the participation of both client and the expert should be there.

COUNSELLING METHODS AND TECHNIQUES

There are 3 major types of counselling.

1. Directive counselling
2. Non directive counselling
3. Eclectic counselling.

Directive Counselling

This technique is also called counsellor centred counselling. In this method counsellor is active and counselee works under counsellor and not with him. Here counsellor does analysis, synthesis, diagnosis, prognosis, description and follow-up, all by himself to resolve the problem. Here counsellor tries to direct the thinking of the council or declined by informing explaining interpreting and advising him.

Steps in Directive Counselling

1. Analysis- In this step counsellor tries to collect data from variety of sources for an understanding of the people.

2. Synthesis- In this step counsellor organisers and summarises the data find out strength and weaknesses adjustment and management of the client.
3. Diagnosis- This is the step where counsellor formulates and concludes regarding the nature and causes of the problems experienced by the client.
4. Prognosis- This step implies predicting the future development of the problem off the client.
5. Counselling- Here the councillor tries to bring adjustment through the process of counselling in the client.
6. Follow-up- This step implies helping and determining the effectiveness of the counselling provided to the client.

2. Non-Directive Counselling

- In this type of counselling the counselee or the client not the counsellor is the pivot of the counselling process. He plays an active role and this type of counselling is a growing process. In this counselling the goal is the independence and integration of the client rather than the solution of the problem. The counsellor establishes rapport with the counselee based on mutual trust, acceptance and understanding.

- The counselee provides all information about his problem. the counsellor assists him to analyse and synthesise diagnose his difficulties, predict the future development of his problem, take a decision about the solution of his problem and analyse the strength and consequences of his situation before taking a final decision. Since the counselee is given full freedom to talk about his problems and work out a solution, this technique is also called the permissive counselling or client cantered counselling.

Steps in Non-directive Counselling

1. The client or the individual comes for help
2. The counsellor defines the situation by indicating that the plaint has the answer but he is able to provide a place and an atmosphere in which the client the individual can think of answer our solution to his problems.
3. Here counsellor is friendly interested in encourages free expression of feeling regarding the problem of the individual.
4. The counsellor tries to understand the feeling of the individual.
5. The counsellor except/ recognises the positive as well as negative feelings
6. The phase of release of free expression of the feelings is gradually helping the individual in development of insight.
7. Has the client recognised and except emotionally as well as intellectually his real attitude and desires he perceives, the decisions that he must make and the possible causes of action open to him.
8. Positive steps towards the solution of the problem.
9. A decreased need for help is felt and the client is the one who decides to end the contract.

Eclectic Counselling

- This is a combination of directive and non-directive technique depending upon the situation. This approach in counselling is the best characterized by its freedom to the counsellor to use whatever procedures or techniques seem to be the most appropriate to any particular time for any particular client. This counselling is one where one who is willing to utilise any procedure which hold promises even though their theoretical bases differed mostly. The counsellor in this counselling may start with directive techniques what's switches over to non-directive counselling if the situation requires. He may also start with the non-directive technique and switches over to direct technique if the situation demands. So, the counsellor in this counselling makes use of the directive and non-directive

counselling and also of any other type which may be considered useful for the purpose of modifying the ideas and attitudes of the counselee. It can be said that directive and non-directive counselling are at the opposite end of the pole of guidance. It is eclectic counselling that bridges the gap between the two and makes adjustment between directive and directive techniques.

Features of Eclectic Counselling

- 1. Flexibility is the key note of this counselling.
- 2. Method of counselling from client to counsellor, or counsellor to client or from time to time.
- 3. Freedom of choice and expression is open to both the counsellor and the client.
- 4. Experience of mutual confidence and faith in the relationship are basic.
- 5. Feeling of comfort are essential.

SKILLS OF A GOOD COUNSELLOR

Counselling efficiency is closely related to the quality of counsellor preparation and training. It is sometimes argued that counselling skills are inborn rather than acquired. This kind of thinking is based on the notion that counselling is an art and not a science. There is no gainsaying the fact that counselling is both an art and a science.
Carl Rogers, a psychologist, emphasized three core conditions – empathy, unconditional positive regard and genuineness as necessary and sufficient skills for counselling.

Empathy has been described as putting oneself in the other person's shoes. It involves translating the counsellor's understanding of the client's experiences, behaviours and feelings into a response and sharing the same with the client. Empathy encourages communication and helps clients see themselves and their problem situation more clearly. It is very important for a counsellor to listen carefully, enter the world of the client and communicate that he understands the client's world as the client sees and experience it. Empathy is the capacity to feel "into" while sympathy is to feel "with". The best understanding how a mother feels when her child is sick. To sense the client's private world as if it were your own but without ever losing the "as if" quality. The counsellor can reach out to this quality by basically fulfilling five dimensions:

- Tone-Expressive and nonverbal dimension which convey harmony and unity.
- Perception of the client's frame of reference.
- The ability of the counsellor to adopt himself to the counselee's situation.
- The resourcefulness of the counsellor to vary his methods of approached, repertoire of leads.
- Pace-The appropriate timing the counsellor leads

Basically, empathy includes two criteria: a) correct understanding of the counselee's feeling and content. B) The ability to communicate this understanding to the counselee.

Unconditional positive regard OR NON-JUDGEMENTAL ATTITUDE is caring and it is expressed by the enthusiasm shown by the counsellor for being the presence of the client. This involves accepting the client as they are, unconditionally, regardless of whether their behaviour or feelings are positive or negative. Rogers (1961) defines acceptance as "a warm regard for the client as a person of unconditional self-worth and of value, no matter what his condition, his behaviour or his feelings are.
"To be understood" touches the deepest feeling of an individual. It is the skill of the counsellor to understand counselee's attitudes and the way he behaves to others and also about the circumstances which have led to the present situation and those which are reinforcing the counselee's behaviour.

Unconditional positive regard is the ability to see the world through the eyes of the client and willingness to let the individual differ from one another in their behaviour. It does not mean to accept the values of a client but to accept the person as he or she is and a realization that the experiences of each person comprises a complex pattern of striving, thinking and feeling. It is a feeling that conveyed by words, gestures and postures that he is not being judged and he is unconditionally respected and understood. This situation help the counselee to explore openly and confidently. Being non-judgemental is to control the value conflicts within the counsellor. Accept that there can be emotional arousal and argument can take place. At that point it is advisable to take a pause and keeping aside the value system of counsellor and listen to counselee. The therapist accepts and values the client without judgement, promoting a sense of safety and trust.

GENUINENESS OR CONGRUENCE, as Rogers called it, means that counsellor do not communicate dishonestly or present an image that can deceive the client. To be genuine counsellors, they should know themselves very well. When the counsellors are genuine, the clients will also be encouraged to be genuine. A genuine person is a whole person or a real person, who accepts his own weaknesses and aware of his strengths. The counsellor is what he is with the client without any professional facade and "role free". A genuine counsellor should be spontaneous, free but not impulsive.

In counselling, genuineness refers to the counsellor's authenticity, sincerity, and transparency in the therapeutic relationship. Facilitative of genuineness refers to the therapist's ability to create an environment that fosters openness, trust and authenticity. The therapist should be authentic and transparent in their words, actions and emotions, creating a sense of consistency and reliability.

The other skills are:

NON-POSSESIVE WARMTH refers to a therapist's ability to provide a warm, empathetic and supportive environment for their clients without being overly attached or possessive. This skill is effective as a counselling ingredient and the higher the level of this variable, the more evidence of constructive change was noted in the client. This conveys to the client that he\she is worthy of respect and is important to the counsellor, and not just another client in the days schedule. This can be easily rated from the non-verbal and kinaesthetic point of view, the therapists show their warmth and respect by their open posture, smile and vocal qualities. It is the counsellor's effort to understand the client, which communicates respect and warmth and which is the major tie between the counsellor and the counselee.

CONCRETENESS quality helps the client to identify and work on a specific problem from the various problems presented.

The attitude of concreteness involves the specific, direct and complete expression by both the counselee and the counsellor in their communication. Concreteness means a grounded person with practical knowledge to respond from the framework of lived experiences with ones feet on the ground.

RAPPORT- Shertzer and Stone (1968) define rapport as an essential condition for a comfortable and unconditional relationship between the counsellor and the counselee. Rapport means interest, responsiveness and sensitive emotional involvement. Counsellors use rapport as a technique in the initial stage of the interview to put up the counselee at ease. Through rapport the counsellor understands and communicates with the client from the commencement to the end of the interview. Taking the counselees needs, moods and conflicts into consideration the counsellor establishes rapport. To help him discuss his feelings freely the counsellor tries to be friendly and attentive. For the establishment of good rapport there is need for counsellor skills and abilities, such as versatility, flexibility and reliability.

IMMEDIACY is the ability of the counsellor to use the immediate situation to invite client to look at the present situation. It may be sometime risky and unfamiliar as some clients always tends to talk in the past tense or think about future. This skill implies the use of present tense to get most effective impact in the session.

COUNSELLING METHODS AND TECHNIQUES

CASE HISTORY AND MENTAL STATUS EXAMINATION:

The key elements of the psychiatric interview are the patient's histories and the mental status examination (MSE). The histories are based primarily on the subjective report of the patient but importantly should be enriched by and compared to available records. The psychiatric interview begins with observation, but the interviewer needs to recall that first impressions work both ways.

Following points are to be considered:

- Most patients come to their first encounter with a mental health professional experiencing some level of trepidation. Some arrive cajoled or forced by others to have come at all. Anxieties are reduced by early clarification of the nature and purpose of the encounter and defining a mutual agenda before embarking on the interview. To the extent feasible, the patient should experience the clinician focused on him or her for the time they have together. Toward this end, unnecessary distractions such as beeper and text alerts and phone calls ought to be minimized.
- Often, inadequate knowledge about mental health care and misconceptions about psychiatric treatment arising from stigma, misinformation, and misconceptions can fuel anxieties. The skilled clinician is aware of these potential issues and interacts in a manner to decrease, or at least not increase, the distress.
- Contacting informants to evaluate concern about imminent suicide or violence risk, transfer of information in medical or psychiatric emergencies and mandated reporting of child abuse or neglect.
- In addition to training and expertise, physicians are expected to behave in ways that project caring, instil hope, and maintain focus on the patient's best interest.
- In the clinical setting, rapport can be defined as the harmonious responsiveness of the physician and patient to one another. It is important that the patient experiences the evaluation as a joint effort and that the psychiatrist is truly interested in their story. Appreciating how and why the patient thinks and feels as she does require an understanding of the patient's life experience and perspectives in some detail and depth.
- Privacy and confidentiality are essential components of therapeutic relationships. Staging the interview to ensure that others do not overhear the content is an important consideration.
- Empathy is the capacity to appreciate and understand the experience of the patient at an emotional level. The development of a healthy patient—physician relationship is reinforced when the physician is perceived as genuine. Being comfortable enough to laugh in response to a humorous comment, admit a mistake, or apologize for an error that inconvenienced the patient, like being late for or missing an appointment, strengthens the therapeutic alliance.
- Minor children need to understand that a parent or guardian must be informed about diagnosis and treatment options to provide surrogate consent.
- Important points to be noted- contacting informants to evaluate concern about imminent suicide or violence risk, transfer of information in medical or psychiatric emergencies and mandated reporting of child abuse or neglect. Specific consent is first obtained when information is shared outside of a genuine emergency or a mandated report.
- It is also important to be flexible in the interview and responsive to patient initiatives in relationship building. If the patient brings in an item, for example, a photo she wants to show the psychiatrist, it is good to look at it, ask questions, and thank the patient for sharing it. Much can be learned about the family history and dynamics from such a seemingly sidebar moment. The psychiatrist should be mindful of the reality that there are no irrelevant moments in the interview room.

- At times patients will ask questions about the psychiatrist that range from inquires about training and experience to more personal matters such as marital status, sexual orientation, or religious beliefs. Depending on the reason for the interview, the nature of the question and the particular characteristics of the setting and patient, these questions may properly be answered directly or reflected back to the patient to gain insight into the motive for the inquiry. Avoiding excessive sharing of personal information is a good general principle to adhere to. On the other hand, the psychiatrist should not be excessively stingy with information for reasons that are more self-serving than patient-centered at risk of appearing aloof or callous.

A patient's history is the single most important tool in establishing a diagnosis. Developing good rapport with patients is the key to effective interviewing and thorough data gathering. Both the content (what the patient says and does not say) and the manner in which it is expressed (body language, topic shifting) are important.

CASE HISTORY:

The Psychiatric interview taking includes Case History taking and the following are collected:

1. Data collection: Collection of basic socio-demographic data like name, age, gender, marital status, occupation, current living situation, language, and ethnic background. For most purposes, it is useful to target variables that are pertinent to the particular interview.

2. Chief complaint: The chief complaint is intended to be the patient's primary psychiatric concern and is generally written as a quotation. This is to understand and explore the patient's current chief concern. This brief section belongs to the patient. Quoting nonsensical or tangential responses can provide an excellent window into the patient's mental status.

3. The History of Present Illness (HOPI): is the interviewer's integrated narrative of the patient's current psychiatric illness. Document current symptoms as described by the patient; date of onset, duration and course of symptoms. Obtain a chronological description of recent events leading up to the presentation, precipitating events, and any other psychosocial stressors. This section should include a psychiatric review of symptoms that assesses the presence of affective, psychotic, and anxiety disorders. Once the actual illness has been clarified, the HOPI should feature a narrative that includes important precipitants as well as the onset, duration, intensity, and debility of symptoms. Commonly associated comorbidities and symptoms should be specifically included or excluded. It is worth noting that many of these historical details may not be accurately recalled or recounted, and that, throughout the interview, the clinician will need to be both earnestly curious and tactfully sceptical.

4. Past Psychiatric History: The past psychiatric history explores psychiatric illness prior to the current presentation including the nature of symptoms, course, and treatment. The patient's previous encounters with psychiatrists and other mental health therapists, past psychiatric hospitalizations, the treatment received, and the length of stay should be listed as well. Details of past episodes including age of onset, context, nature and duration of episodes, the diagnosis offered, treatment applied and its setting, degree of response, treatment adherence, and attitudes toward treatment, are all important facts to gather. Understanding the details of past treatment will lead to a better understanding of which treatments are viable alternatives and which to avoid. It is similarly important to gather details about psychotherapy trials including the type of psychotherapy (individual, group, couple, or family), the model of psychotherapy and the frequency and duration of the treatment (Was it delivered in a manner that one expects to be effective. History of suicide, violent behaviours, Substance Use, Abuse, and Addictive Behaviours is also to be noted down.

5. Medical history: Any medical illnesses should be listed in this category along with the date of diagnosis. Hospitalizations and surgeries should also be included with their dates. Episodes of head trauma, seizures, neurologic illnesses or tumours, and positive assays for human immunodeficiency virus (HIV) are all pertinent to the psychiatric history. Past medical history is potentially critical because psychiatric

and non-psychiatric medical conditions are frequently co-morbid. In addition to eliciting a list of prescribed medications, the clinician should inquire about over-the-counter, complementary, and alternative medications, as well as activities that may potentially be therapeutic, such as exercise, yoga, and meditation. Medical disorders can precipitate a psychiatric disorder (e.g., anxiety disorder in an individual recently diagnosed with cancer), mimic a psychiatric disorder (e.g., hypothyroidism presenting "as if' major depression), be precipitated by treatment of a psychiatric disorder (e.g., metabolic syndrome emerging during exposure to a second-generation antipsychotic medication), or influence the choice of treatment of a psychiatric disorder (e.g., renal insufficiency and the use of lithium carbonate). A thorough review of all current medications is essential because some medications used in other fields in medicine can create side effects that mimic psychiatric disorders and to identify potential drug—drug interactions before prescribing.

6. Family History: Many psychiatric illnesses have a genetic predisposition, if not cause, a careful review of family history is important to the assessment and can aid in diagnosis and establishing expected prognosis. This area of history identifies family members with histories of known or suspected mental illness, substance use problems, and other behavioural problems, for example, criminality. A brief statement about the patient's family history of psychiatric as well as medical disorders should be included. Listing each family member, his or her age, and medical or psychiatric disorders is generally the easiest, clearest way to do this. Presence of psychiatric illness in family members, dementia, and psychiatric treatment, use of psychiatric medication, presence or history of substance abuse, and history of suicide or suicide attempts should be noted. When the patient offers a diagnosis of a family member without much information to assess the reliability of the claim, the alleged diagnosis should be held sceptically or some attempt made to clarify it. Specific inquiry about family history of completed suicide is important to suicide risk assessment because this finding elevates the index patient's future risk. Family history of medical disorders may offer clues to the patient's risk factors. For example, diabetes in first-degree relatives ought to raise concern about the potential for metabolic syndrome with exposure to second-generation antipsychotics.

7. Developmental and Social History: The developmental and social history reviews the stages of the patient's life from gestation to the present with an eye toward understanding the important exposures, relationships, and events that shaped the person's life story. The nature of the person's temperament and character and the degree to which the person has achieved developmentally appropriate role functions such as academic progress, work, peer and romantic relationships, and parenting capacity.

Gestational and birth history, developmental milestones and early childhood development, family of origin, cultural identifications, educational, occupational, legal and military histories are all areas to be explored. Histories of abuse (emotional, physical, and sexual), neglect (emotional and physical) and specific traumatic exposures are important areas for specific inquiry. The nature of the patient's current social environment is defined including financial status, housing, and current relationships. The following points are covered in chronological order:

1. Pregnancy and delivery: The prenatal and perinatal history of the patient is probably relevant for all young children brought to a psychiatrist. It can also be relevant in older children and/or adults if it involves birth defects or injuries.
2. Developmental milestones: For a child, issues such as age of and/or difficulty in toilet training, behavioural problems, social relationships, cognitive and motor development, and emotional and physical problems should all be included
3. Educational (including history of special needs, in-school counselling, disciplinary problems): A childhood history is important when evaluating a child and can be important in evaluating an adult if it involves episodes of trauma, long-standing personal patterns, or problems with education
4. Social/Relationships/committed relationships: including the nature of friendships and interests, romantic relationships. In certain cases, sexual history is also required.

5. Parenting- the kind of parenting style that was involved and all childhood experiences can be accounted for
6. Traumatic or potentially traumatic exposures including neglect, physical and sexual abuse
7. Drug and alcohol history. Both the quantity of substance(s) used and the duration of their use should be documented.

MENTAL STATUS EXAMINATION:

The mental status examination comprises the sum total of the physician's observations of the patient at the time of the interview. Of note is that this examination can change from hour to hour, whereas the patient's history remains stable. The mental status examination includes impressions of the patient's general appearance, mood, speech, actions, and thoughts. Even a mute or uncooperative patient reveals a large amount of clinical information during the mental status examination. As a relatively objective cross- sectional evaluation, it plays a key role in shaping and informing the history. The mental status examination provides a snapshot of the patient's symptoms at the time of the interview. It can differ from the patient's history, which is what has happened to the patient up until the time of the interview. The assessment of mental status begins the moment the interviewer sees the patient, and most of it can be accomplished casually and outside the patient's awareness.

(Tip: The MSE does not require a patient's cooperation or the interviewer's ability to read minds. The MSE is based on an interview-long snapshot of what the patient says and does)-

1. General description:

a. Appearance: A description of the patient's overall appearance should be recorded, including posture, poise, grooming, hygiene, and clothing. Signs of anxiety and other mood states should also be noted, such as wringing of hands, tense posture, clenched fists, or a wrinkled forehead. Level of consciousness (alert, sleepy) is also an important point.

b. Behaviour and psychomotor activity: Any bizarre posturing, abnormal movements, agitation, rigidity, or other physical characteristics should be described.

c. Attitude toward examiner: The patient's attitude should be noted using terms such as "friendly," "hostile," "evasive," "guarded," or any of a host of descriptive adjectives. Eye contact and its modulation in the psychiatric interview offer important clues to the subject's internal emotional state. For example, a depressed patient may make little or no eye contact, an anxious patient's eye contact may be intermittent whereas a patient with psychosis may stare and maintain intense eye contact. Eye contact is normally regulated to modulate intensity and to prevent inadvertent dominance displays. If a patient is especially intense or overtly paranoid, it is useful to avoid prolonged eye contact.

2. Mood and General Emotional status: Mood is the prevailing and conscious emotional feeling expressed by the patient. Emotional status is a general term to indicate the patient's behaviour; it may be evaluated through direct observation of the patient during the examination. **Mood:** Emotional state recorded in the patient's own words (e.g., "depressed," "anxious," "scared," "happy," "angry"). . Although mood can often be inferred throughout the course of an interview, it is best to ask the patient directly, "How has your mood been?" **Affect:** Affect differs from mood in that it is the outward manifestation of a mood state visible to others. Affect is the interviewer's observation of the patient's emotional state, which includes the general quality (eg, dysphoric, euthymic) and depth of the effect (e.g., normal, blunted, or flat). Affect may be labile (alternating rapidly between two extremes) or inappropriate (incongruence between subject matter and emotional expression). A labile effect denotes a patient whose emotional responsiveness varies greatly (and often quickly) within the interview period. A blunted or constricted affect means that there is little variation in facial expression or use of hands; a flat affect is even further reduced in range.

3. Speech: The physical characteristics of the patient's speech should be described. Notations as to the rate, tone, volume, and rhythm should be made. Impairments of speech, such as stuttering, should also be noted. Quantity of speech (e.g., talkative, sparse), rate (eg, rapid, slow), volume (eg. whispered, loud), spontaneous, impediments (e.g., stuttering, lisp), and rhythm are taken into note. Strong emotions, such as intense anxiety, can lead to speech abnormalities that are transient. Certain psychiatric conditions, such as mania and schizophrenia, often have characteristic speech abnormalities that affect both the linear flow of speech and its effectiveness in communication. The psychiatric interviewer should be alert for evidence of aphasic speech which can be mistaken for disordered speech due to a psychiatric condition. Patients with speech disorders are often unaware that the communicative value of their speech is failing and may not show reciprocity in speech that is characteristic of the interactive nature of spoken communication. Speech patterns are a useful window into the patient's thought process. For example, rate, volume, and organization of speech should be observed throughout the interview.

- Pressured, tangential speech is often found in mania.
- Slow speech with impoverished content is often found in depression, schizophrenia, and delirium.
- Guarded, withholding speech can accompany paranoia.
- Dysarthria is a specific disorder of articulation in which basic language (grammar, comprehension, and word choice) is intact. Patients with dysarthria produce distorted speech sounds that have a variable degree of intelligibility.
- Dysprosody is an interruption of speech melody (e.g., tone, accent, and tempo). Speech inflection and rhythm are disturbed, resulting in speech that is monotonic halting, and sometimes mistaken for a foreign accent.
- Apraxia is the inability to perform skilled movements of the face and speech musculature in the presence of normal comprehension, muscle strength, and coordination.
- Aphasia is a true language disturbance in which the patient demonstrates an impaired production and/or comprehension of spoken language.

E.g. At times, she was mute. When she did speak, her speech was excessive, difficult to interrupt and came in rapid, loud bursts that made most of her communication ineffective.

4. Thought process/form: Thought process refers to the form of thinking or how a patient thinks. It does not refer specifically to what a person thinks, which is more appropriate to the thought content. In order of most logical to least logical, thought process can be described as logical/coherent, circumstantial, tangential, flight of ideas, loose associations, and word salad/incoherence. Neologisms, punning, or thought blocking also should be mentioned here. Thought forms refer to the logical and semantic connections between patient's thoughts (form). Verbal expression can follow a linear and logical train of thought called goal-directed (normal), or lapse into increasing levels of disorganization.

The following are some of the abnormal thoughts:

- **Circumstantial:** an inordinately circuitous route from question to answer
- **Tangential:** an answer to a question that veers off from the target of the question, but the connection may still be appreciated or inferred
- **Derailment,** also called **"loose associations"** -thoughts proceed from idea to idea in a manner so oblique that the listener cannot follow the train of thought
- **Word Salad -** Individual ideas and speech are incoherent
- **Clang associations -** Word association by rhyming
- **Neologisms -** Creating new words

5. Thought Content: The actual thought content section should include delusions (fixed, false beliefs), paranoia (a form of delusion), preoccupations, obsessions and compulsions, phobias, ideas of reference, poverty of content, and suicidal and homicidal ideation. Thought content refers to the general themes of the patient's ideation and is an area of the examination that identifies thought abnormalities such as

obsessional thoughts and delusional ideation. The extent to which the examiner gains access to the patient's private ideational life is determined by factors such as the patient's sense of comfort with the examiner and interviewing techniques aimed at eliciting this content. The evaluation of thought content focuses on unusual, preoccupying, or dangerous ideas. Delusions are common in psychosis, for example, whereas ruminations of guilt are common in depression. Such thoughts can be intrusive and unpleasant (e.g., some obsessions in obsessive-compulsive disorder) or gratifying (e.g., some overvalued personal beliefs). Suicidality and homicidally are integral to the evaluation of thought content. For both, the interviewer should assess for ideation, intent, and plan, as well as access to weapons. As with other aspects of the MSE, the suicide and homicide assessment is intended to focus on the patient's current thought content (Perry and Stein 1985).

- A **delusion** is a firmly held, false belief based on an incorrect inference that is unshakeable despite evidence to contradict it. It cannot be simply a cultural belief.
- **Grandiose delusion:** belief that one has special powers, influence, or a special relationship with a deity or famous person.
- **Delusion of Thought broadcasting:** belief that the individual has thoughts that are produced by someone or something outside oneself.
- **Obsession:** a persistent thought, idea, image, or impulse that is experienced as intrusive or inappropriate and results in marked anxiety, distress, or discomfort.
- **Preoccupations:** a state of being self-absorbed and "lost in thought," which ranges from transient absent-mindedness to a symptom of mental disorder, as when an individual with schizophrenia withdraws from external reality and turns inward upon the self.

6. Perception: any perceptual abnormalities, including hallucinations, illusions, derealization, and depersonalization of the sensory inputs received by the body. Distinguishing between these types of misperceptions is crucial for both diagnosis and treatment. When documenting perceptual abnormalities, the interviewer should provide some description of the patient's actual experience, the context(s) in which the experience occurs, its frequency, and intensity, the degree of the patient's conviction of the reality of the perception, and the degree of discomfort it causes, as well as any steps the patient may have taken to alleviate adverse effects of the experience. In the case of auditory hallucinations, details of the nature and character of the voices can be important to diagnosis: Does the patient hear one or several voices, simple statements or complex sentences? Do the voices engage in a conversation?

Examples of Perceptual Abnormalities:

- **Hallucination:** Hallucinations are perceptions in the absence of external stimuli to account for them; they may occur in any of the five senses (auditory, visual, gustatory, olfactory, and tactile) and seem as real in the person's experience as a true perception.
- **Déjà vu:** perception that a present circumstance is the duplicate of an experience that has occurred in the past.
- **Derealisation:** perception that one's surrounding and events are experienced as if the person is detached from them, or that they are distorted, changed, or unreal.
- **Illusion:** inaccurate perception or interpretation of an actual perception. Illusions are misperceptions of actual sensory inputs. For example, a delirious patient might misinterpret the shadows on a television screen as crawling bugs.
- **Jamais Vu:** perception that a present experience in entirely foreign when it actually should be very familiar
- **Depersonalization:** refers to a sense of being detached from one's own thoughts, body, or actions

7. Risk Assessment- Suicidal, violent, and homicidal ideation fall under the category of thought content but many interviewers document these findings in a separate section of the examination labelled risk assessment. Risk assessment is an important aspect of any initial clinical psychiatric evaluation. Ideas about suicide and violence are among the most private of thoughts. Patients are often hesitant to divulge ideation for fear of how the revelation will be received and what actions the clinician may take. A useful approach is to begin with a normalizing statement followed by a question.

For example, "In my experience, people who are struggling with the kinds of emotions and life problems you have described to me are also having ideas about death, dying, or taking their own life. Has this been the case for you?"

8. Domains of cognitive function: important to the initial assessment include level of alertness, orientation, attention/concentration, visual-spatial function, memory (registration and recall), calculation, receptive and declarative language functions, fund of knowledge, capacity to abstract and executive functions including insight and judgment. Brief, validated tools for cognitive assessment include the Mini-Mental Status Examination (Folstein et al. 1975), the Montreal Cognitive Assessment (Nasreddine et al. 2005), and the Clock Drawing Test (Samton et al. 2005). Each has its strengths and weaknesses and is available free on the Internet. None of these assessments is diagnostic, however, and a thorough assessment of the patient will require integration of the findings from the MSE with the rest of the interview.

Sensorium: This portion of the mental status examination assesses organic brain function, intelligence, capacity for abstract thought, and levels of insight and judgment. The basic tests of sensorium and cognition are performed on every patient. Those whom the clinician suspects are suffering from an organic brain disorder can be tested with further cognitive tests beyond the scope of the basic mental status examination.

Consciousness: Common descriptors of levels of consciousness include "alert," "somnolent," "stuporous," and "clouded consciousness." Most clinicians distinguish five principal levels: (1) alertness, (2) lethargy or somnolence, (3) Obtundation, (4) stupor or semi-coma, and (5) coma.

1. **Alertness** implies that the patient is awake and fully aware of normal external and internal stimuli. Barring paralysis, the patient can respond appropriately to any normal stimulus. The alert patient is able to interact in a meaningful way with the examiner.
2. **Lethargy**, or somnolence, is a state in which the patient is not fully alert and tends to drift off to sleep when not actively stimulated. In such patients, spontaneous movements are decreased and awareness is limited.
3. **Obtundation** is a transitional state between lethargy and stupor. The obtunded patient is difficult to arouse and, when aroused, is confusional. Usually, constant stimulation is required to elicit even marginal cooperation from the patient. Meaningful mental status testing is usually futile. The obtunded patient is, by our definition, in an acute confusional state or quiet delirium.
4. **Stupor and semi-coma** are used to describe patients who respond only to persistent and vigorous stimulation. The stuporous patient does not rouse spontaneously and, when aroused by the examiner, can only groan or mumble and move restlessly in the bed.
5. **Coma** is traditionally applied to those patients who are completely unarousable and remain with their eyes closed. In coma, the patient response neither to external stimulation nor spontaneously to internal stimulation.

ORIENTATION: The classic test of orientation is ti discern the patient's ability to locate himself or herself in relation to person, place, and /time. Orientation to person requires not only a knowledge of one's name but also one's address, phone number, age, occupation, and marital status.

MEMORY: Memory is a general term for mental process allows the individual to store information for later recall. The time span for recall can be short as a few seconds, as in a digit repetition task, or as long as many years, as in the recall of one's childhood experiences.

Clinically, memory is subdivided into three types, based on the time span between stimulus presentation and memory retrieval. “Immediate”, “recent, “and “remote” are commonly used to denote these basic memory types.

1. Immediate memory is tested by asking a patient to repeat numbers after the examiner, in both forward and backward orders.
2. Recent memory id tested by asking a patient what he/she ate for dinner the previous night and asking if he/she remembers the examiner’s name from the beginning of the interview.
3. Recent past is tested by asking about news items publicized in the past several months
4. Remote memory is assessed by asking patients about their childhood. Note that information must be verified to be sure of its accuracy because confabulation can occur
5. Amnesia is a general term for a defect memory function. Although applied to a broad spectrum of memory defects, amnesia is used most commonly to label patients with severe and relatively isolated memory deficit. Amnesia may also refer to psychogenic amnesia, in which the patient blocks a period of time from memory. These patients do not demonstrate a recent memory deficit, can learn items during the amnestic period, and, after the amnestic period is over, do not have a defect in recent memory when tested.

CONCENTRATION AND ATTENTION: Attention refers to the ability to sustain interest in a stimulus, whereas concentration involves the ability to maintain mental effort. Subtracting serial 7s from 100 is a common way of testing concentration. Patients who are unable to do this because of educational deficiencies can be asked to subtract serial 3s from 100. Attention is tested by asking to spell the word “world” forward and backward. The patient can also be asked to name five words that begin with a given letter.

Visual-spatial ability: the ability to comprehend and conceptualize visual representations and spatial relationships in learning and in the performance of tasks such as reading maps, navigating mazes, conceptualizing objects in space from different perspectives, and executing various geometric operations. The patient is typically asked to copy the face of a clock and fill in the numbers and hands so that the clock shows the correct time. Images with interlocking shapes or angles can also be used—the patient is asked to copy them.

Abstract thought: Abstract thinking is the ability to deal with concepts. Can patients distinguish the similarities and differences between two given objects? Can patients understand and articulate the meaning of simple proverbs?

Information and intelligence: Answers to questions related to a general fund of knowledge (presidents of the United States, mayors of the city in which the mental status examination is conducted), vocabulary, and the ability to solve problems are all factored in together to come up with an estimate of intelligence. A patient's educational status should of course be taken into account as well.

Judgment: Judgment is another executive function mediated by the frontal lobe that represents the capacity of the individual to appraise a situation or problem, consider and decide among alternatives, plan and execute a course of action and modify the course of action when necessary based on new inputs. At times, judgment is impaired despite adequate insight. For example, a patient may recognize that he is confused about money management, including the funds in his checking account, but decides to make a large purchase without clarifying his account balance. During the course of the interview, the examiner should be able to get a good idea of the patient's ability to understand the likely outcomes of his or her behaviour and whether or not this behaviour can be influenced by knowledge of these outcomes. Judgment is often extrapolated from recent behaviour or by asking such questions as "If you were in a movie theatre and smelled smoke, what would you do?" Having the patient predict what he or she would do in an imaginary scenario can sometimes help with this assessment. For example, what would the patient do if he or she found a stamped envelope

lying on the ground? Tests of judgment that do not require real-world decision making generally offer little value to an accurate assessment of judgment.

Insight: is a frontal lobe/executive function represented by the capacity of the individual to appraise whether one's thoughts, feelings, behaviours, perceptions, and planned actions are appropriate and realistic, and by the capacity to reflect on how one's presentation may be perceived and interpreted by others. Jaspers (1964) defined insight as — "Objectively correct estimate of the severity of the illness and objectively correct judgment of its particular type in everyday clinical practice, degree of insight is typically rated on a continuum from absent to full; many patients have partial insight. The degree of insight does not track neatly with severity of the illness. A person with dementia may be painfully aware of cognitive decline while a person with a mild anxiety disorder may have little or no insight into their overreactions to a fear stimulus.

Insight and judgment are often linked within the MSE because both are part of interrelated skills and behaviors that include such executive functions as reasoning, impulsivity, initiation, organization, and self-monitoring. Because psychiatric diagnoses are rooted in the concept of dysfunction (without dysfunction, there is generally no disorder), a clear assessment of these functions is crucial. Therefore, collaborative data concerning the patient's social judgment are best obtained by history from family members or other informants who have witnessed the patient's actual performance in dealing with day-to-day events. An alternative possibility, though somewhat cumbersome and inefficient, is to place the patient in actual, but experimental, situations that require an immediate, appropriate social response.

<u>In the routine mental status examination, insight is graded as:</u>

I. Complete denial of illness.
2. Slight awareness of being sick and needing help, but denying it at the same time.
3. Awareness of being sick but blaming it on others, external events.
4. Intellectual insight.
5. True emotional insight.

Lack of insight has been variously conceptualized as:

I. Stemming from neuropsychological deficits.
2. Part of the primary psychiatric illness itself, a symptom.
3. A form of defensive denial... stigma, distress.

9. Diagnosis Formulation- Finally after all the case history and MSE taking is done a diagnosis is made by careful evaluation of the database, analysis of the information, assessment of the risk factors, and development of a list of possibilities (the differential diagnosis). The process involves knowing which pieces of information are meaningful and which can be discarded. Experience and knowledge help the physician "key in" on the most important possibilities. The counsellor/psychiatrist will try to formulate a potential/provisional diagnosis and understanding of the psychological issues the client is going through. At times physical examination is also required. A diagnosis can be reached by systematically reading about each possible disease. The patient's presentation is then matched up against each of the possibilities, and each disorder is moved higher up or lower down on the list as a potential etiology based on the prevalence of the disease, the patient's presentation, and other clues.

The patient's risk factors can also influence the probability of a diagnosis. Usually, a long list of possible diagnoses can be pared down to the two or three most likely ones based on a careful delineation of the signs and symptoms displayed by the patient, as well as on the time course of the illness. The next step could be assessing the Severity of the Disease. Based on this diagnosis, the therapeutic treatment or further sessions are planned. At times the cases can also be referred to psychiatrists for evaluation and medication if deemed necessary.

CLIENT CENTRED COUNSELLING

Carl Rogers 'client centred; approach to counselling is more directly related to the field of psychological counselling. It is a humanistic approach that emphasizes the client's autonomy and self-healing capacity. Its aim was not to cure sick people but to help people live more satisfying and creative lives.

In 'client centred' counselling, the therapist does not direct the session or provide interpretations or advice. Instead, they act as a facilitator, helping their client to explore their own thoughts, feelings and experiences. The therapist listens actively and reflects back what the client is saying, helping them to gain deeper self-awareness and understanding.

The client is seen as the expert of their own life, and the therapist trust their ability to find their own solutions to their problems. The focus is on empowering the client to take control of their own growth and healing.

THE COUNSELLING PROCESS:

The goal of 'client centred' counselling is to make the individual a fully functioning person, that is, the denied and distorted part in his experience. The counsellor, by unconditional acceptance of the client, helps him to explore and try and modify his perceptions. To make this happen the client must have feelings of security, acceptance and belongingness. The counsellor provides these by an unconditional acceptance of the client, showing positive regard, warmth, interest and understanding. In this friendly and warm atmosphere, the client, may without any hesitation or fear of criticism or ridicule, be able to do a little self-exploration and self-examination leading to self-understanding. The client slowly and steadily progresses toward self-realization.

The three fundamental qualities that a counsellor should have, as emphasized by Roger:

1. **Empathy**: The therapist strives to understand the client's feelings and perspectives.
2. **Congruence**: The therapist is genuine, authentic, and transparent in their interactions with the client.
3. **Unconditional Positive Regard**: The therapist accepts and values the client without judgment

Congruence in Counselling

Congruence is also called genuineness. According to Rogers, congruence is the most important attribute in counselling.

This means that, unlike the psychodynamic therapist who generally maintains a "blank screen" and reveals little of their own personality in therapy, the Rogerian is keen to allow the client to experience them as they really are.

The therapist does not have a façade (like psychoanalysis); that is, the therapist's internal and external experiences are one and the same. In short, the therapist is authentic.

Unconditional Positive Regard:

The next Rogerian core condition is unconditional positive regard. Rogers believed that for people to grow and fulfil their potential, it is important that they are valued as themselves.

This refers to the therapist's deep and genuine caring for the client. The therapist may not approve of some of the client's actions, but the therapist does approve of the client. In short, the therapist needs an attitude of "I'll accept you as you are."

The person-centred counsellor is thus careful to always maintain a positive attitude to the client.

Empathy:

Empathy is the ability to understand what the client is feeling. This refers to the therapist's ability to understand sensitively and accurately [but not sympathetically] the client's experience and feelings in the here and now.

An important part of the task of the person-centred counsellor is to follow precisely what the client is feeling and to communicate to them that the therapist understands what they are feeling.

In the words of Rogers (1959), accurate empathic understanding is as follows:
"The state of empathy, or being empathic, is to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person, but without ever losing the "as if" condition.
Thus, it means to sense the hurt or the pleasure of another as he senses it and to perceive the causes thereof as he perceives them, but without ever losing the recognition that it is as if I were hurt or pleased and so forth. If this "as if" quality is lost, then the state is one of identification"

Techniques of Client-Centred Therapy:

1. **Active listening.** Simple gestures like nodding, eye contact, and the occasional "uh-huh" show clients that you are listening and engaged in the therapeutic process.
2. **Reflection.** Repeating what the client has said (also known as "paraphrasing") is a great way to demonstrate empathy, especially when you pick up on powerful meanings or feelings a client may have shared.
3. **Clarification.** Simply asking a client to clarify or explain more about a point helps them realize that their thoughts, feelings, and experiences have validity and worth.
4. **Clear boundaries.** A positive therapeutic relationship can only occur when there are clear professional boundaries. Remember that being genuine and warm is still possible with clear client- therapist boundaries.
5. **A client-directed approach.** As the name suggests, client-centred therapy is about what the client wants for their life. Not what the therapist thinks they *should* do.
6. **Validation of emotions.** One of the best ways to demonstrate empathy and congruence is through validating a client's emotions. When combined with CBT, the therapist must take care to present cognitive distortions in a way that doesn't lead to the client feeling they are "defective" or "broken" as a person.
7. **Open-ended questions.** Using plenty of open-ended questions ensures the focus of therapy stays on the client's thoughts, wishes, and experiences. It avoids the problem of the practitioner inadvertently steering the conversation in a particular direction with closed lines of questioning.
8. **Encouragement.** Therapy and coaching is a daunting process for a lot of people. And especially when issues like anxiety, low-self-esteem, trauma, and depression are present, clients might benefit from gentle encouraging phrases, like "Tell me more." "Take your time." Or, "It's ok that you felt that way."

Benefits of Client-Centred Therapy:

- Improve self-esteem
- Alleviate anxiety
- Gain deeper self-understanding
- Achieve self-acceptance
- Build more authentic relationships

The therapeutic relationship developed in this style of treatment, anchored in empathy, unconditional positive regard, and genuineness, can bring about impressive levels of transformative change and personal growth. As individuals come to terms with their true selves and gain new insights into their experiences, they're better equipped to navigate their lives effectively, make healthier decisions, and form more fulfilling relationships.

Strengths:

The effectiveness of the client centred approach is that, the counselling is a personal communication between the client and the therapist. It aids in helping the client's problems by increasing the client's sense of wellbeing. This therapy makes the client to explore their true self by being honest and empowers them to be able to solve

their own problems. It gives the client a chance to have self-direction by allowing them to plan their own session and be in control of the therapy. Therapists give the client's upper hand and not take them as experts but rather a comforting hand to the client. It gives them an opportunity to show their caring nature, being non- judgmental and empathise with the client regardless of their abnormal behaviour or rigid patterns of thinking, (Gross, 2010).

Maslow (1970) explained that self-actualisation helps the client to fully concentrate on themselves and guide in decision making for growth and develop into an honest, selfless and independent person. In return it makes the client to have autonomy and not depend on others all the time. It gives the client self-growth, confidence and better understanding of oneself. Client behaviour is expected to change and the way they view life, giving more appreciation and better relationships. Self-actualisation also makes the client to have self-acceptance and being able to accept others.

Another stronghold of the person-centred approach is that it makes the therapist accept the client the way they are without judging them or pressuring them to change but rather showing empathy. In return it gives the client a platform to explore their true feelings and make them better people in a society. It also gives the client a chance to reflect on their previous behaviour and identify areas

Weaknesses:

However, on the negative side the client is not challenged by anyone or able to engage in a contest in order to find or show their ability. It deprives the opportunity to give opinion or suggestions that might be useful. The therapist cannot question anything even if they are concerned and it is too plain and not complicated. The therapy does not offer a proper structure to the client even though the therapist subscribe to the ethical principles of their profession which gives them guidelines about their boundaries, (Mearns and Thorne, 2007) and this can be difficult for the client to progress and have answers. The approach has developed since the 60's and it does not have much research and modern theory on it. Also there are no techniques in this approach such as questioning or clarifying.

Another drawback of this approach is that there is no intervention of which according to Adams at al (2009) intervention is an act to achieve effects and produce results. There is no involvement or interference from the therapist who might offer sound advice. McNeill et al (2005) identified elements of interventions that have an impact on behavioural change. Out of the elements, client centred therapy lacks the agreement intervention and interactive communication.

In comparison with crisis intervention where help is offered when a service user is faced with a problem, (Adam et al, 2009), person centred therapists are not allowed to offer help. Crisis intervention allows the practitioner to help an individual out of stress and change their behaviour by assessing the situation and making a plan to give support as well as advocating. Adams et al (2009) stated that crisis intervention makes an individual in crisis stronger and able to deal with threats and help them with personal growth.

PROBLEM SOLVING COUNSELLING

Problem solving therapy involves patients learning or reactivating problem-solving skills. These skills can then be applied to specific life problems associated with psychological and somatic symptoms. Problem solving therapy is suitable for use in general practice for patients experiencing common mental health conditions and has been shown to be as effective in the treatment of depression as antidepressants. Problem solving therapy involves a series of sequential stages. The clinician assists the patient to develop new empowering skills, and then supports them to work through the stages of therapy to determine and implement the solution selected

by the patient. Many experienced GPs will identify their own existing problem-solving skills. Learning about PST may involve refining and focusing these skills.

Problem solving therapy has been described as pragmatic, effective and easy to learn. It is an approach that makes sense to patients and professionals, does not require years of training and is effective in primary care settings.[1] It has been described as well suited to general practice and may be undertaken during 15–30 minute consultations.

Problem solving counselling is short term therapy used to help people who are experiencing depression, stress, PTSD, self-harm, suicidal ideation, and other mental health problems develop the tools they need to identify and solve problems. It aims to improve overall quality of life and reduce the negative impact of psychological and physical illness.

STEPS IN PROBLEM SOLVING COUNSELLING:

1. **Identifying the problem:** The first step is to identify the specific problem that is causing distress. This may involve breaking down a larger problem into smaller, manageable parts.
2. **Generating solutions**: Once the problem has been identified, the next step is to brainstorm a variety of possible solutions. This may help the client to look at the problem with a different aspect.
3. **Evaluating solutions**: Once a list of possible solutions has been generated, the next step is to evaluate each solution to determine its feasibility and effectiveness. This may involve considering the pros and cons of each solution, as well as the potential risks and rewards.
4. **Implementing the solution**: Once a solution has been chosen, the next step is to develop a plan for implementing it. This may involve breaking the solution into smaller steps, as well as setting deadlines and identifying resources.
5. **Evaluating the results**: Once the solution has been implemented, the final step is to evaluate the results, this may involve tracking progress, as well as making adjustments to the plan as needed.

PST is based on two overlapping models:

Social problem-solving model

This model focuses on solving the problem “as it occurs in the natural social environment,” combined with a general coping strategy and a method of self-control (Dobson, 2011).

The model includes three central concepts:

1. Social problem-solving
2. The problem
3. The solution

The model is a “self-directed cognitive-behavioural process by which an individual, couple, or group attempts to identify or discover effective solutions for specific problems encountered in everyday living” (Dobson, 2011).

Relational problem-solving model

The theory of PST is underpinned by a relational problem-solving model, whereby stress is viewed in terms of the relationships between three factors:

1. Stressful life events
2. Emotional distress and wellbeing
3. Problem-solving coping

Therefore, when a significant adverse life event occurs, it may require “sweeping readjustments in a person’s life” (Dobson, 2011).

Creators of PST D'Zurilla and Nezu suggest a 14-step approach to achieve the following problem-solving treatment goals (Dobson, 2011):

- Enhance positive problem orientation
- Decrease negative orientation
- Foster ability to apply rational problem-solving skills
- Reduce the tendency to avoid problem-solving
- Minimize the tendency to be careless and impulsive

D'Zurilla's and Nezu's model includes (modified from Dobson, 2011):

1. *Initial structuring*
   Establish a positive therapeutic relationship that encourages optimism and explains the PST approach.
2. *Assessment*
   Formally and informally assess areas of stress in the client's life and their problem-solving strengths and weaknesses.
3. *Obstacles to effective problem-solving*
   Explore typically human challenges to problem-solving, such as multitasking and the negative impact of stress. Introduce tools that can help, such as making lists, visualization, and breaking complex problems down.
4. *Problem orientation – fostering self-efficacy*
   Introduce the importance of a positive problem orientation, adopting tools, such as visualization, to promote self-efficacy.
5. *Problem orientation – recognizing problems*
   Help clients recognize issues as they occur and use problem checklists to 'normalize' the experience.
6. *Problem orientation – seeing problems as challenges*
   Encourage clients to break free of harmful and restricted ways of thinking while learning how to argue from another point of view.
7. *Problem orientation – use and control emotions*
   Help clients understand the role of emotions in problem-solving, including using feelings to inform the process and managing disruptive emotions (such as cognitive reframing and relaxation exercises).
8. *Problem orientation – stop and think*
   Teach clients how to reduce impulsive and avoidance tendencies (visualizing a stop sign or traffic light).
9. *Problem definition and formulation*
   Encourage an understanding of the nature of problems and set realistic goals and objectives.
10. *Generation of alternatives*
    Work with clients to help them recognize the wide range of potential solutions to each problem (for example, brainstorming).
11. *Decision-making*
    Encourage better decision-making through an improved understanding of the consequences of decisions and the value and likelihood of different outcomes.
12. *Solution implementation and verification*
    Foster the client's ability to carry out a solution plan, monitor its outcome, evaluate its effectiveness, and use self-reinforcement to increase the chance of success.

13. *Guided practice*

    Encourage the application of problem-solving skills across multiple domains and future stressful problems.

14. *Rapid problem-solving*

    Teach clients how to apply problem-solving questions and guidelines quickly in any given situation.

Success in PST depends on the effectiveness of its implementation; using the right approach is crucial (Dobson, 2011).

What Problem-Solving Therapy Can Help With

Problem-solving therapy addresses life stress issues and focuses on helping you find solutions to concrete issues. This approach can be applied to problems associated with various psychological and physiological symptoms.

Mental Health Issues

Problem-solving therapy may help address mental health issues, like:

- Anxiety
- Chronic stress due to accumulating minor issues
- Complications associated with traumatic brain injury (TBI)
- Depression
- Emotional distress
- Post-traumatic stress disorder (PTSD)
- Problems associated with a chronic disease like cancer, heart disease, or diabetes
- Self-harm and feelings of hopelessness
- Substance use[5]
- Suicidal ideation

Specific Life Challenges:

This form of therapy is also helpful for dealing with specific life problems, such as:

- Death of a loved one
- Dissatisfaction at work
- Divorce
- Everyday life stressors
- Family problems
- Financial difficulties
- Job loss
- Relationship conflicts

Limitations of problem-solving therapy

PST may be effective for many situations, but it is not a universal therapy for all mental health concerns.

For example, PST is not suitable for people with severe mental health symptoms, such as suicidal ideation or psychosis. These require more intensive therapy and support from medical professionals.

Because it focuses on practical solutions, PST also does not explore deep-rooted emotions, beliefs, or experiences, such as traumatic events. For some people, addressing this is necessary for long-term improvements in mental health and well-being.

PST also requires active participation from the individual. It may be difficult for some people, such as those with significant cognitive impairments, to understand or apply it.

COGNITIVE BEHAVIOUR THERAPY

Introduction:

Cognitive behaviour therapy which combines both cognitive and behavioural principles and methods in a short term treatment approach has following attributes : (1) a collaborative relationship between client and therapist, (2)the premise that psychological distress is largely a function of disturbances in cognitive processes, (3) a focus on changing cognitions to produce desired changes in affect and behaviour, and (4) a generally time-limited and educational treatment focusing on specific and structured target problems. They emphasize the role of homework, place responsibility on the client to assume an active role both during and outside of the therapy sessions, and draw from a variety of cognitive and behavioural strategies to bring about change.

To a large degree cognitive behaviour therapy is based on the assumption that a reorganization of one's self-statements will result in a corresponding reorganization of one's behaviour.

Albert Ellis's Rational Emotive Behaviour Therapy

The basic assumption of REBT is that people contribute to their own psychological problems, as well as to specific symptoms, by the way they interpret events and situations. REBT is based on the assumption that cognitions, emotions and behaviours interact significatively and have a reciprocal cause- and effect relationship.

VIEW OF HUMAN NATURE

Rational emotive behaviourtherapy is based on the assumption that human beings are born with a potential for both rational, or "straight," thinking and irrational, or "crooked", thinking. People have predispositions for self-preservation, happiness, thinking and verbalizing, loving,

Communion with others, *and* growth and self-actualization. They also have propensities for self-destruction; avoidance of thought, procrastination, endless repetition of mistakes, superstition, intolerance, perfectionism and self-blame, and avoidance of actualizing growth potentials. Taking for granted that humans are fallible, REBT attempts to help them accept themselves as

Creatures who will continue to make mistakes yet at the same time learn to live more at peace with themselves. Ellis assumes that we are self-talking, self-evaluating, and self-sustaining. We develop emotional and behavioural difficulties when we mistake simple preferences (desires for love, approval, success) for dire needs. Ellis also affirms that we have an inborn tendency toward growth and actualization, yet we often sabotage our movement toward growth due to self-defeating patterns we have learned.

View of Emotional Disturbance

We originally learn irrational beliefs from significant others during childhood. Additionally, we create irrational dogmas and superstitions by ourselves. Then we actively reinforce self -defeating beliefs by the processes of autosuggestion and self-repetition and by behaving as if they are useful. Hence, it is largely our own repetition of early-indoctrinated irrational thoughts, rather than a parent's repetition, that keeps dysfunctional attitudes alive and operative within us.

Ellis contends that people do not need to be accepted and loved, even though this may be highly desirable. The therapist teaches clients how to feel undepressed even when they are unaccepted and unloved by significant others. Although REBT encourages people to experience healthy feelings of sadness over being unaccepted, it attempts to help them find ways of overcoming unhealthy feelings of depression, anxiety, hurt, loss of self-worth, and hatred.

Ellis insists that blame is at the core of most emotional disturbances. Therefore, to recover from a neurosis or a personality disorder, we had better stop blaming ourselves and others, Instead, it is important that we learn to accept ourselves despite our imperfections Ellis hypothesizes that we

have strong tendencies to escalate our desires and preferences into dogmatic. "Shoulds," "musts," "oughts." Demands and commands. When we are upset, it is a good idea to look to our hidden dogmatic "musts" and absolutist "should." Such demands create disruptive feelings and dysfunctional behaviours.

Here are some irrational ideas that we internalize and that inevitably lead to self-defeat."

"I must have love or approval from all the significant people in my life."

I must perform important tasks competently and perfectly well."

"Because I strongly desire that people treat me considerately and fairly, they absolutely must do so!"

"If I don't get what I want, it's terrible, and I can't stand it."

"It is easier to avoid facing life's difficulties and responsibilities than to undertake more rewarding forms of self-discipline".

We have a strong tendency to make and keep ourselves emotionally disturbed by internalizing self- defeating beliefs such as these, which is why it is a real challenge to achieve and maintain good psychological health.

The A-B-C theory of Personality

The A-B-C theory of Personality is central to REBT theory and practice. A is the existence of a fact, an event, or the behaviour or attitude of an individual. C is the emotional and behavioural consequence or reaction of the individual; the reaction can be either healthy or unhealthy. A (the activating event) does not cause C (the emotional consequence). Instead, B, which is the person's belief about A. Largely causes C, the emotional reaction.

The interaction of the various components can be diagrammed like this.

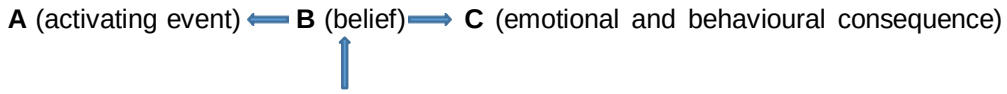

Fig. 1

If a person experiences depression after a divorce, for example, it may not be the divorce itself that causes the depressive reaction but the person's belie fs about being a failure, being rejected, or losing a mate. Ellis would maintain that he beliefs about the rejection and failure, (at point B) are what mainly cause the depression (at point C) ---not the actual event of the divorce (at point A). Thus, human beings are largely responsible for creating their own emotional reactions and disturbances. Showing people how they can change the irrational beliefs that directly "cause" their disturbed emotional consequences is the heart of REBT.

After A, B, and C comes D (disputing). Essentially, D is the application of methods to help clients challenge their irrational beliefs. There are three components of this disputing process: *Detecting, debating,* and *discriminating.* First, clients learn how to detect their irrational beliefs, particularly their absolutist “should" and "musts," their "awfulizing," and their "self-downing." Then clients debate their dysfunctional beliefs by learning how to logically and empirically question them and to vigorously argue themselves out of and act against believing them. Finally, clients learn to discriminate irrational (self- defeating) beliefs from rational (self-helping) beliefs).

Eventually clients arrive at E, an effective philosophy, which has a practical side. A new and effective belief system consists of replacing unhealthy thoughts with healthy ones. If we are successful in doing this, we also create F, a new set of feelings. Instead of feeling seriously anxious and depressed, we feel healthily sorry and disappointed in accord with a situation.

To sum-up philosophical restructuring to change our dysfunctional personality involves these steps:

(1) Fully acknowledging that we are largely responsible for creating our own emotional problems;

(2) Accepting the notion that we have the ability to change these disturbances significantly;

(3) Recognizing that our emotional problems largely stem from irrational beliefs;

(4) Clearly perceiving these beliefs;

(5) Seeing the value of disputing such self-defeating beliefs;

(6) Accepting the fact that if we expect; to change we had better work hard in emotive and behavioural ways to counteract our beliefs and the dysfunctional feelings and actions that follow; and

(7) Practicing REBT methods of uprooting or changing disturbed consequences for the rest of our life.

A basic goal in REBT is to teach clients how to change their dysfunctional emotions and behaviours into healthy ones. Ellis (200ib) states that two of the main goals of REBT are to assist clients; in the process of achieving unconditional self-acceptance (USA) and unconditional other acceptance (U0A) and to see how these are interrelated. As clients become more able to accept themselves, they are more likely to unconditionally accept others.

Therapist's Function and Role

The therapist has specific tasks, and the first step is to show clients that they have incorporated many irrational "should," "oughts," and "musts." Clients learn to change their rigid "musts" into preferences. The therapist encourages and often persuades clients to engage in activities that will counter their self-defeating beliefs.

A second step in the therapeutic process is to demonstrate that clients are keeping their emotional disturbances active by continuing to think illogically and unrealistically. In other words, because clients keep re-indoctrinating themselves, they are largely responsible for their own neuroses.

Merely showing clients that they have illogical processes is not enough, however, for a client is likely to say, "now I understand that I have fears of failing and that these fears are exaggerated and unrealistic. But I'm still afraid of failing!" To get beyond client's mere recognition of irrational thought, the therapist takes a third step—helping clients modify their thinking and abandon their irrational ideas. The therapist assists clients in understanding the vicious circle of the self-blaming process, which also changes their self-defeating behaviours.

The fourth step in the therapeutic process is to challenge clients to develop a rational philosophy of life so that in the future they can avoid becoming the victim of other irrational beliefs. Tackling only specific problems or symptoms can give no assurance that new illogical fears will not emerge. What is desirable, then, is for the therapist to dispute the core of the irrational thinking and to teach clients how to substitute rational beliefs and behaviours for irrational ones.

The therapist mainly employs a persuasive methodology that emphasizes education. Ellis outlines some of the functions the REBT practitioner performs

Encourages clients to discover a few basic irrational ideas that motivates much disturbed behaviour. Shows how these beliefs are inoperative and how they will lead to future emotional and behavioural disturbances.

- ❖ Challenges clients to change their self-sabotaging beliefs
- ❖ Uses several cognitive, emotive, and behavioural methods to help clients work directly on their feeling and to act against their disturbances.

Clients Experience in Therapy

Once clients begin to accept that their beliefs are the primary cause of their emotions and behaviours, they are able to participate effectively in the cognitive restructuring process.

The therapeutic process focuses on clients' experiences in the present. REBT mainly emphasizes here-and —now experiences and clients' present ability to change the patterns of thinking and emoting that they constructed earlier. The therapist does not devote much time to exploring clients' early history and making connections between their past and present behaviour; nor does the therapist usually explore in depth clients' early relationships with their parents or siblings. Instead, the therapeutic process stresses to clients that they are presently disturbed because they still believe in and act upon their self-defeating view of themselves and their world.

Clients are expected to actively work outside the therapy sessions. Clients learn that by working hard and carrying out behavioural homework assignments they can minimize faulty thinking, which leads to disturbances; in feeling and behaving. Homework is carefully designed and agreed upon and is aimed at getting clients to carry out positive actions that induce emotional and attitudinal change. These assignments are checked in later sessions, and clients learn effective ways to dispute self-defeating thinking. Toward the end of therapy, clients review their progress, make plans, and identify strategies for dealing with continuing or potential problems.

APPLICATION:
THE THERAPEUTIC TECHNIQUES AND ROCEDURES

Practice of Rational Emotive Behaviour Therapy:

COGNITIVE METHODS: REBT practitioners usually incorporate a forceful cognitive methodology in the therapeutic process. They demonstrate to clients in a quick and direct; manner what it is that they *are continuing* to tell themselves. Then they teach clients how to deal with these self-statements so that they no longer believe them, encouraging them to acquire a philosophy based on reality. REBT relies heavily on thinking, disputing, debating, challenging, interpreting, explaining, and teaching. Here are some cognitive techniques available to the therapist.

• **Disputing irrational beliefs**-. The most common cognitive method of REBT consists of the therapist actively disputing clients' irrational beliefs and teaching them how to do this *challenging* on their own. Clients go over a particular "must," "should," or "ought" until they no longer hold that irrational belief, or at least until it is diminished in strength.

.Here are some examples of questions or statements clients learn to tell themselves.

`."Why must people treat me fairly? "How do I become a total flop if I don't succeed at important tasks I try?"

"If I don't get the job I want, it may be disappointing, but I can certainly stand it. "

"if life doesn't always go the way I would like it to, it isn't *awful,* just inconvenient."

• **DOING COGNITIVE HOMEWORK**- REBT clients are expected to make lists of their problems, look for their absolutist beliefs, and dispute these beliefs. Homework assignments are away of tracking down the absolutist "should" and "musts" that are part of their internalized self-messages. Part of homework consists of applying the A-B-C theory to many of the problems clients encounter in daily life. The REBT therapist actually teaches the client how to think differently, or models for them, as opposed to the other forms of cognitive behaviour therapy.

In carrying out homework, clients are encouraged to put themselves in risk-taking situation that will allow them to challenge their self-limiting beliefs. For example, a client with a talent for acting who is afraid to

act in front of an audience because of fear of failure may be asked to take a small part in stage play. The client is instructed to replace negative self-statements such as "I will fail". " I will look foolish," or "No one will like me,**"** with more positive messages such as "Even if I do behave foolishly at times, this does not make me a foolish person. I can act, I will do the best I can. It's nice to be liked but not everybody will like me, and that isn't the end of the world."

The theory behind this and similar assignments is that often create a negative, self-fulfilling prophecy and actually fail because they told themselves in advance that they would. Clients are encouraged to carry out specific assignments during the session and, especially, in everyday situations between sessions. In this way clients gradually learn to deal with anxiety and challenge basic irrational thinking.

❖ ***Changing one's language.*** **REBT contends that imprecise language is one of the causes** of distorted thinking process. Clients learn that "musts," "oughts," and "should" can be replaced by preferences. Instead of saying "it would be absolutely awful if "they learn to say "it **would be** inconvenient

"Clients who use language patterns that ***reflect*** helplessness and self-condemnation can learn to employ new self-statements, which help them think and behave differently. As a consequence, they also begin to feel differently.

- **Using humour**. REBT contends that emotional disturbances often result from taking oneself too seriously and losing one's sense of prospective and humour over the events of life. Humour shows the absurdity of certain ideas that clients steadfastly maintain, and it can be of value in helping clients, take themselves much less seriously.

EMOTIVE TECHNIQUES: REBT practitioners use a variety of emotive procedures, including unconditional acceptance, rational emotive role playing, modelling, rational-emotive imagery, and shame-attacking exercises. Clients are taught the value of unconditional self-acceptance. Even though their behaviours may be difficult to accept, they can decide to see themselves as worth- while persons. Clients are taught how destructive it is to engage in "putting oneself down' for perceived deficiencies.

- **Rational-emotive imagery**. This technique is a form of intense mental practice designed to establish new emotional patterns. Clients imagine themselves thinking, feeling, and behaving exactly the way they would like to think, feel and behave in real life (Maultsby, 1984). They can also be shown how to imagine one of the worst things that could happen to them, how to feel unhealthily upset about this situation, how to intensely experience their feeling, and then how to change the experience to a healthy negative feeling (Ellis, 1999,2000a). As clients change their feelings about adversities, they stand a better chance of changing their behaviour in the situation. Such a technique can be usefully applied to interpersonal and other situations that are problematic for the individual.

- **Role playing**. There are both emotional and behavioural components in role playing. The therapist often interrupts to show clients what they are telling themselves to create their disturbances and what they can do to change their unhealthy feelings to healthy ones. Clients can rehearse certain behaviours to bring out what they feel in a situation. The focus is on working through the underlying irrational beliefs that are related to unpleasant feelings. For example, a woman may put off applying to a graduate school because of her fears of not being accepted. Just the thought of not being accepted to the school of her choice brings out her feelings of "being stupid." She role-plays an interview with the dean of graduate students. Notes her anxiety and the specific beliefs leading to it, and challenges her conviction that she absolutely must be accepted and that not gaining such acceptance means that she is a stupid and incompetent person.

- **Shame-attacking exercises**. Ellis has developed exercises to help people reduce shame over behaving in certain ways. He thinks that we can stubbornly refuse to feel ashamed by telling ourselves that it is not catastrophic if someone thinks we are foolish. The main point of these exercises, which typically involve both emotive and behavioural components, is that clients work to feel unashamed even when others clearly disapprove of them. The exercises are aimed at increasing self-acceptance and mature responsibility, as well as helping clients see that much of what they think of as being shameful has to do with the way they define reality for themselves. Clients may accept a homework assignment to take the risk of doing something that they are ordinarily afraid to do because of what others might think. For example, clients may shout out the stops on a bus or a train, wear "loud" clothes designed to attract attention, sing at the top of their lungs, and ask a silly question at a lecture. By carrying out such assignments, clients are likely to find out that other people are not really that interested in their behaviours. They work on themselves so that they do not feel ashamed or humiliated, even when they acknowledge that some of their acts will lead to judgments by others. They continue practicing these exercises until they realize that their feelings of shame are self-created and until they are able to behave in less inhibited ways. Clients eventually learn that they often have no reason for continuing to let others; reactions or possible disapproval stop them from doing the things they would like to do.

- **Use of force and Vigor***:* Ellis has suggested the use of force and energy as a way to help clients go from intellectual to emotional insight. Clients are also shown how to conduct forceful dialogues with themselves in which they express their unsubstantiated beliefs and then powerfully dispute them. Sometimes the therapist will engage in reverse role playing by strongly clinging to the client's self-defeating philosophy. Then, the client is asked to vigorously debate with the therapist in an attempt to persuade him or her to give up these dysfunctional ideas. Force and energy are a basic part of shame-attacking exercises.

BEHAVIORAL TECHNIQUES: REBT practitioners use most of the standard behaviours therapy procedures, especially operant conditioning, self - management principles, systematic desensitization, relaxation techniques, and modelling. Behavioural homework assignments to be carried out in real-life situations are particularly important.

REBT clients may be encouraged to desensitize themselves gradually but also, at times, to perform the very things they dread doing implosively: For example, a person with a fear of elevators may decrease this fear by going up and down in an elevator 20 or 30 times in a day. Clients actually do new and difficult things, and in this way, they put their insights to use in the form of concrete action

APPLICATION OF REBT TO CLIENT POPULATION

REBT has been widely applied to treatment of anxiety, hostility, character disorders, psychotic disorders, and depression; to problems of, love, and marriage (Ellis & Blau, 1998); to child rearing and adolescences (Ellis &Wilde,2001); and to social skills training and self -management. However, Ellis does not assert that all clients can be helped through logical analysis and philosophical reconstruction. Therefore, REBT includes many emotive -experiential and behavioural methods.

AARON BECK'S COGNITIVE THERAPY:

Aaron T. Beck developed an approach known as cognitive therapy (CT) as a result of his research on depression (Beck 1963, 1967); His observations of depressed clients revealed that they had a negative bias in their interpretation of certain life events, which contributed to their cognitive distortions.

Like REBT, CT is an insight-focused therapy that emphasizes recognizing and changing negative thoughts and maladaptive beliefs, Beck's approach is based on the theoreti cal rationale that the way people feel and behave is determined by how they perceive and structure *their* experience. **Basic Principles of Cognitive Therapy**

Beck contends that people with emotional difficulties tend to commit characteristic "logical errors" thattiltobjectiverealityinthedirectionof self-deprecation" Cognitive therapy perceives psychological problems as stemming from commonplace; processes such as faulty thinking, making incorrect inferences on the basis of inadequate or incorrect information, and failing to distinguish between fantasy and reality.

Some of the systematic errors in reasoning that lead to faulty assumptions and misconceptions, which are termed ***cognitive distortions*** are:

1. Arbitrary inferences

Refer to making conclusions without supporting any relevant evidence. This includes "catastrophizing," or thinking of the absolute worst scenario and outcomes for most situations. You might begin your first job as a counsellor with the conviction that you will not be liked or valued by either your colleagues or your client. You are convinced that you fooled your professors and somehow just managed to get your degree, but now people will certainly see through you.

2. Selective abstraction

Consists of forming conclusions based on an isolated detail of an event. In this process other information is ignored, and the significance of the total context is missed. The assumption is that the events that matter are those dealing with failure and deprivation. As a counsellor, you might measure your worth by your errors and weaknesses, not by your successes.

3. Overgeneralization

It is a process of holding extreme beliefs on the basis of a single incident and applying them inappropriately to dissimilar events or settings. If you have difficulty working with one adolescent, for example, you might conclude that you will not be effective counselling any adolescents. You might also conclude that you will not be effective working with any clients!

4. Magnification and Minimization

Consist of perceiving a case or situation in a greater or lesser light than it truly deserves. You might make this cognitive error by assuming that even minor mistakes in counselling a client could easily create a crisis for the individual and might result in psychological damage.

5. Personalization

It is a tendency for individuals to relate external events to themselves, even when there is no basis for making this connection. If a client does not return for a second counselling session, you might be absolutely convinced that this absence is due to your terrible performance during the initial session. You might tell yourself. “This situation proves that I really let that client down, and now she may never seek help again."

6. Labelling and mislabelling

It involves portraying one's identity on the basis of imperfections and mistakes made in the past and allowing them to define one's true identity. Thus, if you are not able to live up to all of a client's expectation, you might say to yourself, "I'm totally worthless and should turn my professional license in right away,

7. Polarized thinking

It involves thinking and interpreting in all-or —nothing terms, or categorizing experiences in either- or-extremes. With such dichotomous thinking, events are labelled in black or white terms. You might

give yourself no latitude for being an imperfect person and imperfect counsellor. You might view yourself as either being the perfectly competent counsellor (which means you always succeed with all clients) or as a total flop if you are not fully competent (which means there is no room for any mistakes)Beck writes that, in the broadest sense, "cognitive therapy consists of all of the approaches that alleviate psychological distress through the medium of correcting faulty conceptions and self- signals"(For him the most direct way to change dysfunctional emotions and behaviours is to modify inaccurate and dysfunctional thinking. The cognitive therapist teaches clients how to identify these distorted and dysfunctional cognitions through a process of evaluation. Through a collaborative effort, clients learn to discriminate between their own thoughts and events that occur in reality. They learn the influence that cognition has on their feelings and behaviours and even on environmental events. Clients are taught to recognize, observe, and monitor their own thoughts and assumptions, especially their negative automatic thoughts.

After they have gained insight into how their unrealistically negative thoughts are affecting them, clients are trained to test these automatic thoughts against reality by examining and weighing the evidence for and against them. This process involves empirically testing their beliefs by actively engaging in a Socratic dialogue with the therapist, carrying out homework assignments, gathering data on assumptions they make, keeping a record of activities, and forming alternative interpretations. Clients form hypotheses about their behaviours and eventually learn to employ specific problem-solving and coping skills. Through a process of guided discovery, clients acquire insight about the connection between their thinking and the ways they act and feel.

The Client-Therapist Relationship

Beck emphasizes that the quality of the therapeutic relationship is basic to the application of cognitive therapy. Successful counselling rests on a number of desirable characteristics of therapists, such as genuine warmth, accurate empathy, non-judgmental acceptance, and the ability to establish trust and rapport with clients, the core therapeutic conditions described by Rogers in his person-centred approach are viewed by cognitive therapists as being necessary, but not sufficient, to produce optimum therapeutic effect. Therapists must also have a cognitive conceptualization of cases, be creative and active, be able to engage clients through a process of questioning, and be knowledgeable and skilled in the use of cognitive and behavioural strategies aimed at guiding clients in significant self-discoveries that will lead to change. The therapist functions as a catalyst and a guide who helps clients understand how their beliefs and attitudes influence the way they feel and act. In agreement with Ellis's assumption about cognitive change, Beck also assumes that therapists promote corrective experiences that lead to cognitive change and acquiring new skills. Cognitive therapists encourage clients to take an active role in the therapy process. Clients are expected to bring up topics to explore, identify the distortions in their thinking, summarize important points in the session, and collaboratively devise homework assignments that they agree to carry out.

Beck places more weight on the client's role in self-discovery. Beck's assumption is that lasting changes in the client's thinking and behaviours will most likely to occur with the client’s initiative, understanding, awareness, and effort.

Homework is often used as a part of cognitive therapy. The homework; is tailored to the client’s specific problem and arises out of the collaborative therapeutic relationship. The purpose of homework in cognitive therapy is not merely to teach clients new skills but also to enable them to test their beliefs in daily-life situations. Homework is generally presented to clients as an experiment, which increases the openness of clients to get involved in an assignment.

INTERPERSONAL COUNSELLING

Interpersonal psychotherapy (IPT) was initially developed as a time-limited treatment for depression. It has since been extended to treat several other mood and non-mood disorders and validated in multiple clinical research studies (Weissman, Markowitz, & Klerman, 2000).

The underlying principle of IPT is that while the problem presented by a client may have many factors and causes, it typically occurs within a social and interpersonal context. Losing a job, divorce, death of a loved one, relocation, and retirement impact our environment and relationships.

In IPT, the client focuses on "the relationship between the onset and fluctuation in their symptoms and what is currently going on in their life" (Weissman et al., 2000). They learn to understand interpersonal problems and how to deal with them.

IPT interventions correct maladaptive interpersonal problems, increase self-awareness while deepening emotions associated with interpersonal needs, and are highly successful in treating generalized anxiety disorder (Lipsitz & Markowitz, 2013).

Appropriate techniques encourage interpersonal relationships and reduce interpersonal difficulties, facilitating improvements to *emotional processing* and enhancing *empathy* (Newman, Jacobson, & Castonguay, 2014; Lipsitz & Markowitz, 2013).

Interpersonal therapy techniques

There are a range of interpersonal therapy techniques commonly used to help individuals achieve their therapeutic goals. These techniques are designed to improve communication, enhance problem-solving skills, and strengthen relationships.

Some of the key techniques used in interpersonal therapy include:

1. Role-playing: This is a common technique used in IPT that allows you to practice different ways of interacting with others in a safe and supportive environment. By acting out scenarios with your therapist, you can experiment with new communication strategies and gain confidence in your ability to navigate difficult conversations.

2. Communication analysis: This involves examining your communication patterns to identify areas where misunderstandings or conflicts may arise. Your therapist will help you to become more aware of your verbal and non-verbal communication, as well as the impact it has on your relationships. By improving these communication skills, you can foster more positive and constructive interactions with others.

3. Decision analysis: In situations where you are faced with difficult decisions, decision analysis can be a valuable tool. This technique involves breaking down the decision-making process into smaller, manageable steps and evaluating the potential consequences of each option. The goal is to help you make informed choices that align with your personal values and goals; while also considering the impact it may have on your relationships.

4. Problem-solving strategies: IPT often involves teaching you specific problem-solving strategies to address interpersonal issues. These strategies may include identifying the problems, brainstorming possible solutions, evaluating the pros and cons of each option, and implementing the chosen solution. By developing these skills, you'll be better equipped to handle interpersonal challenges constructively and effectively.

These techniques, along with the structured nature of IPT, make it a practical and goal-oriented therapy that can lead to significant improvements in a relatively short period of time.

The main goal of IPT is to improve the quality of a client's interpersonal relationships and social functioning, it aims to help reduce overall distress. IPT provides strategies to resolve problems within four key areas.

- It addresses interpersonal deficits, including social isolation or involvement in unfulfilling relationships.
- It can help patients manage unresolved grief—if the onset of distress is linked to the death of a loved one, either recent or past.
- IPT can help with difficult life transitions like retirement, divorce, or a move.

- IPT is recommended for dealing with interpersonal disputes that emerge from conflicting expectations between partners, family members, close friends, or co-workers.

IPT was originally developed to treat major depressive disorder, but it's also used effectively to treat eating disorders, perinatal depression, drug and alcohol addiction, dysthymia, bipolar disorder, and other mood-related conditions. IPT differs from other traditional psychodynamic approaches in that it examines current rather than past relationships, and recognizes—but does not focus on—internal conflicts.

The practice differs from cognitive and behavioural therapy approaches because it addresses maladaptive thoughts and behaviours only as they apply to interpersonal relationships. IPT aims to change relationship patterns rather than the associated depressive symptoms, as well as target relationship difficulties that exacerbate these symptoms. Interpersonal psychotherapy is less directive than cognitive- behavioural approaches, focusing on the patient's specified target areas without dwelling on his or her personality traits.

The Benefits of IPT:

IPT offers numerous benefits, making it a valuable option for many individuals seeking therapy.

- **Improved relationships**: IPT focuses on enhancing communication skills and strengthening relationships, which can have a profound impact on many aspects of life, both immediately and long into the future.
- **Time-limited structure**: IPT typically involves 12-16 sessions, which allows for significant progress in a short period.
- **Proven effectiveness**: It's extremely effective for a wide range of mental health conditions, particularly in reducing depressive symptoms and preventing relapse.
- **Collaborative approach**: IPT empowers the client to actively participate in therapy, building confidence and equipping him/her to manage future challenges.

Overall, the benefits of IPT extend well beyond symptom relief. By fostering healthier relationships, improving communication, and developing practical problem-solving skills, IPT can lead to long-lasting improvements in both mental health and quality of life.

IPT is a beneficial treatment for several different illnesses in addition to depression. It can also help deal with attachment issues, grief, life adjustment and changes, and relationship challenges. Furthermore, IPT can treat the following:

- Anxiety
- Eating disorders
- Substance use disorder
- Bipolar disorder
- Borderline Personality Disorder
- Perinatal and postpartum depression
- PTSD
- Dysthymia
- Social phobia

PSYCHODYNAMIC COUNSELLING

The theory supporting psychodynamic therapy originated in and is informed by psychoanalytic theory. There are four major schools of psychoanalytic theory, each of which has influenced psychodynamic therapy. The four schools are: Freudian, Ego Psychology, Object Relations, and Self Psychology.

Freudian psychology is based on the theories first formulated by Sigmund Freud in the early part of this century and is sometimes referred to as the drive or structural model. The essence of Freud's theory is that sexual and

aggressive energies originating in the *id* (or unconscious) are modulated by the *ego*, which is a set of functions that moderates between the id and external reality. Défense mechanisms are constructions of the ego that operate to minimize pain and to maintain psychic equilibrium. The *superego*, formed during latency (between age 5 and puberty), operates to control id drives through guilt (Messer and Warren, 1995).

Ego Psychology derives from Freudian psychology. Its proponents focus their work on enhancing and maintaining ego function in accordance with the demands of reality. Ego Psychology stresses the individual's capacity for defence, adaptation, and reality testing (Pine, 1990).

Object Relations psychology was first articulated by several British analysts, among them Melanie Klein, W.R.D. Fairbairn, D.W. Winnicott, and Harry Guntrip. According to this theory, human beings are always shaped in relation to the significant others surrounding them. Our struggles and goals in life focus on maintaining relations with others, while at the same time differentiating ourselves from others. The internal representations of self and others acquired in childhood are later played out in adult relations. Individuals repeat old object relationships in an effort to master them and become freed from them (Messer and Warren, 1995).

Self-Psychology was founded by Heinz Kohut, M.D., in Chicago during the 1950s. Kohut observed that the self refers to a person's perception of his experience of his self, including the presence or lack of a sense of self-esteem. The self is perceived in relation to the establishment of boundaries and the differentiations of self from others (or the lack of boundaries and differentiations). "The explanatory power of the new psychology of the self is nowhere as evident as with regard to the addictions" (Blaine and Julius, 1977, p. vii). Kohut postulated that persons suffering from substance abuse disorders also suffer from a weakness in the core of their personalities--a defect in the formation of the "self." Substances appear to the user to be capable of curing the central defect in the self.

Psychodynamic concepts of Freud

The human personality has two basic urges, namely, Eros- the urge to live-The life instinct, and Thanatos- The urge to die-The death instinct. The Eros is the creative force and the Thanatos is the destructive or self-destructive force. The ego has to deftly balance these two instinctual urges and personality development is a result of this process. Freud assumes that the early part of the childhood is the most important in the personality development of the individual. The highly emotionally charged ideas called complexes are repressed during this early part of life and Freud explains that what the adult individual experiences as a problem is only the result of a repressed complex in his/her early childhood.

Psychotherapy or psychoanalysis is a method of unearthing these repressed complexes and this process is called catharsis. When a repressed idea is brought to the conscious and interpreted it ceases to be a problem. The symptom caused by it disappears. The psychoanalytic point of view, as explained by Freud, looks upon the individual as a biological entity craving for the gratification of instinctual urges. The classical psychoanalytical technique consists in bringing repressed wishes, desires and complexes to the conscious level. This process is long, arduous and time consuming.

The techniques are:

- **FREE ASSOCIATION**

Freud's primary root to the unconscious was free-association, whereby the client is asked to relax on a couch and give free expressions to any and every idea that comes to his mind. The client simply verbalizes whatever thoughts come to his mind, in whatever order they occur, taking care not to sensor then either for logic or for priority. The rational is that the unconscious has its own logic and that if client report their thoughts exactly as they occurred, the connective threads between verbalisations and unconscious impulses will be revealed.

- **DREAM INTERPRETATION**

The second important tunnel to the unconscious is dream interpretation. Freud believed that in sleep the ego defences were lower, allowing unconscious material to surface but defences are never completely abandoned, therefor even in dreams repressed impulses reveal themselves only in symbolic passion. Beneath the dreams manifest contents or surface meaning, lies it latent content unconscious understory.

After the dream is reported the analyst asks the client to free associate to its contents and the resulting association are taken as clues to the meaning of the dream.

- **ANALYSIS OF RESISTENCE**

As clients are guided toward unwelcomed knowledge of their unconscious motivations, they may begin to show resistance using various defences to avoid confronting the painful material. They may change the subject, make jokes or pick up a fight with the analyst, they may even begin missing appointments. It is then the analyst's job to point out the resistance and if possible, to interpret it and suggest what the patient is trying not to find out.

- **ANALYSIS OF TRANSFERENCE**

As psychoanalysis progresses with the client, revealing his/her secret life to the analyst, the relationship between the therapist and the client become understandably complex. In his practice Freud noted that while he tried to remain neutral, many of his patients began responding to him with passionate emotions, with a childlike love or dependency, at other time with hostility and rebellion. Freud interpreted this phenomenon as a transference onto him of his clients' childhood feelings toward important people in their lives, above all, their feelings toward their parents.

From the point of view of therapy, psychodynamic therapy has not found much favour because it is time consuming and expensive. Another point is, Freud minimizes the role of rationality in human behaviour. It is mistake to assume that the unconscious is responsible for all our actions. Unconscious thoughts are not unconscious in the sense Freud conceives them. At any given moment we have awareness, a conscious field, which may be called 'fovea-centralis'. Beyond this lies a region of vagueness and we are not quite clear or aware of the things that lie in this region. It corresponds to the dim perception or sight outside the field of vision. Full consciousness in the sense of full awareness is an exception and is extremely limited. Most of the time, we are only partially aware of what we are doing. In this sense we are not aware of the motivation for all our behaviour.

However, the most significant contribution of Freud and his psychoanalytical technique cannot be underestimated. The Freudian discovery that man is often motivated in thought and behaviour by unconscious impulses is of great significance.

OTHER PSYCHODYNAMIC APPROACHES:

ALFRED ADLER

Focus of individual psychotherapy is improving on clients:

Techniques:

- Inferiority versus superiority
- Striving for self-growth
- Compensatory mechanism
- Masculine protest (self-identity of gender)
- Frictional goals (life ideologies of heroes, utopian)
- Life style
- Social interest
- Creative self

CARL GUSTAV JUNG (Founder of analytical psychology)

Concept of mind

- Unconscious (Personal and collective)
- Preconscious
- Conscious

Creative self of any individual can integrate and unify internal forces for healthy personality.

GOALS OF PSYCHODYNAMIC THERAPY:

1. **Increased self-awareness**: The individual gains a deeper understanding of their thoughts, feelings, and behaviours.
2. **Improved relationships**: The individual develops healthier and more fulfilling relationships with others.
3. **Reduced symptoms:** The individual experiences a reduction in symptoms such as anxiety, depression, and other psychological distress.
4. **Increased emotional regulation**: The individual develops better emotional regulation and coping skills.

LIMITATIONS OF PSYCHODYNAMIC THERAPY:

1. **Time-consuming:** Psychodynamic therapy can be a long-term process, requiring a significant investment of time and effort.
2. **Emotionally challenging**: The therapy can be emotionally challenging, as individuals are encouraged to explore and confront their unconscious thoughts and feelings.
3. **Requires a skilled therapist**: Psychodynamic therapy requires a skilled and experienced therapist who is trained in the psychodynamic approach.
4. **May not be suitable for everyone**: Psychodynamic therapy may not be suitable for individuals who are looking for a quick fix or who are not willing to explore their unconscious thoughts and feelings.

CRISIS COUNSELLING

Crisis is a 'sudden emergency' which is perceived by the crisis person as utterly distressing, overwhelming, leading to inability to cope helplessness, defeatist attitude, functional impairment, sense of failure and a state of shock.

According to Caplan (1961), crisis may occur when the individual faces a problem that he cannot solve, which causes a rise in inner tension and signs of anxiety and inability to function in extended period of emotional upset.

Brockopp (1973) feels- The crisis is not the situation itself, but the persons response to the situation, this approach shows that everyone in difficulty does make some random efforts to successfully emerged out of it, but it is the failure which makes him panicky and helpless and may further deepen the crisis fir him.

A more comprehensive definition of crisis can be: "A crisis then is an intolerable situation which must be resolved, for it has the potential to cause the psychosocial deterioration of the person (Brockopp).

Types of Crisis:

- **Maturational/Development type**: Age related crisis like, infancy-childhood, pre-puberty, adolescence, adulthood, middle age, old age crisis.
- **Situational type**: Due to life problems like child abuse, family violence, rape, illness, drug dependence, suicide, death, grief, bereavement, burn-out, financial crisis suicidal attempt. Body image crisis, war victims, anorexia, bulimia, relationship crisis, adaptation crisis any other situation as perceived by a person to be crisis.

Crisis counselling is a short-term therapy provided to people in emotional distress. It is designed to help people cope with a crisis and develop coping mechanisms for future crises.

Crisis counselling can be helpful for people who are experiencing a wide range of emotional distress, including:

- **Grief and loss**
- **Trauma**
- **Stress**
- **Anxiety**
- **Depression**
- **Relationship problems**
- **Substance abuse**

GOALS/OBJECTIVES:

1. Self-esteem enhancement- For problem coping and solution seeking
2. Treatment focus for only 'Specific problem' at a time by active focusing technique.
3. Interaction is geared around conscious and pre conscious, emotional conflicts not around the unconscious level.
4. Not underestimating the importance of precipitating events and the extent of devastation by event.
5. Not gearing for total character or personality, modification, intervention is short term.
6. Intervention counsellor must utilize and focus on developmental stage needs and changes, ego functioning levels, changing role and status due to socio cultural demands for crisis person.

STEPS OF CRISIS COUNSELLING:

- Understanding the event, the person and the extent of damage done by crisis event to person. Focus on client's view of event, listening skills, extent of threat to client (actual or perceived).
- Ensuring clients safety (physical and emotional).
- Planning for therapeutically interventions based on client's personality, basic coping skills, extent and duration of crisis, extent of disruption in clients life.
- Actual intervention steps to help client for a) rational understanding of crisis b) awareness of sub conscious feelings, c) exploring coping mechanisms d) re-opening the social world as new alternatives and new relationships.
- Resolution of crisis and anticipatory future planning, positive coping attempts to deal with anxiety and stress,
- Obtaining commitment of client toward survival, growth orientation and attempting to achieve even higher level of equilibrium then the pre-crisis state.

METHODS OF COUNSELLING:

1. **Individual method**: Anonymity and confidentiality has to be maintained specially in case of rape, drug abuse, domestic violence death and bereavement, suicidal cases.
2. **Group method**: This is used for common shared problems like age related, menopausal crisis, loss of body part crisis, terminal illness crisis.
3. **Socio cultural methods**: This deals with specific sub culture related problem and counsellor must have knowledge and sensitivity of culture.
4. **Problem solving method of Guilford(1961)**: Steps of problem solving are : a)input(information),b) filtering(attention , focusing) c) cognitive production of alternatives) cognition(new information),e) production(more alternatives) f) evaluation of all slopes.

DO AND DON'TS FOR CRISIS COUNSELLOR:

1. Never identify with turbulence, grief and disorganized thinking of clients.
2. Do not reassume the impossible as "all will be well and all right"
3. Remain calm, poised and in control, this helps you and the client both
4. Encourage full expressions of conflicts, emotions, catharsis by initial sympathy and later empathy.
5. Encourage client for sharing more in order to access client's perceptions interpretations and reaction to crisis events.
6. Successful intervention means, helping client to achieve: a) correct cognition b) dealing of affect c) tapping of resources (social, institutional) d) reorganizing life style.

COUNSELLING IN MEDICINE AND PSYCHIATRY

TREATMENT PLANNING IN COUNSELLING:

Treatment planning in counselling is a collaborative process between the counsellor and client to identify and address the client's specific needs and goals. For therapists and their clients, a counselling treatment plan outlines a clear path to follow.

What is a Counselling Treatment Plan?

A counselling treatment plan is a document that creates in collaboration with a client. It includes important details like the client's history, presenting problems, a list of treatment goals and objectives, and interventions use to help the client progress.

Ingredients of an Effective Counselling Treatment Plan

Although there's no one-size-fits-all approach to creating a treatment plan, there are several key components that make up an effective plan.

1. **Client History, Background, and Assessments**

This section contains basic demographic information about the client, past and present diagnosis, and when the presenting problems first started to occur. If the client has seen a counsellor or other mental health professional in the past. The results of any formal assessments should go in this section too.

2. **Problem Statements**

List in detail what presenting problems led the client to seek care. What questions or symptoms were they experiencing that drove them to seek professional help?

3. **Strengths**

The client strengths section is an essential but sometimes-overlooked element of a counselling treatment plan. Here, list the client's self-stated personal strengths and available family supports. When the going gets tough, reviewing this information with the client can help give them encouragement.

4. **Treatment Contract**

A treatment contract details who's responsible for what. It lists out actions that both parties are responsible for completing during treatment. The contract summarizes the client's goals for counselling and the plan for achieving them. While not absolutely necessary, including a treatment contract can help create a sense of ownership for the client.

5. **Goals**

Treatment goals form the bedrock of any treatment plan. They define success. Goals should be realistic, concrete, and tailored to meet the unique needs of the client.

6. **Objectives**

If a goal is a story, objectives are the individual chapters within that story. Treatment objectives are small, incremental steps that together will result in the achievement of a treatment goal.

7. **Interventions**

Counsellors use various techniques, interventions, and other strategies to help their clients meet their treatment goals. The interventions section is where you list the methods you plan to use with the client.

8. **Progress**

Documenting client progress is one of the most important aspects of a counselling treatment plan. As treatment progresses, being able to look back on past successes is a significant source of inspiration to stay the course. Insurers also require documentation of client progress.

Three criteria's for making counselling treatment plans more effective.

1. **Client's guidance**

Leverage client's insights and knowledge of their issues heavily as the counsellor and the client work together on creating a treatment plan. Let them take the lead in areas like defining the presenting problems, listing their strengths, and goal-setting.

2. Use **SMART** Goals

Goals are the foundation of the counselling treatment plan. It's what all the following components rest on. The SMART framework for goal-setting can keep focused on writing goals that are likely to be achieved. The SMART acronym is below.

S- Specific

M- Measurable

A- Achievable

R – Relevant

T -Time-bound

3. **Flexibility**

Life rarely unfolds as we expect them to. That's why counselling treatment plans are meant to be adjusted as treatment progresses. If things are moving more slowly than anticipated or secondary issues arise that deserve their own goals and objectives, revise the treatment plan.

The Value of a Treatment Plan

For clients seeking help, the path to an improved sense of well-being is littered with obstacles. A good counselling treatment plan identifies those obstacles and shows what the course forward looks like. It clearly charts out the final destination, how to get there, and important waypoints to look out for along the way. A treatment plan can be a source of encouragement to the client as well as a map to guide the counsellor.

ASSESSMENT AND DIAGNOSIS

- Initial assessment: Conduct a comprehensive assessment to identify the client's strengths, weaknesses, and areas of concern using case history and MSE.
- Diagnosis: Develop a diagnosis based on the assessment, using standardized diagnostic criteria such as the DSM-5.

GOAL SETTING

- Identify client goals: Collaborate with the client to identify their specific goals and objectives.
- Prioritize goals: Prioritize the client's goals, focusing on the most pressing concerns.

TREATMENT OBJECTIVES

- Develop treatment objectives: Create specific, measurable, achievable, relevant, and time-bound (SMART) objectives for each goal.
- Identify interventions: Select evidence-based interventions and strategies to achieve each objective.

INTERVENTION STRATEGIES

- Counselling theories and models: Select counselling theories and models that align with the client's needs and goals.
- Techniques and interventions: Identify specific techniques and interventions to address each objective.

TREATMENT PLAN DEVELOPMENT

- Create a written treatment plan: Develop a comprehensive, written treatment plan that outlines the client's goals, objectives, and interventions.
- Review and revise: Regularly review and revise the treatment plan to ensure progress and adjust interventions as needed.

IMPLEMENTATION AND MONITORING

- Implement the treatment plan: Begin implementing the treatment plan, using the identified interventions and strategies.
- Monitor progress: Regularly monitor the client's progress, adjusting the treatment plan as needed.

EVALUATION AND TERMINATION

- Evaluate treatment effectiveness: Evaluate the effectiveness of the treatment plan, using outcome measures and client feedback.
- Terminate treatment: Terminate treatment when the client has achieved their goals, or when it is determined that further treatment is not necessary.

PRINCIPLES OF TREATMENT PLANNING:

1. **Client-centred**: The treatment plan should be centred on the client's needs and goals.
2. **Collaborative**: The treatment plan should be developed in collaboration with the client.
3. **Culturally sensitive**: The treatment plan should be sensitive to the client's cultural background and values.
4. **Evidence-based:** The treatment plan should be based on evidence-based interventions and strategies.
5. **Flexible**: The treatment plan should be flexible, allowing for adjustments as needed.

PSYCHOLOGICAL TESTING IN COUNSELLING

In counselling, information regarding the personality assets and liability of the counselees is a helpful point for a session. In the preliminary interview the counsellor can secure some information that would help in understanding the counselee's problems. In the course of the counselling sessions the counsellor may feel the need for objective information. At this stage the need for using psychological tests may be indicated. Often, along with the test data, information from non-test data, such as case study, cumulative records and such other information may be used for diagnostic purpose. Tests can also be used to assess the counselee's initial psychological status such that the progress made during the counselling sessions can be evaluated.

The relation between the use of tests and psychological counselling has been far from new, controversial or cordial. A psychological test is a tool developed for a specific purpose to be used with a defined population. Psychological tests are based on the theory that they are comparable to objective observations and that they

sample the defined psychological ‘trait universe’ from a wide range of responded behaviour. Psychological tests can also be used in providing self-knowledge. Most self-administering tests fall under this category.

Psychological testing can be an intimidating concept, but in reality, it is a powerful and highly useful tool designed to help the client. Therapists often refer their clients to psychologists for psychological testing and assessment. These assessments can help the client identify which problems to tackle in therapy (especially when a client has more than one presenting concern), as well as many other real-world problems, such as whether it may be beneficial to see a doctor about medication, engage in school child study, or simply continue therapy.

Psychological testing can also help differentiate specific disorders within a family of disorders in order to formulate appropriate goals for the client in consideration of a more specific diagnosis. For example, a person suffering from anxiety may choose psychological testing to narrow their disorder to Generalized Anxiety Disorder, Posttraumatic Stress Disorder, or a phobia. This can help optimize the benefits a client receives during therapy. Career testing is also an available assessment service.

If a child is struggling in school, psychological testing and assessment can help identify a specific disability, and allow the child to receive proper accommodations. Children can also be assessed when behavioural issues or issues with impulse-control are present in the home or school environment. Testing reports can be beneficial to allow schools or other professionals to be a partner in interventions.

Sometimes, in instances of legal cases, psychological testing can be used to determine whether a person is fit to stand trial, or if they are psychologically/emotionally competent. Psychological testing can sometimes be helpful in determining a person’s parental capacity.

The testing process can include both formal/normative tests and assessments, which are then interpreted by a licensed psychologist. Depending on the presenting concerns, a set of tests will be chosen, as well as a clinical assessment by the psychologist.

Testing provides a thorough documentation of the client’s history, symptom timeline, and impact on functioning. It provides a framework for addressing a client’s issues and a better understanding of how therapeutic intervention/counselling can be most helpful.

Key Benefits of Psychological Testing in counselling

1. Accurate Diagnosis

One of the primary benefits of psychological testing is its ability to aid in accurate diagnosis. Mental health conditions often present with overlapping symptoms, making differentiation challenging. For instance, distinguishing between major depressive disorder and **bipolar disorder** requires careful evaluation of mood patterns and other psychological markers. Psychological tests like the Beck Depression Inventory or Mood Disorder Questionnaire can provide data that clarifies these distinctions, ensuring patients receive the correct diagnosis.

2. Tailored Treatment Plans

Psychological testing helps clinicians create personalized treatment plans by identifying an individual's strengths and challenges. For example, cognitive assessments can detect **learning disabilities,** guiding interventions that support academic success. A child wit**h ADHD might benefit from behavioural therapy** and classroom accommodations to enhance focus and learning. Similarly, psychological evaluations can uncover emotional struggles like **loss & grief,** helping therapists tailor coping strategies. Even dietary

issues, which can affect mood and concentration, may be addressed through a holistic approach based on test results.

3. Early Identification of Issues

Psychological testing can detect mental health issues in their nascent stages, allowing for timely intervention. For example, early signs of **autism spectrum disorder (ASD)** can be identified through developmental screenings and cognitive assessments, enabling early behavioural interventions that significantly improve outcomes. Similarly, screenings for anxiety and **depression** in adolescents can prevent the escalation of these conditions into chronic issues.

4. Objective Measurement of Progress

Tracking therapeutic progress is essential in mental health care, and psychological testing provides an objective measure of improvement. By administering tests at regular intervals, clinicians can evaluate whether interventions are effective or require modification. For instance, a patient undergoing **cognitive-behavioural therapy (CBT)** for anxiety may show reduced scores on the **Generalized Anxiety Disorder** scale over time, indicating positive progress.

5. Enhanced Communication with Patients and Families

Psychological testing facilitates clear and structured communication between clinicians, patients, and their families. Test results provide concrete data that can help explain complex psychological concepts understandably. For example, parents of a child with learning difficulties may better comprehend the challenges their child faces and the rationale behind specific interventions after reviewing test findings.

6. Identification of Co-occurring Conditions

Many individuals with mental health issues have co-occurring conditions that complicate treatment. Psychological testing can uncover these conditions, ensuring a holistic approach to care. For instance, a person diagnosed with substance use disorder may also exhibit symptoms of **post-traumatic stress disorder (PTSD)** or depression, which testing can help identify.

7. Legal and Educational Applications

In addition to clinical use, psychological testing has significant applications in legal and educational settings. Mental health clinics often provide testing for legal cases, such as competency evaluations or custody disputes. In schools, psychological assessments help identify students requiring special education services, ensuring they receive appropriate support.

Improved Therapeutic Relationships

Comprehensive psychological testing fosters trust and collaboration between clinicians and clients. Patients often feel validated when their struggles are recognized through objective measures, enhancing their engagement in therapy. Moreover, the structured nature of testing helps clinicians build a deeper understanding of their clients, paving the way for stronger therapeutic alliances.

Challenges and Ethical Considerations

While psychological testing offers numerous benefits, it is not without challenges. Tests must be administered and interpreted by qualified professionals to avoid inaccuracies. Additionally, cultural biases in testing instruments can lead to misdiagnoses if not carefully accounted for. Mental health clinics must prioritize:

- **Ethical Testing Practices:** Ensuring confidentiality, informed consent, and appropriate use of results.
- **Cultural Sensitivity:** Adapting tests to account for cultural and linguistic differences.
- **Continuous Training**: Keeping clinicians updated on advancements in psychological assessment tools.

MAIN AREAS OF STANDARDIZED TESTS

1. **Personality test a) non- projective tests b) projective tests**
2. **Intelligence test**

3. **Aptitude test**
4. **Interest test**
5. **Achievement test**

TYPES OF PSYCHOLOGICAL TESTS USED IN COUNSELLING

1. Personality Tests: Assess personality traits, such as the Minnesota Multiphasic Personality Inventory (MMPI), The DISC assessment, etc.

2. Intelligence Quotient (IQ) Tests: Measure cognitive abilities, like the Wechsler Adult Intelligence Scale (WAIS).

3. Achievement Tests: Evaluate academic achievement, such as the Wide Range Achievement Test (WRAT).

4. Neuropsychological Tests: Assess cognitive functioning, including attention, memory, and executive functions.

5. Behavioural Assessments: Evaluate behavioural patterns, such as the Behaviour Assessment System for Children (BASC).

Brammer and Shostrom (1968) list the following cautions in the use of tests in diagnosis:

- Not to overstretch when the test data is incomplete and inaccurate.
- Not to overemphasize the test results to the neglect of present attitudes and current behaviour of the client.
- Not to administer psychological tests too quickly to facilitate diagnosis without paying attention to other available information.
- Not to lose sight of the counselees total personality and become pre occupied with morbidity rather than healthy behaviour.
- Not to assume a judgemental attitude toward the client.

By incorporating psychological tests into counselling practice, counsellors can provide more accurate diagnosis, effective treatment plans, and better outcomes for their clients but n0 test is infallible and counsellor's neutrality is the most important factor.

Conclusion:

Psychological testing plays a pivotal role in mental health clinics, enabling accurate diagnoses, personalized treatment plans, and improved therapeutic outcomes. By providing objective data, these tests enhance the quality of care and empower patients on their mental health journey. As mental health awareness grows, the demand for reliable psychological assessments will continue to rise, underscoring their importance in fostering emotional well-being.

Psychiatric disorders are highly prevalent and cause an enormous burden of suffering, loss of productivity, morbidity, and mortality. Clinicians may increasingly play a role in preventive interventions through (1) identifying individuals at risk, (2) consulting with agencies, school personnel, and employers who may identify individuals at risk, (3) providing treatment that can reduce the chronicity, severity, and total duration of psychiatric illness, and (4) providing mental health care to a specific population within our evolving health care system, in which health promotion and disease prevention play an increasingly important role.

There is sufficient evidence indicating the efficacy of interventions in reducing risk factors, increasing protective factors, preventing psychiatric symptoms and new cases of mental disorders. Macro-policy interventions to improve nutrition, housing and education or to reduce economic insecurity have proven to reduce mental health problems. Specific interventions to increase resilience in children and adolescents through parenting and early interventions, and programmes for children at risk for mental disorders such as those who have a mentally ill parent or have suffered parental loss or family disruption, have also shown to increase mental well-being and

decrease depressive symptoms and the onset of depressive disorders. Interventions for the adult population, from macro-policy strategies, such as taxation of alcohol products or workplace legislation, to individual support for those with signs of a mental disorder, can reduce mental health problems and associated social and economic burdens. Exercise, social support or community participation have also shown to improve mental health of older populations. Public mental health will benefit from continuing building the evidence base through combining different evaluation methods across low-, middle- and high-income countries. The translation of evidence into policy and practice calls for action at the international, national and local level, including building capacity, advocacy, mainstreaming mental health into public health and other policies and securing infrastructures and sustainability. Mental health professionals have an important role to play in improving the evidence on prevention and promotion in mental health, in engaging relevant stakeholders for developing programmes, and as professional care providers in their practice.

The potential and possibilities for prevention of mental and behavioural disorders have increased substantially in recent years. Universal, selective and indicated preventive interventions are included within primary prevention. Universal prevention targets the general public or a whole population group that has not been identified on the basis of increased risk. Selective prevention targets individuals or subgroups of the population whose risk of developing a mental disorder is significantly higher than average, as evidenced by biological, psychological or social risk factors. Indicated prevention targets high-risk people who are identified as having minimal but detectable signs or symptoms foreshadowing mental disorder or biological markers indicating predisposition for mental disorder, but who do not meet diagnostic criteria for disorder at that time.

Secondary prevention seeks to lower the rate of established cases of the disorder or illness in the population (prevalence) through early detection and treatment of diagnosable diseases. Tertiary prevention includes interventions that reduce disability, enhance rehabilitation and prevent relapses and recurrences of the illness.

The distinction between mental health promotion and mental disorder prevention lies in their targeted outcomes. Mental health promotion aims to promote positive mental health by increasing psychological well-being, competence and resilience, and by creating supporting living conditions and environments. Mental disorder prevention has as its target the reduction of symptoms and ultimately of mental disorders. It uses mental health promotion strategies as one of the means to achieve these goals. Mental health promotion, when aiming to enhance positive mental health in the community, may also have the secondary outcome of decreasing the incidence of mental disorders. Positive mental health serves as a powerful protective factor against mental illness. However, mental disorders and positive mental health cannot be described as the different ends of a linear scale, but rather as two overlapping and interrelated components of a single concept of mental health. Prevention and promotion elements are often present within the same programmes and strategies, involving similar activities and producing different but complementary outcomes.
Prevention of psychiatric disorders involves a range of strategies aimed at reducing the risk of developing mental health conditions. Here are some ways to prevent psychiatric disorders:

PROMOTION OF MENTAL HEALTH:

- Healthy lifestyle: encourage healthy habits, such as regular exercise, balanced diet, and adequate sleep.
- Stress management: teach stress management techniques, such as relaxation, meditation, and deep breathing.
- Social connections: foster social connections and relationships to reduce feelings of loneliness and isolation.

EARLY INTERVENTION:

- Early identification: identify individuals at risk of developing psychiatric disorders, such as those with a family history of mental illness.
- Early intervention: provide early intervention and treatment to prevent the progression of mental health conditions**.**

RISK FACTOR REDUCTION:

- Substance abuse prevention: prevent substance abuse by educating individuals about the risks and consequences of substance use.
- Trauma prevention: prevent trauma by promoting healthy relationships, reducing violence, and providing support for individuals who have experienced trauma.
- Stigma reduction: reduce stigma around mental illness by promoting education, awareness, and understanding.

RESILIENCE BUILDING:

- Coping skills: teach coping skills, such as problem-solving, emotional regulation, and cognitive restructuring.
- Self-esteem enhancement: enhance self-esteem by promoting positive self-talk, self-care, and self-compassion.
- Social support: foster social support by encouraging individuals to build strong relationships with family, friends, and community.

COMMUNITY-BASED PREVENTION:

- Community education: educate communities about mental health, mental illness, and the importance of seeking help.
- Community resources: provide community resources, such as support groups, counselling services, and hotlines.
- Collaboration with healthcare providers: collaborate with healthcare providers to ensure that individuals receive comprehensive care**.**

SCHOOL-BASED PREVENTION:

- Mental health education: educate students about mental health, mental illness, and the importance of seeking help.
- School counselling: provide school counselling services to support students' mental health needs.
- Teacher training: train teachers to recognize early warning signs of mental health conditions and provide support.

WORKPLACE-BASED PREVENTION:

- Employee assistance programs: provide employee assistance programs (EAPS) to support employees' mental health needs.
- Workplace wellness initiatives: implement workplace wellness initiatives, such as stress management and mental health education.
- Manager training: train managers to recognize early warning signs of mental health conditions and provide support**.**

Important Considerations:

- Mental health is a spectrum, and everyone can benefit from strategies that promote well-being.
- Prevention efforts should be tailored to the specific needs of different populations.
- A collaborative approach involving individuals, families, communities, and healthcare professionals is essential.

By addressing these factors, we can work towards creating a society that promotes mental health and well-being for all.

POST TRAUMATIC STRESS DISORDER (PTSD)

Post-traumatic stress disorder (PTSD) is a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event, series of events or set of circumstances. An individual may experience this as emotionally or physically harmful or life-threatening and may affect mental, physical, social, and/or spiritual well-being. Examples include natural disasters, serious accidents, terrorist acts, war/combat, rape/sexual assault, historical trauma, intimate partner violence and bullying.

PTSD has been known by many names in the past, such as “shell shock” during the years of World War I and “combat fatigue” after World War II, but PTSD does not just happen to combat veterans. PTSD can occur in all people, of any ethnicity, nationality or culture, and at any age. People with PTSD have intense, disturbing thoughts and feelings related to their experience that last long after the traumatic event has ended. They may relive the event through flashbacks or nightmares; they may feel sadness, fear or anger; and they may feel detached or estranged from other people. People with PTSD may avoid situations or people that remind them of the traumatic event, and they may have strong negative reactions to something as ordinary as a loud noise or an accidental touch.

A diagnosis of PTSD requires exposure to an upsetting traumatic event. Exposure includes directly experiencing an event, witnessing a traumatic event happening to others, or learning that a traumatic event happened to a close family member or friend. It can also occur as a result of repeated exposure to horrible details of trauma such as police officers exposed to details of child abuse cases.

Symptoms and Diagnosis:

Symptoms of PTSD fall into the following four categories. Specific symptoms can vary in severity.

1. **Intrusion:** Intrusive thoughts such as repeated, involuntary memories; distressing dreams; or flashbacks of the traumatic event. Flashbacks may be so vivid that people feel they are reliving the traumatic experience or seeing it before their eyes.
2. **Avoidance**: Avoiding reminders of the traumatic event may include avoiding people, places, activities, objects and situations that may trigger distressing memories. People may try to avoid remembering or thinking about the traumatic event. They may resist talking about what happened or how they feel about it.
3. **Alterations in cognition and mood:** Inability to remember important aspects of the traumatic event, negative thoughts and feelings leading to ongoing and distorted beliefs about oneself or others (e.g., “I am bad,” “No one can be trusted”); distorted thoughts about the cause or consequences of the event leading to wrongly blaming self or other; ongoing fear, horror, anger, guilt or shame; much less interest in activities previously enjoyed; feeling detached or estranged from others; or being unable to experience positive emotions (a void of happiness or satisfaction).
4. **Alterations in arousal and reactivity:** Arousal and reactive symptoms may include being irritable and having angry outbursts; behaving recklessly or in a self-destructive way; being overly watchful of one's surroundings in a suspecting way; being easily startled; or having problems concentrating or sleeping.

Many people who are exposed to a traumatic event experience symptoms similar to those described above in the days following the event. For a person to be diagnosed with PTSD, however, symptoms must last for more than a month and must cause significant distress or problems in the individual's daily functioning. Many individuals develop symptoms within three months of the trauma, but symptoms may appear later and often

persist for months and sometimes years. PTSD often occurs with other related conditions, such as depression, substance use, memory problems and other physical and mental health problems.

The four tabs below provide brief descriptions of four conditions related to PTSD:

1. Acute Stress
2. Adjustment Disorder
3. Disinhibited social engagement disorder
4. Reactive attachment disorder

Treatment:

It is important to note that not everyone who experiences trauma develops PTSD, and not everyone who develops PTSD requires psychiatric treatment. For some people, symptoms of PTSD subside or disappear over time. Others get better with the help of their support system (family, friends or clergy). But many people with PTSD need professional treatment to recover from psychological distress that can be intense and disabling. It is important to remember that trauma may lead to severe distress. That distress is not the individual's fault, and PTSD is treatable. The earlier a person gets treatment, the better chance of recovery.

Cognitive Behavioural Therapy:

One category of psychotherapy, cognitive behavioural therapies (CBT), is very effective. Cognitive processing therapy, prolonged exposure therapy and stress inoculation therapy (described below) are among the types of CBT used to treat PTSD.

- **Cognitive Processing Therapy** is an evidence-based, cognitive behavioural therapy designed specifically to treat PTSD and comorbid symptoms. It focuses on changing painful negative emotions (such as shame, guilt, etc.) and beliefs (such as "I have failed;" "the world is dangerous") due to the trauma. Therapists help the person confront such distressing memories and emotions.
- **Prolonged Exposure Therapy** uses repeated, detailed imagining of the trauma or progressive exposures to symptom "triggers" in a safe, controlled way to help a person face and gain control of fear and distress and learn to cope. For example, virtual reality programs have been used to help war veterans with PTSD re-experience the battlefield in a controlled, therapeutic way.
- **Trauma Focused Cognitive Behavioural Therapy** is an evidence-based treatment model for children and adolescents that incorporates trauma-sensitive interventions with cognitive behavioural, family, and humanistic principles and techniques.
- **Eye Movement Desensitization and Reprocessing for PTSD** is a trauma-focused psychotherapy which is administered over approximately 3 months. This therapy helps a person to reprocess the memory of the trauma so that it is experienced in a different way. After a thorough history is taken and a treatment plan developed the therapist guides the patient through questions about the traumatic memory. Eye movements similar to those in REM sleep is recreated during a session by having the patient watch the therapist's fingers go back and forth or by watching a light bar. The eye movements last for a brief time period and then stop. Experiences during a session may include changes in thoughts, images, and feelings. After repeated sessions the memory tends to change and is experienced in a less negative manner.
- **Group therapy** encourages survivors of similar traumatic events to share their experiences and reactions in a comfortable and non-judgmental setting. Group members help one another realize that many people would have responded the same way and felt the same emotions. Family therapy may also help because the behaviour and distress of the person with PTSD can affect the entire family.

Other psychotherapies such as interpersonal, supportive and psychodynamic therapies focus on the emotional and interpersonal aspects of PTSD. These may be helpful for people who do not want to expose themselves to reminders of their traumas.

Medication:

Medication can help to control the symptoms of PTSD. In addition, the symptom relief that medication provides allows many people to participate more effectively in psychotherapy.

Some antidepressants such as SSRIs and SNRIs (selective serotonin re-uptake inhibitors and serotonin-norepinephrine re-uptake inhibitors), are commonly used to treat the core symptoms of PTSD. They are used either alone or in combination with psychotherapy or other treatments.

Other medications may be used to lower anxiety and physical agitation, or treat the nightmares and sleep problems that trouble many people with PTSD.

Other Treatments

Other treatments including complementary and alternative therapies are also increasingly being used to help people with PTSD. These approaches provide treatment outside the conventional mental health clinic and may require less talking and disclosure than psychotherapy. Examples include acupuncture, yoga and animal-assisted therapy.

GOALS OF PTSD COUNSELING:

- Reducing PTSD symptoms (flashbacks, nightmares, anxiety, etc.).
- Developing coping skills for managing stress and triggers.
- Changing negative thought patterns.
- Improving emotional regulation.
- Enhancing overall quality of life.

IMPORTANT CONSIDERATIONS:

- Finding a Qualified Therapist: It's essential to seek help from a licensed mental health professional with experience in treating PTSD.
- Individualized Treatment: PTSD treatment is not one-size-fits-all. The best approach will vary depending on the individual's needs and experiences.
- Support Systems: Having a strong support system of family and friends can be crucial for recovery.

POST NATAL DEPRESSION

Post natal depression (PND) comes on within 12 months of having a baby, usually within the first few weeks or months. It can also affect fathers or family members. The birth of a baby can start a variety of powerful emotions, from excitement and joy to fear and anxiety. Most new mothers experience postpartum depression (PPD) or "baby blues" after childbirth, which commonly include mood swings, crying spells, anxiety and difficulty sleeping.

Postpartum depression is a type of mood disorder associated with childbirth. It involves feelings of extreme sadness, anxiety, and fatigue that can make it difficult for new parents to care for themselves or their babies. It's important to understand that PPD is a medical condition, not a personal failing.

Symptoms:

Symptoms of depression after childbirth vary, and they can range from mild to severe.

Baby blues symptoms

Symptoms of baby blues — which last only a few days to a week or two after your baby is born — may include:

- Mood swings

- Anxiety
- Sadness
- Irritability
- Feeling overwhelmed
- Crying
- Reduced concentration
- Appetite problems
- Trouble sleeping

Postpartum depression symptoms:

Postpartum depression may be mistaken for baby blues at first — but the symptoms are more intense and last longer. These may eventually interfere with your ability to care for your baby and handle other daily tasks. Symptoms usually develop within the first few weeks after giving birth. But they may begin earlier — during pregnancy — or later — up to a year after birth.

Postpartum depression symptoms may include:

- Depressed mood or severe mood swings
- Crying too much
- Difficulty bonding with your baby
- Withdrawing from family and friends
- Loss of appetite or eating much more than usual
- Inability to sleep, called insomnia, or sleeping too much
- Overwhelming tiredness or loss of energy
- Less interest and pleasure in activities you used to enjoy
- Intense irritability and anger
- Fear that you're not a good mother
- Hopelessness
- Feelings of worthlessness, shame, guilt or inadequacy
- Reduced ability to think clearly, concentrate or make decisions
- Restlessness
- Severe anxiety and panic attacks
- Thoughts of harming yourself or your baby
- Recurring thoughts of death or suicide

Untreated, postpartum depression may last for many months or longer.

Postpartum psychosis:

With postpartum psychosis — a rare condition that usually develops within the first week after delivery — the symptoms are severe. Symptoms may include:

- Feeling confused and lost
- Having obsessive thoughts about your baby
- Hallucinating and having delusions
- Having sleep problems
- Having too much energy and feeling upset
- Feeling paranoid
- Making attempts to harm yourself or your baby

Postpartum psychosis may lead to life-threatening thoughts or behaviors and requires immediate treatment.

Postpartum depression in the other parent:

Studies show that new fathers can experience postpartum depression, too. They may feel sad, tired, overwhelmed, anxious, or have changes in their usual eating and sleeping patterns. These are the same symptoms that mothers with postpartum depression experience.

Fathers who are young, have a history of depression, experience relationship problems or are struggling financially are most at risk of postpartum depression. Postpartum depression in fathers — sometimes called paternal postpartum depression — can have the same negative effect on partner relationships and child development as postpartum depression in mothers can.

Postpartum Depression Causes and Risk Factors

- A history of depression prior to becoming pregnant, or during pregnancy
- Age at time of pregnancy
- Ambivalence about the pregnancy
- Number of Children (more likely to be depressed in a later pregnancy)
- Family history of mood disorders
- Going through an extremely stressful event, like a job loss or health crisis
- Having a child with special needs or health problems
- Having twins or triplets
- Having a history of depression or premenstrual dysphoric disorder (PMDD)
- Limited social support
- Living alone
- Marital conflict

Counselling for postpartum depression (PPD) is a vital component of treatment, providing emotional support, education, and coping strategies to manage symptoms.

Treatment and recovery time vary, depending on how severe depression is and what the individual needs are.

Baby blues:

The baby blues usually fade on their own within a few days to 1 to 2 weeks. In the meantime:

- Get as much rest.
- Accept help from family and friends.
- Connect with other new mothers.
- Create time to take care of own self.
- Avoid alcohol and recreational drugs, which can make mood swings worse.

Postpartum depression:

Postpartum depression is often treated with psychotherapy — also called talk therapy or mental health counselling — medicine or both.

- **Psychotherapy.** It may help to talk through one's concerns with a psychiatrist, psychologist or other mental health professional. Through therapy, one can find better ways to cope with your feelings, solve problems, set realistic goals and respond to situations in a positive way. Sometimes family or relationship therapy also helps. Examples of therapies used for postpartum depression include cognitive-behavioural therapy (CBT) and interpersonal psychotherapy.
- **Antidepressants.** Health care provider may recommend an antidepressant. Most antidepressants can be used during breastfeeding with little risk of side effects for the baby. One must be aware of the potential risks and benefits of specific antidepressants.

- **Other medicines.** When needed, other medicines may be added to treatment. For example, if one have postpartum depression that includes severe anxiety or insomnia, an antianxiety medicine may be recommended for a short time.

TYPES OF COUNSELLING FOR POSTPARTUM DEPRESSION

1. **Individual counselling**: One-on-one counselling sessions with a therapist.
2. **Group counselling**: Group therapy sessions with other mothers experiencing PPD.
3. **Couples therapy**: Counselling sessions with the mother and father
4. **Family therapy**: Counselling sessions with the mother, father, and other family members.

TECHNIQUES USED IN COUNSELLING FOR POSTPARTUM DEPRESSION

1. **Cognitive-behavioural therapy (CBT**): Helps mothers identify and challenge negative thought patterns.
2. **Interpersonal therapy (IPT**): Focuses on improving relationships and communication skills.
3. **Emotional expression and validation**: Encourages mothers to express and validate their emotions.
4. **Mindfulness and relaxation techniques**: Teaches mothers relaxation techniques, such as deep breathing and progressive muscle relaxation.

IMPORTANT CONSIDERATIONS:

Postpartum depression can affect anyone, regardless of age, race, or socioeconomic status.
It's crucial to seek help if you are experiencing symptoms of PPD.
Early intervention can improve outcomes.
It is important to remember that fathers can also get postpartum depression.

STRESS INDUCED DISORDER

Stress-Related Disorders:

Stress-related disorder is defined as an increased stress load or reduced ability to adapt that depletes the reserve capacity of individuals, increasing their vulnerability to health problems. Stress-related illness can encompass the previously mentioned conditions as the primary cause of dysfunction or as the result of the stress of the dysfunction. Excessive stress sometimes manifests as cardiovascular problems, including hypertension; digestive difficulties, including heartburn, ulcer, and bowel syndromes; respiratory illness and susceptibility to bacterial and viral illness; endocrine dysfunction, particularly adrenal or thyroid dysfunction and delayed or reduced cellular repair; sleep disorders; and breathing pattern disorders, just to mention a few conditions.

Stress is a natural response to life's challenges. However, when stress becomes overwhelming and persistent, it can lead to serious mental health issues known as stress disorders.

These issues include acute stress disorder (ASD), post-traumatic stress disorder (PTSD), depression, and anxiety. They each present differently, but all share common roots in significant stress or trauma.

Stress disorders can profoundly impact an individual's mental, emotional, and physical health, making everyday tasks seem insurmountable. Therefore, early recognition and intervention are essential.

This article provides an overview of various stress disorders and outlines some standard treatment approaches.

Stress disorders refer to emotional and behavioural problems that develop in response to overwhelming stress or trauma, such as abuse, accidents, natural disasters, or life-threatening events.

These disorders significantly affect an individual's mental and physical health, leading to a range of symptoms that interfere with daily functioning and overall well-being.

Acute stress disorder:

ASD occurs in the immediate aftermath of a traumatic event. The sudden shock from such incidents can overwhelm a person's ability to cope, leading to ASD.

It shares many symptoms with PTSD but has a shorter duration. Common symptoms of ASD include:

- intrusive thoughts or flashbacks of the traumatic event
- avoidance of reminders of the trauma
- intense anxiety or panic attacks
- emotional numbness or detachment
- difficulty sleeping or concentrating
- irritability or aggression

Causes:

The causes of ASD include exposure to a traumatic event, such as a natural disaster, serious accident, physical assault, or witnessing a death.

Individuals with a history of previous trauma or those with pre-existing mental health conditions are more susceptible to developing ASD.

POST TRAUMATIC STRESS DISORDER:

PTSD is a severe and chronic mental health disorder that can develop Trusted Source after an individual has exposure to a traumatic event. It involves severe, unsettling thoughts and emotions connected to the trauma that remain long after the incident.

Individuals with PTSD may experience flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the traumatic event. These symptoms can significantly impair daily functioning and quality of life, often requiring long-term treatment and support.

Causes:

PTSD can arise from various traumatic experiences, including:

- military combat
- sexual or physical assault
- childhood abuse
- accidents
- natural disasters

Several factors influence the likelihood of developing PTSD, including:

- severity of the trauma
- duration of exposure
- individual resilience
- genetic predisposition

PTSD usually develops 3 months after a person experiences the traumatic event.

Depression:

Depression is a prevalent but severe mood disorder featuring a persistent low mood, hopelessness, and a lack of interest in activities the person once enjoyed. Individuals with depression may also experience:

- changes in appetite
- disturbed sleeping patterns
- fatigue
- difficulty concentrating
- thoughts of death or suicide

Depression is common, affecting nearly 17 million adults in the United States, with significant differences between age groups. In 18- to 29-year-olds, the prevalence is three times that of people aged 60 years or older. Furthermore, females experience 1.5 to three-fold higher rates than males.

Causes:

The causes of depression can include:

- genetic predisposition
- brain chemistry imbalances
- trauma
- chronic stress
- certain medical conditions and medications

Life events such as the loss of a loved one, divorce, or financial difficulties can also trigger depressive episodes.

Anxiety:

Anxiety disorders involve excessive fear Trusted Source or worry that can interfere with daily activities and significantly impact quality of life. These disorders encompass a range of conditions, including:

- generalized anxiety disorder
- panic disorder
- social anxiety disorder
- specific phobias

People with anxiety disorders may experience symptoms such as:

- persistent worry
- restlessness
- fatigue
- difficulty concentrating
- muscle tension
- sleep disturbances

The intensity and duration of anxiety symptoms can vary, often leading to avoidance of certain situations and activities.

Causes:

A combination of genetic, environmental, and psychological factors can cause anxiety disorders. Chronic stress, traumatic events, substance misuse, and certain medical conditions may contribute to the development of anxiety disorders.

Additionally, an imbalance of neurotransmitters in the brain can link to anxiety.

Treating stress disorders:

Treating stress disorders typically involves a combination of therapy, medication, and lifestyle changes. Cognitive behavioural therapy (CBT) is a common therapeutic approach that helps individuals identify and change negative thought patterns. CBT helps individuals develop healthier ways of thinking and coping with stress by focusing on the relationship between thoughts, emotions, and actions.

The therapy involves cognitive restructuring, which challenges and modifies irrational beliefs, and behavioural activation, which encourages positive activities. Additionally, CBT teaches problem-solving skills and relaxation techniques to manage anxiety and depression, making it a versatile treatment for a range of mental health disorders. Additionally, health professionals may recommend medications such as antidepressants, anti-anxiety drugs, and mood stabilizers to manage symptoms. Lifestyle modifications, including regular exercise, healthy eating, adequate sleep, and stress management techniques, can further support the treatment.

Physical Health Problems:

1. **Cardiovascular disease**: Chronic stress can increase the risk of heart disease, high blood pressure, and stroke.
2. **Gastrointestinal problems**: Stress can lead to irritable bowel syndrome (IBS), ulcers, and other digestive issues.
3. **Weakened immune system**: Prolonged stress can suppress the immune system, making individuals more susceptible to infections.
4. **Headaches and migraines**: Tension headaches and migraines are often triggered by stress.
5. **Sleep disorders**: Stress can disrupt sleep patterns, leading to insomnia.

COUNSELLING NEEDS

1. Chronic stress: If stress persists or worsens over time.

2. Emotional distress: If stress leads to emotional distress, such as anxiety, depression, or mood swings.

3. Impaired functioning: If stress impairs daily functioning, relationships, or work performance.

4. Physical symptoms: If stress leads to physical symptoms, such as headaches, stomach problems, or sleep disturbances.

Counselling for stress-induced disorders typically involves a combination of techniques and strategies to help individuals manage stress, regulate their emotions, and develop coping skills.

Following counselling techniques can be applied:

1. Cognitive-behavioural therapy (CBT): Helps individuals identify and challenge negative thought patterns, behaviours, and coping mechanisms.

2. Mindfulness-based stress reduction (MBSR): Teaches mindfulness techniques, such as meditation and deep breathing, to reduce stress and increase relaxation.

3. Dialectical behaviour therapy (DBT): Combines CBT with mindfulness techniques to help individuals manage emotions, tolerate distress, and improve relationships.

4. Psychodynamic therapy: Explores the underlying causes of stress, including past experiences, relationships, and unconscious thoughts and feelings.

OTHER STRATEGIES:

1. Stress management techniques: Teach individuals stress management techniques, such as relaxation, deep breathing, and exercise.

2. Coping skills training: Help individuals develop coping skills, such as problem-solving, communication, and emotional regulation.

3. Emotional expression and validation: Encourage individuals to express and validate their emotions, reducing feelings of guilt, shame, or anxiety.

4. Self-care and relaxation: Encourage individuals to engage in self-care activities, such as yoga, meditation, or hobbies, to reduce stress and increase relaxation.

BENEFITS OF COUNSELLING

1. Reduced stress: Counselling can help individuals reduce stress levels and improve emotional regulation.

2. Improved coping skills: Counselling can help individuals develop effective coping skills, reducing feelings of overwhelm and anxiety.

3. Enhanced well-being: counselling can promote overall well-being, including physical, emotional, and mental health.

4. Increased resilience: counselling can help individuals develop resilience, reducing the risk of stress-induced disorders.

While counselling for stress-induced disorders can be highly effective, there are some limitations to consider:

LIMITATIONS OF COUNSELLING

1. **Time-consuming**: counselling can be a time-consuming process, requiring regular sessions over several months or even years.
2. **Emotional intensity**: counselling can be emotionally intense, requiring individuals to confront and process difficult emotions and experiences.
3. **Limited accessibility**: counselling services may not be readily available or accessible to all individuals, particularly those in rural or underserved areas.
4. **Cost**: counselling services can be costly, and insurance coverage may vary.

CONCLUSION

Stress disorders, including acute stress disorder, PTSD, depression, and anxiety, are mental health conditions triggered by significant stress or trauma.

Effective management typically involves a combination of therapy, medication, and lifestyle changes, which can improve the outlook for people living with the disorders.

ADJUSTMENT DISORDER

Adjustment disorder is a type of mental health disorder that is characterized by emotional distress and difficulty in adapting to a stressful life transition or situation in life. Adjustment problems are characterized by the development of emotional and behavioural symptoms that occur within three months of the event and cause significant distress or impairment in social, occupational, or other areas of functioning.

Some common signs and symptoms of adjustment disorder are:

1. Emotional symptoms: This involves experiencing feelings of sadness, hopelessness, anxiety, worry, or anger that are out of proportion to the event.

2. Behavioural symptoms: This involves engaging in behaviours that are out of character or out of proportion to the event, such as avoidance, isolation, or increased use of drugs or alcohol.

3. Physical symptoms: People with adjustment problem could also experience physical symptoms such as headaches, stomach aches, or muscle tension that are not caused by a medical condition.

4. Difficulty with daily activities: Individual with Adjustment disorder involves difficulty completing daily activities, such as work or school, due to the emotional and behavioural symptoms.

5. Difficulty with relationships: People experiencing adjustment problem might have difficulty maintaining relationships with family, friends, or co-workers due to the emotional and behavioural symptoms.

6. Suicidal thoughts or behaviours: In severe cases, adjustment disorder can lead to suicidal thoughts or behaviours.

Causes, Issues and challenges of adjustment disorder

Adjustment disorder is characterized by emotional and behavioural symptoms that occur in response to this stressor and can include feelings of sadness, anxiety, worry, and difficulty coping with daily life. The specific causes of adjustment problems can vary widely from person to person, as everyone's experience of stress and their ability to cope with it is unique.

Some common causes of adjustment disorder include:

1. Major life changes: This can include changes such as moving to a new city, starting a new job, or getting married.

2. Relationship issues: Relationship problems such as divorce, separation, or the death of a loved one can trigger adjustment disorder.

3. Health issues: Dealing with a serious health issue or chronic illness can be a significant stressor that leads to adjustment disorder.

4. Trauma: Exposure to a traumatic event, such as a natural disaster, assault, or accident, can trigger adjustment disorder.

5. Financial problems: Financial difficulties, such as job loss or bankruptcy, can be a significant stressor that leads to adjustment disorder.

6. Academic or work-related stress: Pressure to perform well in school or at work can be a significant stressor that leads to adjustment disorder.

Adjustment issues and problems are normal responses to a stressful life event and can affect anyone. However, some individuals may be more susceptible to the condition due to factors such as genetics, past trauma, or a history of mental health issues. Consulting the best psychologist in India and an online counsellor can be an important step in managing adjustment problems.

Some common issues faced by persons with adjustment disorder include:

1. Anxiety: Feeling anxious, nervous, or tense in response to stressors.

2. Depression: Feeling sad, hopeless, or unmotivated as a result of stressors.

3. Difficulty concentrating: Difficulty focusing or making decisions due to stressors.

4. Changes in sleep patterns: Sleeping too much or too little, or having trouble falling or staying asleep.

5. Changes in appetite: Eating too much or too little, or having changes in eating habits.

6. Avoidance behaviour: Avoiding activities or situations that are associated with stressors.

7. Relationship problems: Difficulties in maintaining healthy relationships with family, friends, or romantic partners due to stressors.

8. Work or school problems: Difficulty performing at work or school due to stressors.

9. Physical symptoms: Headaches, stomach aches, or other physical symptoms that cannot be explained by an underlying medical condition.

***It is often observed that the loved ones of those struggling with adjustment disorder can face a number of challenges such as*:**

1. Difficulty in understanding the person's behaviour: Loved ones may struggle to understand why their loved one is behaving in certain ways, which can lead to frustration and conflict.

2. Emotional strain: Supporting someone with an adjustment disorder can be emotionally draining, as loved ones may feel helpless, worried, or overwhelmed.

3. *Changes in relationship dynamics:* The person with an adjustment disorder may become withdrawn, irritable, or difficult to communicate with, which can strain the relationship between the person and their loved ones.

4. Changes in responsibilities: Loved ones may need to take on additional responsibilities, such as caring for children or managing household tasks, due to the person's inability to manage them.

5. Financial strain: If the person with adjustment disorder is unable to work or has medical bills to pay, loved ones may experience financial strain.

6. Isolation: Loved ones may feel isolated if they are unable to engage in activities or social events due to

the person's adjustment disorder.

Faced by family:
Frustration and Interpersonal Conflict.
Feeling of Helplessness
Strained Relationship
Unmanageable Responsibilities
Feeling Isolated and Aloof
Treatment of adjustment disorder
Treatment for adjustment disorder typically involves a combination of therapy online or offline, medication (if necessary), and self-care strategies.

Here are some common treatment options for adjustment disorder:
1. Psychotherapy: Various forms of therapy and counselling can be helpful in treating adjustment disorder, including cognitive-behavioural therapy (CBT), interpersonal therapy (IPT), and supportive therapy. The focus of therapy is on addressing the specific stressor that led to the adjustment disorder and developing coping strategies to manage symptoms.
2. Medication: In some cases, medication from the psychiatrist may be prescribed to help manage symptoms of adjustment disorder, such as anxiety or depression. Antidepressants, anti-anxiety medications, and sleep aids are commonly used. Offline or online psychiatric consultation is recommended before taking any medication.
3. Self-care strategies: Self-care strategies can be helpful in managing symptoms of adjustment disorder. These may include mindfulness practices, exercise, healthy eating, and getting enough sleep.
4. Stress management techniques: Stress management techniques, such as relaxation techniques, breathing exercises, and time management skills, can help individuals manage symptoms and reduce stress. Consulting the psychologist can be an effective way to manage stress.
5. Support groups: Joining a support group can provide individuals with adjustment disorder with a supportive community and a safe space to share their experiences.

Here are some common management strategies for adjustment disorder:

1. Identify triggers: Understanding what triggers the symptoms can help better manage them. Identify the specific stressors that led to adjustment disorder and try to avoid or minimize exposure to them.
2. Practice self-care: Engaging in self-care activities can help reduce stress and improve overall well-being. This may include regular exercise, getting enough sleep, eating a healthy diet, and engaging in hobbies or activities that brings joy.
3. Build a support system: Having a strong support system can be helpful in managing symptoms of adjustment disorder. This may include family, friends, a therapist, or a support group.
4. Develop coping strategies: Developing effective coping strategies can help manage symptoms when they arise. This may include practicing relaxation techniques, mindfulness, or positive self-talk.
5. Manage stress: Manage stress through stress-reduction techniques such as meditation, deep breathing, or yoga.

Therapies for adjustment disorder:

1. Anger Management Therapy
2. Psychodynamic Therapy
3. Cognitive Behavioural Therapy (CBT)

4. Dialectical Behaviour Therapy (DBT)
5. Interpersonal Therapy (IPT)

Counselling can offer several benefits for individuals with adjustment disorder:

1. Emotional support: Counselling can provide a safe and supportive environment for individuals to express their emotions and feelings related to their adjustment disorder, and receive validation and empathy from a trained professional.
2. Coping skills: Through counselling, individuals can learn effective coping strategies and techniques to manage the stress, anxiety, and other symptoms associated with adjustment disorder.
3. Improved Self-awareness: Counselling can help individuals develop a greater understanding of their adjustment disorder and its impact on their life, which can lead to greater self-awareness and self-acceptance.
4. Better communication: Counselling can improve communication skills, including active listening, empathizing, and expressing oneself clearly and effectively, which can help individuals communicate more effectively with loved ones and others in their life.
5. Problem-solving: Counselling can help individuals develop problem-solving skills, enabling them to identify and overcome challenges related to their adjustment disorder.
6. Reduction of symptoms: Counselling can help individuals reduce the symptoms associated with adjustment disorder, such as depression, anxiety, anger and irritability.
7. Improved relationships: By reducing symptoms and improving communication skills, counselling can improve relationships with loved ones, friends, and colleagues.
8. Better quality of life: Counselling can help individuals improve their overall well-being and quality of life by providing them with the tools and support they need to manage their adjustment disorder effectively.

GRIEF COUNSELING

Grief counselling is a type of therapy that helps people deal with the emotional and physical pain and distress that follows significant loss, such as death of a loved one, a terminal illness, or a major life change. It can help people make sense and move on.
People commonly refer to the five familiar stages of grief, initially coined in 1969 by psychiatrist Elisabeth Kubler-Ross. They are:

- Denial
- Anger
- Bargaining
- Depression
- Acceptance

When one is grieving, he/she may go through at least two of the five stages. But it is important to note that there is no common pathway for grief. Everyone experiences it differently.

- Shock
- Disbelief and denial
- Anxiety
- Distress
- Anger
- Periods of sadness
- Loss of sleep

- Loss of appetite

Counselling will help to address some of the reactions as one processes the new reality. Some people recover from grief usually within 6 months, but for some others, it may take up to a year or longer.

Different Types of Grief

Complicated Grief

With time, many overcome or learn to manage grief. But for about 15% of the people who lose a loved one, they may experience a "complicated grief." It's a type of grief in which symptoms and signs that last for up to a year or longer.

While the intensity may vary from person to person depending on the context of the loss. Complicated grief may make it hard to get through the daily routine and function properly.

Severe symptoms can include:

- Intense sadness and emotional pain
- Feeling empty and hopeless
- Yearning to be reunited with your loved one
- Constantly thinking about the deceased person or how they died
- Difficulty engaging in happy memories of the lost person
- Avoiding anything that reminds you of the loved one
- A reduced sense of identity
- Detachment and isolation from friends and family
- Lack of desire to make plans or have interests

Traumatic Grief

If the client loses someone, he/she cares about in a traumatic event like an accident or if they witness them die or become severely injured, the client could be experiencing traumatic grief. It mostly occurs when one is unprepared to lose someone suddenly.

Broken Heart Syndrome

While grief is highly unlikely to kill you, the severe stress from living with it may affect heart health in situations of sudden shock. If the grief is very intense, body may release stress hormones that may cause part of the heart to swell and pump blood unevenly and beat irregularly. It can cause chest pains similar to a heart attack. This is called broken heart syndrome.

Most people who experience this type of grief recover in a couple of weeks and may not have a similar event again. Women are more prone to broken heart syndrome than men.

Depression and Grief

Grief's symptoms like lack of joy, anxiety, or sense of despair, can look a lot like depression.

What Are the Techniques Used in Grief Counselling?

The goals of grief or bereavement counselling can include four main stages such as:

- 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 with a loved one lost while finding ways to move on with life

Grief Counselling for Children

Unlike adults, children may experience grief differently. They may not understand the loss and what it means to their reality at first. They may often look to adults on how to mourn and process their feelings. Being direct and honest with them may help them assess and accept their grief.

If a child loses a close family member, they may benefit from a counsellor for children to learn to grieve in a healthy manner or also use family therapy as a unit. Activities like storytelling and play may also help them understand the loss.

Grief Counselling Techniques

These are some of the techniques that grief counsellors or therapists use:

- **Acceptance and Commitment Therapy (ACT)**: Encourages to accept negative feelings and circumstances so the client can focus on healthier patterns of life.
- **Cognitive Behaviour Therapy (CBT)**: Involves identifying and changing thought patterns that can negatively influence the behaviour
- **Group Therapy**: Carried out in a group setting in which participants share their feelings to work toward recovery together.
- **Art Therapy:** Uses creative activities to help people of all ages express their emotions and promote healing
- **Play Therapy:** Often used to gain insights into a child's thoughts and feelings to help them process unresolved emotions and build constructive behaviour patterns

WHAT GRIEF COUNSELLING CAN HELP WITH

1. Extreme mourning
2. Being unable to separate from the person who died
3. Behavioural and physical problems
4. Identifying unhealthy behaviours
5. Building coping strategies
6. Learning to accept grief as a normal process
7. Building new relationships
8. Developing a new identity

PRINCIPLES OF GRIEF COUNSELLING

1. Validation: Acknowledge and validate the individual's feelings and experiences.
2. Empathy: Provide a supportive and non-judgmental space for the individual to express their emotions.
3. Education: Inform the individual about the grieving process and what to expect.
4. Support: Offer ongoing support and guidance as the individual navigates the grieving process.
4. Anticipatory Grief: Grief that occurs before a loss, such as when a loved one is terminally ill.

BENEFITS OF GRIEF COUNSELLING

1. Reduced emotional pain: Grief counselling can help individuals manage their emotions and reduce their distress.
2. Improved mental health: Grief counselling can help individuals develop coping strategies and reduce their risk of developing mental health conditions such as depression and anxiety.
3. Increased social support: Grief counselling can provide individuals with a sense of connection and support from others who have experienced a similar loss.
4. Enhanced personal growth: Grief counselling can help individuals develop a greater sense of self-awareness and personal growth.

COUNSELLING ON RECENT AND PAST TRAUMA

Trauma is defined as exposure to death, severe injury, or sexual violence, which can occur directly to an individual through witnessing the event, indirectly, or via repeated exposure to distressing details. The effects of trauma vary among individuals and populations, manifesting in diverse ways and significantly impacting survivors. Traumatic incidents can profoundly affect cognitive, emotional, and physical functioning. Trauma-informed therapy is a framework designed to acknowledge and address the impact of traumatic experiences on individuals' and communities. Trauma-informed therapy focuses on recognizing trauma symptoms and understanding their root causes. The therapy provides a safe and supportive environment for patients, addressing their individual experiences and needs and fostering healing and resilienc

Objectives:

- Identify the various manifestations and effects of trauma in individuals, including cognitive, emotional, and physical impacts.
- Implement trauma-informed practices in therapeutic settings to create a safe and supportive environment for patients.
- Apply trauma-informed principles to develop individualized treatment strategies that address the unique experiences and needs of trauma survivors.
- Collaborate with an inter-professional healthcare team to integrate trauma-informed approaches across all aspects of patient care and support.

Trauma is a complex response to deeply distressing or disturbing events that overwhelm an individual's ability to cope. Dealing with recent or past trauma can be a challenging but essential step towards healing. Counselling for recent and past trauma involves a sensitive and supportive approach to help individuals process and cope with their traumatic experiences. Counselling can create a safe and trusting environment for the individual to share their experiences. It can also process and integrate traumatic memories by helping the individual process and integrate traumatic memories into their narrative. Counselling reduce symptoms and distress, reduce symptoms of post-traumatic stress disorder (PTSD), anxiety, and depression, and also enhance coping skills and trauma can have long-lasting effects on mental and physical health. A qualified therapist can provide specialized support and guidance.

Trauma-focused psychotherapy is defined as any therapy that uses cognitive, emotional, or behavioural techniques to facilitate the processing of a traumatic experience, with the trauma focus being a central component of the therapeutic process. Trauma-informed therapy encompasses a range of therapeutic modalities aimed at addressing the complex needs of individuals affected by trauma. These therapies are applied in behavioural health contexts to create a safe and supportive environment that fosters healing and resilience while integrating trauma awareness into every facet of care.

Trauma-informed therapy is often used to address a range of mental health conditions where trauma plays a significant role in symptom development or aetiology. These conditions include PTSD, acute stress disorder, reactive attachment disorder, disinhibited social engagement disorder, prolonged grief disorder, and adjustment disorders. Although evidence is limited and knowledge on tolerability is insufficient, trauma-informed therapy may also be considered for dissociative disorders, which are closely related to trauma-related conditions. Many individuals with borderline personality disorder have a history of trauma. Trauma-informed approaches such as dialectical behaviour therapy (DBT), mentalization-based therapy (MBT), and eye movement desensitization and reprocessing (EMDR) can help address trauma-related distress, including flashbacks, nightmares, anxiety, and depression.

Trauma-informed therapy can also improve the management of borderline personality disorder symptoms by promoting skills such as emotional regulation, interpersonal effectiveness, and distress tolerance. Integrating trauma-focused cognitive behavioural therapy (TF-CBT) into the treatment of substance use disorders can be particularly effective due to the connection between trauma and substance use. Evidence indicates that EMDR, CBT, and other cognitively oriented approaches, such as mindfulness exercises, can be effective trauma-informed therapies for depression and anxiety.

Psychosis is a leading global cause of disability and mortality, with evidence suggesting that developmental trauma may contribute to psychotic symptoms in adulthood. Clinicians might find it beneficial to incorporate the following areas into treatment—emotion regulation, psychological acceptance, interpersonal skills, attachment, dissociation, and trauma memory reprocessing.

Trauma-Informed Psychotherapies:

Modalities such as exposure therapy, TF-CBT, and EMDR have demonstrated efficacy in treating trauma. These therapies include components designed to help individuals address and work through their traumatic memories, cognitive patterns, and perceptions of traumatic experiences.

Common elements of trauma-informed therapy include:

- Psychoeducation: Providing information about stress reactions, coping with trauma reminders, and managing distress.
- Emotion regulation and coping skills.
- Imaginal exposure.
- Cognitive processing, restructuring, and meaning-making.
- Targeting emotions such as trauma, guilt, shame, anger, grief, or sadness.

Exposure therapy involves exposing individuals to the thoughts, feelings, and situations that individuals fear or avoid. This therapy is based on the principle of habituation, which suggests that repeated exposure to feared stimuli leads to a reduction in anxiety over time. Exposure therapy often involves guiding individuals to revisit the trauma using methods such as mental imagery, writing, or recording a detailed account of the event. The individual is then encouraged to repeatedly engage with the narrative through listening or reading, which helps build.

An alternative method of exposure therapy involves systematically reintroducing cues associated with the traumatic event, using a hierarchy of stimuli to address the trauma. Virtual reality is an emerging form of exposure therapy that offers multisensory cues within an interactive and emotionally engaging environment. This approach potentially provides better control over stimuli, allows for unlimited exposure repetitions, and enables the creation of challenging environments, although it requires further study.

Prolonged exposure therapy is a manualized form of exposure therapy for treating PTSD, comprising 3 main components—psychoeducation, in vivo exposure, and imaginal exposure, followed by processing. In vivo exposure is usually assigned as homework, where the individual confronts safe but trauma-related situations they typically avoid. This therapy generally involves 8 to 15 individual 90-minute sessions, delivered once or twice weekly by mental health clinicians. TF-CBT assists individuals in identifying, exploring, and modifying negative beliefs about themselves, others, and the world. This manualized approach addresses issues such as mistrust, self-blame, feelings of inadequacy, and perceptions of danger. TF-CBT also targets maladaptive behaviours that may exacerbate trauma symptoms or impair functioning, such as avoiding certain activities or excessive substance use.

Common Therapeutic Approaches:

Several effective therapies are used in trauma counselling:

Cognitive Behavioural Therapy (CBT):

Helps identify and change negative thought patterns and behaviours related to the trauma.

Trauma-focused CBT (TF-CBT) is specifically designed for trauma survivors.

Eye Movement Desensitization and Reprocessing (EMDR):

Uses guided eye movements or other bilateral stimulation to help process traumatic memories.

Can help reduce the intensity of distressing emotions and thoughts.

Prolonged Exposure Therapy (PE):

Involves gradually exposing individuals to trauma-related memories, feelings, and situations.

Helps reduce avoidance behaviours and decrease anxiety.

Psychodynamic Therapy:

This form of therapy explores how past experiences, including traumatic ones, influence present behaviours and feelings.

Group Therapy:

Provides a supportive environment for survivors to share their experiences and connect with others who have experienced similar trauma.

Techniques and Strategies

1. Establishing a trauma narrative: Helping the individual create a narrative of their traumatic experiences.
2. Emotional regulation: Teaching techniques to regulate emotions and manage distress.
3. Cognitive restructuring: Helping the individual reframe negative thoughts and beliefs associated with the trauma.
4. Exposure therapy: Gradually exposing the individual to situations or stimuli that trigger traumatic memories.

Considerations:

1. Client-centred approach: Prioritizing the individual's needs, preferences, and boundaries.
2. Cultural sensitivity: Being sensitive to the individual's cultural background and experiences.
3. Avoiding re-traumatization: Avoiding techniques that may re-traumatize the individual.
4. Collaboration with other professionals: Collaborating with other professionals, such as psychiatrists or medical professionals, to ensure comprehensive care.

COUNSELLING SETTING

COUNSELLING IN PRIMARY CARE

Primary care counselling services have expanded rapidly over the last twenty years. Their principal focus has been to manage the demands placed on general practitioners by high service users, such as frequent attenders and patients with mental health problems. To date, very little research has been conducted to ascertain the impact of counselling for other patient groups in terms either of psychological outcomes or of cost-benefits.

Counselling in primary care refers to the integration of counselling services into primary care settings, such as general practitioner (GP) offices, community health canters, and hospitals. Here are the benefits and key aspects:

BENEFITS OF COUNSELLING IN PRIMARY CARE

1. Improved access: Counselling services are more accessible to patients, especially those who may not have sought help otherwise.

2. Early intervention: Counselling can help identify and address mental health issues early on, reducing the risk of more severe problems developing.

3. Holistic care: Primary care providers can address patients' physical and emotional needs in a single setting.

4. Increased patient engagement: Counselling can help patients take a more active role in their healthcare, leading to better health outcomes.

KEY ASPECTS OF COUNSELING IN PRIMARY CARE

1. Collaboration: Primary care providers work closely with counsellors to ensure comprehensive care.

2. **Brief interventions:** Counselling sessions are often brief, focusing on specific issues or concerns.

3. Solution-focused: Counselling in primary care tends to be solution-focused, emphasizing practical strategies and coping skills.

4. Cultural sensitivity: Counsellors in primary care settings must be culturally sensitive, adapting their approach to meet the diverse needs of patients.

COMMON ISSUES ADDRESSED IN PRIMARY CARE COUNSELLING

1. Anxiety and depression: Counselling can help patients manage symptoms of anxiety and depression.

2. Stress management: Counsellors can teach patients effective stress management techniques.

3. Chronic illness management: Counselling can help patients cope with the emotional and psychological aspects of chronic illness.

4. Relationship issues: Counsellors can provide support and guidance on relationship concerns, such as communication and conflict resolution.

TRAINING AND QUALIFICATIONS FOR PRIMARY CARE COUNSELORS

1. Mental health training: Counsellors in primary care settings typically require specialized training in mental health.

2. Certification: Many primary care counsellors hold certifications, such as licensed professional counsellor (LPC) or licensed mental health counsellor (LMHC).

3. **Experience working with diverse populations**: Primary care counsellors should have experience working with diverse patient populations, including those with varying cultural backgrounds and socioeconomic statuses.

COUNSELLING STUDENT HEALTH

Counselling in student health is an essential service that supports the mental health and well-being of students. Here are some key aspects. Student Health and Counselling is committed to providing safe, accessible, cost-effective, culturally-sensitive, and student-focused care. Counselling provides care for acute and chronic health problems, preventative health services, as well as mental health and counselling, crisis management, and consultations.

BENEFITS OF COUNSELLING IN STUDENT HEALTH

1. Improved mental health: Counselling helps students manage stress, anxiety, and depression.

2. Better academic performance: By addressing mental health concerns, students can improve their focus, motivation, and overall academic performance.

3. **Increased self-awareness**: Counselling helps students develop a better understanding of themselves, their values, and their goals.
4. Enhanced coping skills: Students learn effective coping strategies to manage stress, anxiety, and other challenges.
5. **Support for personal growth**: Counselling provides a safe space for students to explore their identity, relationships, and future plans.

COMMON ISSUES ADDRESSED IN STUDENT COUNSELLING

1. Academic stress and pressure
2. Anxiety and depression
3. Relationship issues (romantic, family, and friends)
4. Identity and self-esteem concerns
5. Trauma and crisis support
6. Adjustment to university life
7. Career development and planning

TYPES OF COUNSELLING SERVICES IN STUDENT HEALTH

1. Individual counselling: One-on-one sessions with a trained counsellor.
2. Group counselling: Small groups focused on specific topics or concerns.
3. Workshops and seminars: Educational programmes on mental health, wellness, and life skills.
4. Crisis intervention: Emergency support for students in crisis.
5. Referral services: Connecting students with off-campus resources and services.

Qualities of Effective Student Counsellors

1. Empathy and understanding
2. Cultural competence and sensitivity
3. Knowledge of student development and mental health
4. Strong communication and interpersonal skills
5. Ability to work with diverse student populations

GENERAL HOSPITAL SETTING

Counselling in a general hospital setting is an essential service that supports the emotional and psychological well-being of patients, families, and healthcare staff.

BENEFITS OF COUNSELLING IN GENERAL HOSPITAL SETTING

1. Improved patient outcomes: Counselling can help patients cope with illness, treatment, and recovery, leading to better health outcomes.
2. Enhanced patient satisfaction: Counselling can address patients' emotional and psychological concerns, improving their overall hospital experience.
3. Support for families and caregivers: Counselling can help families and caregivers cope with the emotional impact of a loved one's illness or injury.
4. Staff support and well-being: Counselling can help healthcare staff manage stress, burnout, and compassion fatigue.

COMMON ISSUES ADDRESSED IN HOSPITAL COUNSELLING

1. Adjustment to illness or injury
2. Coping with pain and symptoms
3. Anxiety and depression
4. End-of-life concerns and bereavement
5. Organ transplantation and donation
6. Chronic illness management
7. Palliative care

TYPES OF COUNSELLING SERVICES IN GENERAL HOSPITAL SETTING

1. Individual counselling: One-on-one sessions with a trained counsellor.
2. Family counselling: Sessions with patients and their families to address shared concerns.
3. Group counselling: Small groups focused on specific topics or concerns.
4. Crisis intervention: Emergency support for patients and families in crisis.
5. Consultation and liaison: Counsellors work with healthcare teams to address patient care concerns.

QUALITIES OF EFFECTIVE HOSPITAL COUNSELLORS

1. Empathy and understanding
2. Knowledge of medical and mental health conditions
3. Strong communication and interpersonal skills
4. Ability to work with diverse patient populations
5. Collaboration with healthcare teams

VOLUNTARY ORGANISATION

Counselling in voluntary organizations provides essential emotional support and guidance to individuals, families, and communities in need

BENEFITS OF COUNSELLING IN VOLUNTARY ORGANIZATIONS

1. Accessible and affordable: Counselling services are often free or low-cost, making them accessible to marginalized or disadvantaged populations.
2. Community-based: Voluntary organizations are often embedded in local communities, allowing counsellors to develop strong relationships and understand community-specific issues.
3. Specialized support: Voluntary organizations may offer specialized counselling services, such as trauma support, addiction counselling, or bereavement care.
4. Holistic approach: Counselling in voluntary organizations often addresses the whole person, including their emotional, social, and practical needs.

TYPES OF COUNSELLING SERVICES IN VOLUNTARY ORGANIZATIONS

1. Individual counselling: One-on-one sessions with a trained counsellor.
2. **Group counselling**: Small groups focused on specific topics or concerns.
3. Family counselling: Sessions with families to address shared concerns.
4. Crisis intervention: Emergency support for individuals in crisis.
5. Advocacy and support: Counsellors may advocate for clients' rights and provide practical support.

EXAMPLES OF VOLUNTARY ORGANIZATIONS OFFERING COUNSELLING SERVICES

1. Mental health charities: Organizations focused on mental health, such as Mind or Rethink Mental Illness.

2. Cancer support organizations: Organizations providing emotional support to individuals affected by cancer.

3. Refugee and asylum seeker organizations: Organizations offering counselling and support to refugees and asylum seekers.

4. Domestic violence and abuse organizations: Organizations providing counselling and support to survivors of domestic violence and abuse.

CHALLENGES AND CONSIDERATIONS

1. Limited resources: Voluntary organizations may face funding constraints, limiting the scope and availability of counselling services.

2. Counsellor burnout: Counsellors in voluntary organizations may experience high levels of burnout due to heavy caseloads and limited support.

3. Cultural sensitivity and awareness: Counsellors must be culturally sensitive and aware of the diverse needs and experiences of their clients.

4. Confidentiality and data protection: Voluntary organizations must ensure confidentiality and data protection for their clients.

WORK PLACE

A 'workplace' may refer to a specific location or space where an individual works to produce capital for oneself and/or for others. However, it has become difficult to define 'workplace' as it has undergone drastic changes from pre-industrial revolution to the post-industrial revolution and the digital era of today. We can say that life has come to a full circle, i.e., before industrial revolution many people worked from home as in cottage industries (a portion of the house usually had a workshop). Industrialization witnessed a huge workforce working outside their homes, in factories, offices, roads etc. Post industrialization, with more advanced technology emerged the era of multinational companies and outsourcing that reverted the workplace to home for many workers. The digital era now, especially after the COVID 19 pandemic, has put the focus on working from home culture.

Counselling in the workplace provides employees with emotional support and guidance to manage work-related issues, personal problems, and career development or in other words we can say, Workplace counselling is a type of therapy that is offered to the employees of a company. It is often provided through the **Employee Assistance Programme (EAP).** The main goal is to understand the problems of your employees and solve them.

DEFINITION

"Workplace counselling" refers to the ability to deal with issues that occur within an organization, such as conflict, stress-related absence, work-related trauma, and harassment/bullying" (Hughes & Kinder, 2007). Counselling at Workplace 307 According to Donne (1990), workplace counselling does not imply 'treatment', but it involves sharing experiences and providing a set of attitudes or techniques by the counsellor to individuals to help them cope with the problem/crisis. So, workplace counselling is a situation- specific and time-limited endeavour that is focused on resolution of a current problem. Some common features are:

- To address an issue that has been caused by workplace
- To address non-work issues that can create problems in the workplace
- To create a positive impact in the workplace

Counselling is often provided by qualified professionals to navigate the mental health challenges that can negatively impact employee performance, employee engagement and retention.

- Workplace counselling is different from other types of counselling as, • it is provided in the workplace setting. • It focuses only on workplace issues or workplace related issues that might adversely affect the employees' productivity. • Workplace counsellors must understand the organizational processes, its culture, practices, and challenges that can influence the well-being of an organization and its employees.

BENEFITS OF WORKPLACE COUNSELLING

1. Improved employee well-being: Counselling helps employees manage stress, anxiety, and other mental health concerns.

2. Increased productivity: Supported employees are more focused, motivated, and productive.

3. Enhanced job satisfaction: Counselling helps employees address work-related issues, leading to increased job satisfaction.

4. Reduced absenteeism and turnover: Supported employees are less likely to take sick leave or leave the organization.

5. Better work-life balance: Counselling helps employees manage personal and professional responsibilities.

TYPES OF WORKPLACE COUNSELLING

1. Employee Assistance Programs (EAPs): Confidential counselling services for employees and their families.

2. Managerial counselling: Counselling for managers to develop leadership skills and address team issues.

3. Team counselling: Counselling for teams to improve communication, collaboration, and conflict resolution.

4. Career counselling: Counselling to support employees' career development and transition.

5. Trauma and crisis counselling: Counselling for employees affected by workplace trauma or crisis.

MODES OF COUNSELLING

1. In-house counselling: Employers hire internal counsellors or HR staff trained in counselling.

2. External EAP providers: Employers partner with external EAP providers to offer counselling services.

3. Online counselling: Online platforms provide counselling services to employees, often with flexible scheduling.

CONSIDERATIONS

1. **Confidentiality**: Ensure counselling services maintain confidentiality.

2. Accessibility: Provide easy access to counselling services, including flexible scheduling.

3. Promotion: Promote counselling services to employees, reducing stigma.

4. Evaluation: Regularly evaluate counselling services to ensure effectiveness.

5. Integration: Integrate counselling services with other employee support initiatives.

ETHICAL AND LEGAL ISSUES IN COUNSELLING

ETHICAL AND LEGAL ISSUES

Ethical and Professional issues of counselling Principles direct attention to important ethical responsibilities. Each principle is described below and is followed by examples of good practice that have been developed in response to that principle. Ethical decisions that are strongly supported by one or more of these principles without any contradiction from others may be regarded as reasonably well founded. However, practitioners will encounter circumstances in which it is impossible to reconcile all the applicable principles and choosing between principles may be required. A decision or course of action does not necessarily become unethical

merely because it is contentious or other practitioners would have reached different conclusions in similar circumstances. A practitioner's obligation is to consider all the relevant circumstances with as much care as is reasonably possible and to be appropriately accountable for decisions made.

Fidelity: honouring the trust placed in the practitioner being trustworthy is regarded as fundamental to understanding and resolving ethical issues. Practitioners who adopt this principle: act in accordance with the trust placed in them; regard confidentiality as an obligation arising from the client's trust; restrict any disclosure of confidential information about clients to furthering the purposes for which it was originally disclosed.

Autonomy: respect for the client's right to be self-governing this principle emphasizes the importance of the client's commitment to participating in counselling or psychotherapy, usually on a voluntary basis.
Practitioners who respect their clients' autonomy: ensure accuracy in any advertising or information given in advance of services offered; seek freely given and adequately informed consent; engage in explicit contracting in advance of any commitment by the client; protect privacy; protect confidentiality; normally make any disclosures of confidential information conditional on the consent of the person concerned; and inform the client in advance of foreseeable conflicts of interest or as soon as possible after such conflicts become apparent. The principle of autonomy opposes the manipulation of clients against their will, even for beneficial social ends. **Beneficence:** a commitment to promoting the client's well-being the principle of beneficence means acting in the best interests of the client based on professional assessment. It directs attention to working strictly within one's limits of competence and providing services on the basis of adequate training or experience. Ensuring that the client's best interests are achieved requires systematic monitoring of practice and outcomes by the best available means. It is considered important that research and systematic reflection inform practice. There is an obligation to use regular and on-going supervision to enhance the quality of the services provided and to commit to updating practice by continuing professional development.

An obligation to act in the best interests of a client may become paramount when working with clients whose capacity for autonomy is diminished because of immaturity, lack of understanding, extreme distress, serious disturbance or other significant personal constraints.

Non-maleficence: a commitment to avoiding harm to the client non-maleficence involves: avoiding sexual, financial, and emotional or any other form of client exploitation; avoiding incompetence or malpractice; not providing services when unfit to do so due to illness, personal circumstances or intoxication.
The practitioner has an ethical responsibility to strive to mitigate any harm caused to a client even when the harm is unavoidable or unintended. Holding appropriate insurance may assist in restitution. Practitioners have a personal responsibility to challenge, where appropriate, the incompetence or malpractice of others; and to contribute to any investigation and/or adjudication concerning professional practice which falls below that of a reasonably competent practitioner and/or risks bringing discredit upon the profession.

Justice: the fair and impartial treatment of all clients and the provision of adequate services the principle of justice requires being just and fair to all clients and respecting their human rights and dignity. It directs attention to considering conscientiously any legal requirements and obligations, and remaining alert to potential conflicts between legal and ethical obligations. Justice in the distribution of services requires the ability to determine impartially the provision of services for clients and the allocation of services between clients. Commitment to fairness requires the ability to appreciate differences between people and to be committed to equality of opportunity, and avoiding discrimination against people or groups contrary to their legitimate personal or social characteristics.

Practitioners have a duty to strive to ensure a fair provision of counselling and psychotherapy services, accessible and appropriate to the needs of potential clients.

Self-respect: fostering the practitioner's self-knowledge and care for self the principle of self-respect means that the practitioner appropriately applies all the above principles as entitlements for self. This includes seeking counselling or therapy and other opportunities for personal development as required. There is an ethical responsibility to use supervision for appropriate personal and professional support and development, and to seek training and other opportunities for continuing professional development. Guarding against financial liabilities arising from work undertaken usually requires obtaining appropriate insurance. The principle of self-respect encourages active engagement in life-enhancing activities and relationships that are independent of relationships in counselling or psychotherapy.

Transference is a concept in psychoanalysis that owes its origin and use to Sigmund Freud. It defines the unconscious revival of past psychological experiences with objects and other persons such as figures of authority (e.g. parents). The process involves the projection of these attitudes and feelings from earlier life into other people-such as the physician in cases of a counselling relationship set up. It may be termed as the patient's active effort to re-enact or revive these attitudes and feelings from the past as though they belonged to the present time-time of analysis.

Counter-transference in analysts can be demonstrated by situations which an analyst begins to feel excessively sympathetic to the client concerning how other people treat the client. This kind of sympathetic feelings may lead to empathy which may impel the analyst to do something active for the client such as offering suggestions or advice. Failure to obtain informed consent, failure to obtain legal consent is an issue that is related to counselling and psychotherapy, especially; in the management of the client's records. This issue is closely related to client abandonment and cessation of practice. A practitioner whether still practicing or not, still has an ethical and legal obligation to maintain the records of his clients in confidentiality and adhere to obtaining of legal consent in the securing and disposition of a client's records.

COUNSELLING ETHICS

Like most professionals and practitioners working with human beings, so also for mental health professionals and counsellors, there are 'Professional Ethics' largely recommended, agreed upon and practiced. Most important ones are strictly to be followed. Ethics are:

- **Anonymity**
- **Confidentiality**
- **Counselee's right as consumer**
- **No exploitation**
- **Equality relationship**
- **Legal issues**
- **Credentialism and Licensure**

Anonymity

The personal identity of the counselee must be strictly kept hidden and guarded and not shared with anyone without counselees' permission. The only exception in the case of small children for their welfare, parents and guardians can be given the identity of the child client.

Confidentiality

Along with the personal identity protection, whatever content that the counselee shares, must be protected and not shared or else the counselee loses confidence in all counsellors and may doubt the profession itself. The only exception can be made in special cases where a counsellor may feel the need to share some counselee communication with fellow professionals for expert advice to solve the problem.

Counselees' right as consumer

Despite healthy relationship between counsellor and counselee, optimum benefits must be received by counselee in proportionate exchange of the time spent, expenditure incurred and expectations unmet.

No Exploitation

Counselees' exploitation or physical/ sexual abuse or emotional abuse is unpardonable. Since the counselee during counselling process at some stage or another may become emotionally dependent/attached/entangled with counsellor, he/she may be in a vulnerable position, the counsellor must still maintain emotional detachment within and not abuse/misuse counselee's vulnerability.

Equality Relationship

The counselee's human dignity must be respected and equality relationship during counselling sessions should be maintained. If the counsellor feels superior to counselee by virtue of own expertise, the counsellor may become dominating. If counsellor feels lesser than counselee (due to status or power of health) the counsellor may lose confidence to counsel.

Limits of Confidentiality in Counselling

While counsellors must respect patient confidentiality as a general rule, certain situations permit (if not require) them to share information, even if it is private or sensitive in nature.

When Confidentiality Can Be Broken

As stated by the APA, therapists may disclose patient information without consent to prevent patients from harming themselves or others. They are legally required to report ongoing domestic violence, abuse and neglect of children, elderly individuals and people with disabilities. In many cases, therapists are compelled to release information according to an official court order.

Client Consent and Exceptions

Although patient confidentially laws may differ from state to state, in most situations, information can be shared if the patient provides written consent to do so. Beyond the client consent and the exceptions outlined by the APA, confidential information can be shared with a payer, aka insurance, for relevant billing purposes and to share critical health information among multiple providers.

Legal Issue

Sharing information, incidents and actions by counsellee during counselling is legally 'privileged communication' and none of it, in full or in part should be ethically or legally shared, disclosed or made public. Such a revelation will not only a personal moral offence but also legal offence.

Credentialism and Licensure

No one, without proper education, training and credentialism must take on the noblest profession of being a 'Mental Health Practitioner'/Counsellor or else it will mean deception of innocent, suffering people as counselee. Licensing is compulsory in some countries, but not in all countries, so without licensing, it is a counsellor's own professionalism to be honest about his /her specialization, credentials and expertise. Despite credentialism and expertise, the counsellor must refer a counselee, if counsellor feels inadequate experience for a specific problem.

➢ UNIT- 2 COUNSELLING SPECIFIC

STRUCTURE

2.0 OBJECTIVES

After studying this unit, we will be able to understand

- Child counselling
- Student counselling
- Counselling for different disorder
- Marriage and marital counselling
- Counselling for elderly care
- Counselling for sexual problems

TEACHING CHILDREN SELF CONTROL THROUGH COUNSELLING

Before understanding the meaning of self-control, first we need to understand the meaning of the 'self.' The 'self' is an individual's sense of being an autonomous agent with their own independent thoughts and behaviours.

Although 'control' can be associated with a child who willingly complies with directives from adults, the ability to truly self-regulate is autonomous and self-initiated (Duckworth, Szabo-Gendler, & Gross, 2014).

One of the central models in the self-control literature is the *ego depletion model*. The ego depletion model suggests that self-control relies on a limited energy source, and every attempt to harness self-control results in a depletion of that energy.

However, the *process model* emphasizes that response tendencies that develop over time and our emotional responses are partly determined by which situations we select from a range of options (Augimeri et al., 2018).

The process model also emphasizes that emotions fundamentally involve valuation, which is a determination of what is good for someone versus what is bad for them. A valuation system comprises four parts, which are broken down below (Ford & Gross, 2018):

1. *Exposure to the world*
   Changes to external and internal factors in the person's environment.

2. *Perception of the world*
   How an individual perceives what is happening and what it looks like to them.

3. *Evaluation of the world*
   Whether their perception of the world is good or bad.

4. *Desired state of the world*
   The individual's desire to engage in action based on their perception of the world and desired state of the world.

This model emphasizes that self-control is a multi-step process that can go through several cycles and iterations.

It is important for children to have the space to develop their perception of the world around them and understand how their desires coincide. It is also important for them to understand how to cope when these two constructs do not align and healthily balance their emotional responses.

The ability of children to control their impulses is a key factor in long-term success. One of the most widely known studies followed children for over five decades (Mischel, Ebbesen, & Raskoff-Zeiss, 1972).

The original study put a marshmallow in front of preschool-aged children and told them if they waited 20 minutes, then they would get a bigger snack (Mischel, 2014). Sixty-seven percent (67%) of the children could not resist, which indicated a lower level of self-control. After the test, the children were followed for over five decades, tracking how the ability to exercise self-control correlated with various life outcomes.

Children who resisted had higher SAT scores, educational attainment, sense of self-worthiness, and ability to cope with stress (Mischel et al., 1972).

Young children who have poor self-regulation skills tend to have poorer health and behaviour outcomes. The years between ages 6 and 12 are considered a key time for intervention and prevention, as this age group is considered to be the most responsive to self-control strategies (Howell, Lipsey, & Wilson, 2014).

Teaching self-control to children involves a combination of strategies and techniques.

The structured approach is:

1) <u>BUILDING EMOTIONAL AWARENESS-</u>

- **Label emotions –**Help children identify and label their emotions,(example- “I see you look angry/frustrated “or ”You look excited/happy”). It helps the child recognize situations, emotions or events that trigger impulsive behaviour.
- **Emotion regulation skills**- Introduce relaxation techniques like deep breathing, counting 1-10, visualisation, physical activity or positive self-talk to help the child manage stress or anxiety.

2) <u>MODELING SELF CONTROL-</u>

- **Be a role model-** Children learn from what they see, to become a role model demonstrate self-control in your own actions, responses. Express your feeling in a healthy way, showing calmness and patience can reinforce those behaviours.
- **Use stories or examples-** Share stories or examples where individuals practice self-control and show the positive outcomes. For younger children, use relatable characters or scenarios in book or media.

3) <u>POSITIVE REINFORCEMENT-</u>

- **Reinforce good behaviour-** Praise the children when they exhibit self-control, provide reward or incentives for good behaviour. Reinforcing these behaviours increases the likelihood of them being repeated.
- **Use a reward system-** A reward system like a sticker chart, or a token gift system can help incentivize self-control and patience over time.

4) <u>SETTING CLEAR EXPECTATIONS AND BOUNDARIES-</u>

- **Establish rules-** Ensure the children understands the rules and importance of self-control. Be consistent with consequences if rules are broken but also provide rewards when expectations are met.
- **Role playing-** Engage children in role playing where they practice self-control in various situations such as waiting for their turn in a game or speaking calmly when upset.

5) <u>PROBLEM SOLVING AND DECISION MAKING-</u>

- **Teach problem solving skills-** Help the children develop problem solving skills by asking open ended questions like “What do you think you could do instead?” Help them to understand that practicing self-control often leads to better outcome.
- **Decision making practice-** Give the children opportunities to make choices to in counselling sessions , guiding them through the decision making process while considering self-control as a factor.

6) MINDFULNESS AND RELAXATION-

- **Introduce mindfulness-** Mindfulness exercises, such as focusing on the present moment or paying attention to breathe, can be powerful in helping children control impulsive behaviours.
- **Relaxation techniques-** Help children practice relaxation techniques like deep breathing, progressive muscle relaxation, or guided imagery to reduce stress and improve impulse control.

7) GRADUAL EXPOSURE AND PRACTICE-

- **Start small-** Introduce task that requires self-control in a controlled environment and gradually increase the level of difficulty as the child improves.
- **Practice delayed gratification-** Give opportunities for children to practice waiting or delaying gratification, like waiting for a snack.

8) DISCUSS CONSEQUENCES OR EMPHASIS REFLECTIONS-

- **Reflect on behaviour-** After situations where a child struggles with self-control, encourage them to reflect on what happened, what they were feeling, and what could have been done differently.
- **Discuss natural consequences-** Help children understand that actions have natural consequences (e.g., if they don't clean up their toys, they won't be able to play with them next time)

9) SOCIAL SKILLS TRAINING-

- **Teach empathy**- Encourage empathy by helping children understand how their actions affect others. When they learn to consider other people's feelings, they may naturally practice more self-control.
- **Communication skills**- Work on teaching assertiveness and how to communicate frustrations without resorting to impulsive behaviours.

10) COLLABORATIVE GOAL SETTING-

- **Self-achievable goal-** Work with children to set gaols related to improving self-control. Make these goals small and specific, such as "I will take three deep breaths when I feel angry".
- **Involve parents and caregivers-** Collaborate with parents and caregivers to ensure consistency and reinforce self-control skills in different settings.

Some effective counselling techniques are:

- **Cognitive behavioural therapy (CBT)**
- **Dialectical behaviour therapy (DBT)**
- **Social skills training**
- **Mindfulness based interaction therapy**
- **Parent child interaction therapy (PCIT)**

CONCLUSION

By providing children with practical strategies and positive reinforcement, you can help them develop better self-control. Developing self-control helps children in many areas, such as forming healthy relationships, succeeding in school and making responsible choices. It's a skill that is often taught and reinforced overtime through practice and guidance from caregivers, teachers and role models. But in the whole process of counselling, we need to remember that every child is unique, and its essential to tailor your approach to the child's individual needs and circumstances.

COUNSELLING VICTIMS OF CHILD ABUSE AND THEIR FAMILIES

Victims of violence mostly are in a varying state of crisis, be it verbal, mental, physical, or sexual abuse. Level of damage done at each level also has very lasting and deep effects. All of them, therefor, should be handled sympathetically with warmth and understanding, so that initial shock and grief, guilt and remorse (in some cases) can be dealt with their emotional states.

Identifying abuse or neglect can be difficult. It requires careful evaluation of the situation, including checking for physical and behavioural signs.

Factors that may be considered in determining child abuse include:

- Physical exam, including evaluating injuries or signs and symptoms of suspected abuse or neglect
- Lab tests, X-rays or other tests
- Information about the child's medical and developmental history
- Description or observation of the child's behaviour
- Observing interactions between parents or caregivers and the child
- Discussions with parents or caregivers
- Talking, when possible, with the child

If child abuse or neglect is suspected, a report needs to be made to an appropriate local child welfare agency to further investigate the case. Early identification of child abuse can keep children safe by stopping abuse and preventing future abuse from occurring.

Treatment

Treatment can help both children and parents in abuse situations. The first priority is ensuring the safety and protection for children who have been abused. Ongoing treatment focuses on preventing future abuse and reducing the long-term psychological and physical consequences of abuse.

Medical care

If necessary, help the child seek appropriate medical care. Seek immediate medical attention if a child has signs of an injury or a change in consciousness. Follow-up care with a health care provider may be required.

Psychotherapy

Talking with a mental health professional can:

- Help a child who has been abused learn to trust again
- Teach a child about healthy behaviour and relationships
- Teach a child conflict management and boost self-esteem

Several different types of therapy may be effective, such as:

- **Trauma-focused cognitive behavioural therapy (CBT).** Trauma-focused cognitive behavioural therapy (CBT) helps a child who has been abused to better manage distressing feelings and to deal with trauma-related memories. Eventually, the supportive parent who has not abused the child and the child are seen together so the child can tell the parent exactly what happened.
- **Child-parent psychotherapy.** This treatment focuses on improving the parent-child relationship and on building a stronger attachment between the two.

Psychotherapy also can help parents:

- Discover the roots of abuse
- Learn effective ways to cope with life's unavoidable frustrations
- Learn healthy parenting strategies

If the child is still in the home, social services may schedule home visits and make sure essential needs, such as food, are available. Children who are placed into foster care may need mental health services.

The counsellor must first assess the:

1. Gravity of the abuse and assault
2. Extent of damage done to the child and family
3. The duration of the abuse
4. Arrange for medical help to avert the dangers of threat to survival or suicide
5. Help to develop a support system around the victim and orient the supporters to habe a knowledge about disorganized changes of behaviour, personality and emotions.
6. Use prolonged emotional counselling to help victim deal with emotions of trauma, guilt, regret, PTSD.
7. Debriefing exercises to reduce the negative impact of trauma, rebuild self-esteem and autonomy
8. Help in developing new and healthy coping styles
9. Open the new social world, by making new relations, developing hobbies creatively express ones emotions and not keep them suppressed.
10.

The following techniques are used for counselling such victims:

- Establish Trust
- Validate Emotions
- Use Trauma –Focused Interventions
- Foster Coping Skills
- Monitor Progress

In cases of victims, the role of “Family and Friends” is of maximum importance as they can best understand the extent of damage to the ‘psyche’ of the victim member. Such emotional bruises are so personal that they should not be discussed with many, the counsellor’s role is also, do ‘family counselling’ to sensitize them how to handle the victim and hoe ‘reintegrate’ the child back to normal relations.

Counsellors can use the following techniques:

- **Support the non-offensive caregiver**- Provide emotional support and guidance to help the caregiver manage their own feelings and responses.
- **Foster a supportive environment**- Encourage open communication, empathy, and understanding within the family.
- **Address guilt and shame**- Help family members work through feelings of guilt, shame, or responsibility related to the abuse.
- **Promote healthy boundaries**- Educate family members on establishing and maintaining healthy boundaries to prevent future abuse.
- **Connect with community resources**- Help the family access community service centres such as support groups, to aid un their healing process.

Additional considerations

- **Cultural sensitivity** – Be aware of cultural differences and nuances when working with diverse families
- **Confidentiality**- maintain confidentiality while also ensuring the child’s safety and well being
- **Collaboration with other professionals**- Work with other professionals, such as social workers, medical professionals, and law enforcement, to ensure a comprehensive response to the abuse.
- **Self-care**- Prioritize self-care to avoid burnout and compassion fatigue when working with traumatized individuals.

We need to remember the fact that most victims of violence can rarely be counselled as they remain hidden due to social stigma, still by providing a safe, supportive, and non-judgemental environmental, counsellors can help victims of child abuse and their families heal and rebuild their lives.

COUNSELLING ADOLESCENTS

The word “adolescence” means a “period of growth to maturity”. “Adolescence” as we know tends to be linked to notions of personal, private and psychological identity. It is often divided into three overlapping periods.

- **Puberty(10-12 years to 14-16 years)**
- **Middle adolescence (14 years to 17 years)**
- **Late adolescence (18 years to 20 years)**

PUBERTY

This period begins with a bursting of biological changes that can evoke simultaneous feelings of anxiety, bewilderment, and delight. Physically, girls and boys develop primary and secondary sexual characteristics. Psychologically, puberty is marked by identity formation and recognition of one’s personality traits. Adolescents learn and adapt new behaviours, thoughts and perspectives to understand who they are.

MIDDLE ADOLESCENCE

Teenagers in this stage of adolescence, begin to leave childhood behind and prepare young adulthood. This period has fewer physical changes but the adolescent must adapt to his or her new identity as a person with an adult body, and this can be one of the hardest teenage developmental stages. Adolescents in this stage are marked by intense peer relations. Peer pressure, conflicts and the desire to fit in, but also differentiate themselves as their own person, are some of the challenges that teens face during this period. Teens may suffer from mental health issues such as depression, anxiety, suicidal thoughts or eating disorders. Support from family members and friends is crucial in determining an individual’s mental health.

LATE ADOLESCENCE

This is the period that begins when high school ends. Neither child nor adult, the young person in this period is faced with tasks of moving comfortably into adult society, assuming adult responsibilities, shifting to an independent status, and formulating a distinct lifestyle. Planning for the future, further education, choosing a mate, and moving into a career are all tasks that take time and energy.

To an outside observer, or counsellor much adolescent behaviour may seem to make no sense. However, it is not difficult to understand adolescents if we focus on these issues as values clarifications. Despite their apparent isolation from the adult community, the vast majority of adolescents really want to know what adults think, particularly the adults close to them and especially parents. This tremendous important fact is often overlooked by the parents and counsellors, and we start to judge the nature of adolescence especially later adolescence, until we recognize that **young people need to answer at least four crucial questions during this time in life.**

First, is the question of identity: “Who am I?”
Second, is the question of relationships: “How do I get along with others?”
Third, the adolescent is concerned about the future: “Where do I fit?”
Fourth, there is the question of ideology: “What do I believe?”

Too often, the society and people in the older generation give little in the view of clear values and practical help. Perhaps it is not surprising that many adolescents struggle with feelings of inner emptiness confusion, interpersonal tension and anxiety.

Adolescent society changes quickly and most adults find themselves out of touch with contemporary teenagers. In spite of the changes, however, several issues persist and create problems for adolescents regardless of the times in which they live.

THE EFFECTS OF PROBLEMS IN ADOLESCENCE

Even though most teenagers do grow up into a relatively normal adulthood, the pressures of adolescence do take their toll. Teenage insecurities, feelings of guilt, inferiority, loneliness and rejection can persist far into the adult years.

1. **Holding in the problems-** Some adolescents struggle with their problem alone. There may be loneliness, daydreaming, alienation, or withdrawal from friends, apathy, a forsaking of usual interest and activities, or perpetual inner turmoil that sometimes appears in the form of psychosomatic illness, anxiety, scholastic failure, or more serious emotional and behavioural disorders.
2. **Acting out the problems-** Adolescents often act out their problems in socially disapproved ways that have the effect of resisting parents and asserting independence. Excessive drinking, drug abuse, lying, stealing, crime, "gang" behaviour, another forms of delinquency or rebellion give the adolescent a sense of power, I feeling of independence, a way of challenging authority and a means for gaining and retaining the attention and acceptance of one's friends, most of whom also may acting out.
3. **Running from the problems-** Every year large number of adolescents between the ages of fifteen and seventeen run away from home. Many of these young people are frustrated at school, unable to communicate, in conflict with parents, lacking in self-esteem, victimized by abusive family members, impulsive or having problem with peers.
4. **Sticking with the problems-** Not all adolescents hold on, act out, or run away from their problems. Many face the challenges squarely, talk them over with friends or trusted adults, read about teenage stress, and react to failures by trying harder next time. These young people and their parents could benefit from preventive, educative, and supportive counselling, but they rarely come for help.

THE ADOLESCENTS PARENTS

The adolescent's parents are often a great source of difficulty for the counsellor. The more the adolescent displays autonomy, the more resentful some parents become, with their resentment often directed at counsellor. Counsellors must be willing to maintain confidentiality with regard to their clients while, at the same time, walk a tight rope with the parents. The parents often demand to know what their teen is thinking, doing or feeling. When this occurs family therapy may be indicated.

The counsellor can focus on whether the teen can return to the family system, or should be emancipated. Some adolescents are so close to their families that they reach adulthood without having made a successful separation from their family psychologically.

INTERVIEW PROCESS

The counsellor should be keenly aware of the developmental processes of an adolescent so as to obtain important information about the young people and make appropriate responses to their concerns.
After rapport and a mutually respectful relationship are established, many adolescents can be helped by a systematic interview.

The following are some special points to keep in mind when seeing adolescents:

1. **When to see the adolescent** – If there will be more than one interview with the young person and these will involve the parents or other consult adults, it is best to interview the adolescent first. Esmaan (1988) suggests that "even the unwilling, angry, defiant adolescent will often respond to the

counsellor's recognition that he has his own schedule of activities that deserves respect and recognition.

2. **Establishing the limits of confidentiality-** Confidentiality is a particularly important matter when adolescents are to be interviewed and it should be emphasized early on. Counsellor should take adolescents permission to discuss any matter with his or her parents but if the counsellor guess that any kind of self-harm activity can be carried out by the adolescent, then it should be informed to the parents immediately.
3. **Purpose of the interview-** The purpose of the interview should be clearly discussed with the adolescent. Many related questions may arise during such a discussion, such as, whether the adolescent believes he or she actually has a problem to require your service, and his or her concerns about the implications of being interviewed.
4. **Language and terminology-** It is always helpful to be able to speak the same language as the person you are interviewing. A knowledge of adolescent's language and the terms they use helps ensure clear communication, this does not necessarily imply using the same words. Adolescents often use swear words and coarse terms to shock the counsellor or to test how far they are genuinely accepted as they are. Such behaviour should be accepted by the counsellor without any comment and without using the same pattern. On the other hand, it is always a good idea to ask the adolescent to clarify anything the counsellor do not understand.

CONCLUSION

Adolescents are fraught with difficulties. Successful counsellors accept all adolescents as they are at the moment, are non-judgemental and flexible, approach and participating in counselling as a learning process. Many of the problems that adolescents face is related to the way they are treated by society and at home. Therefore, to be effective, counsellors must remain detached. If they become too involved as advocates for the adolescent against the family, school, or community, the effectiveness of the counselling is significantly reduced.

SPECIAL CHILDREN AND THEIR ASSESSMENTS

A section of child in our society has not only been marginalized but largely been neglected due to their physical or mental deficits. Of late, this section, including children and adults alike, which has had a transition from "Disabled to Challenged" to the "Differently Abled" class of people has emerged out of odds and has awakened the society about their special needs.

Special children, also known as children with special needs, are kids who require assistance for disabilities that affect their cognitive, developmental, emotional, physical, or behavioural growth. These disabilities can be medical, mental, or psychological in nature, and may include conditions such as autism, cerebral palsy, Down syndrome, dyslexia, blindness, deafness, ADHD, and many more.

The assessment of children with special needs is already, and still is, a dilemma in the everyday school's life either form the teachers' point of view to the pupils' one and their parents' too.

Assessments are a foundational part of special education. They help special education teachers and administrators identify a student's strengths and weaknesses, determine their eligibility for special education services, and develop individualized educational plans (IEPs) to support their learning. However, conducting assessments in special education can be complex and challenging.

Special needs can vary in severity and may impact a child's ability to learn, interact with others, or participate in daily activities. Some common categories of special needs include:

- **Physical and sensory impairment needs**: Limb disabilities, blindness or visual impairments, deafness or hearing impairment, and epilepsy.
- **Neurodevelopmental needs**: Learning disabilities, ADHD, autism, and Down syndrome.
- **Social-emotional/behavioural needs**: Behavioural and emotional challenges caused by trauma, poor living conditions, or other factors.

Assessing special children requires a comprehensive and multidisciplinary approach to understand their unique needs, strengths, and challenges. Here are some key aspects of assessing special children:

Step 1: Understanding the Purpose of the Special Education Assessment

Before starting any assessment, it's important to understand the legal requirements involved in special education assessments. That's where the Individuals with Disabilities Education Act (IDEA) comes in—it lays out all the guidelines and procedures that must be followed for students with disabilities, including conducting assessments.

Under IDEA, assessments must be fair and unbiased. Consider a student's native language, cultural background, and any potential physical or developmental challenges that may affect their ability to participate in the assessment process.

In addition, guardians play a crucial role in the assessment process. They have to give informed written permission before assessments can take place and have the right to review and challenge the results if they don't agree with them—allowing them to stay as involved in their child's education and related services as possible.

Remember, the end goal of an assessment is to get students extra educational assistance if they need it.

Step 2: Gathering Information and Data Collection

Gathering data gives all the evidence is needed to make informed decisions about disability related educational needs. Educators have many ways of gathering this information, including observation, interviews, and standardized tests.

Though a child's initial evaluation may be a single assessment, it's important to remember that we have a variety of methods to understand student's abilities and needs:

- Observe the student in different settings.
- Talk with guardians about behaviour both in and out of school.
- Vary the assessment types.
- Consider cultural and linguistic diversity when choosing assessment strategies.

The final pre-assessment step to take is identifying a baseline of the student's current skills and abilities. This involves gathering information from different sources, like teachers, parents, previous assessments, and academic records.

By finding that baseline, educators get a better understanding of the student's strengths, weaknesses, and areas for growth. This information helps guide the assessment process and tailors it to meet the individual needs of the student.

Step 3: Analysing Data and Identifying Patterns

The process doesn't stop at collecting data—It has to be analysed. Data analysis involves examining both qualitative and quantitative data:

- Qualitative data—observations, interviews, and open-ended questions.
- Quantitative data—numerical information gathered from standardized tests or checklists.

For example, if a student consistently struggles with reading comprehension across different assessments, they may need specialized instruction for reading.
By looking for patterns and trends in data, educators can make guided decisions to develop intervention plans, accommodations, or special education services for the student.

Step 4: Making Recommendations Based on Assessment Results

As we said before, educators make the best recommendations when it's based on data and analysis. This process will look different for every student and situation. Where one student may need different seating to resolve barriers, another student may need to spend part of their day in a special education classroom.

Note: Making recommendations is another step that's crucial to involve guardians in. Collaboration and communication will result in the most effective educational plan that meets the student's unique needs.

Step 5: Monitoring Progress and Reassessing as Needed

Ongoing assessment and progress monitoring are key contributors to a child's educational success. As educators track student growth, they can make any necessary adjustments to their educational placement or plan. Once a student has tried out new strategies, educators might find that the plan is ineffective or needs adjusting–and that's ok. That's the point of ongoing progress monitoring.
Likewise, if significant changes are noted in the student's abilities or needs, reassessment may be necessary to ensure their educational plan appropriately meets their current needs.
It's difficult to rack manually students' progress—that's where purpose-built tech comes into play. Through digital progress monitoring, one can easily enter data on a student and see instant results displayed on a graph. This tech allows to compare existing evaluation data, past data, and forecasted trends so that to make interventions as early as possible.

Assessments are More Than Just Numbers

The most important thing to remember is that the assessments conducting are more than just numbers–they're the foundation for a student's future.
By following the steps, one can gather valuable information, analyse data, and make recommendations to help students achieve the best possible outcomes. Coupled with ongoing assessment and progress monitoring, students are sure to receive an education that appropriately challenges them and fosters growth.

Assessment Tools and Strategies

1. Observations: Observe the child's behaviour, interactions, and responses to different situations.
2. Standardized Tests: Use standardized tests, such as IQ tests, achievement tests, or behavioural rating scales.
3. Interviews: Conduct interviews with parents, caregivers, teachers, or other professionals who work with the child.

4. Play-Based Assessments: Use play-based activities to assess cognitive, social-emotional, and physical development.
5. Collaborative Assessments: Involve multiple professionals, such as psychologists, occupational therapists, or speech therapists, to provide a comprehensive understanding of the child's needs.

Assessment Areas for Special Children

1. Cognitive Development: Assess cognitive abilities, such as attention, memory, problem-solving, and language skills.
2. Social Emotional Development: Evaluate social skills, emotional regulation, and relationships with others.
3. Physical Development: Assess gross and fine motor skills, sensory integration, and physical abilities.

4. Communication: Evaluate verbal and nonverbal communication skills, including speech, language, and augmentative and alternative communication (AAC) methods.
5. Adaptive Behaviour: Assess daily living skills, such as self-care, feeding, and dressing.

Importance of Comprehensive Assessments
1. Identify Strengths and Needs: Comprehensive assessments help identify the child's strengths and needs, informing intervention strategies.
2. Develop Personalized Plans: Assessments inform the development of personalized plans, such as Individualized Education Programs (IEPs) or Individualized Family Service Plans (IFSPs).
3. Monitor Progress: Regular assessments help monitor the child's progress, making adjustments to interventions as needed.
4. Support Family-oriented Care: Comprehensive assessments support family-oriented care, empowering families to make informed decisions about their child's care and education.
It's essential to remember that every child with special needs is unique, with their own strengths, challenges, and requirements. By providing tailored support and accommodations, we can help these children reach their full potential and lead fulfilling lives.

COUNSELLING COLLEGE STUDENTS

There is a lot to handle and experience in college life learning new courses, new relationships liberated environments, and exploration. The majority of college students are experiencing their first experience living away from home. Poor academic performance, despair, worry, and uncertainty might result from the stress and changes. The college **counsellor** or **academic counsellor** can help a lot in terms of issues and challenges. College students probably worry about more than just their classes. With homework, internships, a social life, placement, and extracurricular activities, the average student nowadays has their hands full. It can be daunting. And this is where counselling and help are needed.

The advantages of counselling for college students are numerous. For pupils who are engaged in a struggle, **counselling** may be helpful. It may also be used by students who need support and direction.

Advantages of counselling:

- Increased capacity to control challenging emotion regulation
- **Reduced anxiety**, elevated mood, or mood disturbance
- **Increased confidence and self-esteem**
- Learning how to handle difficulties in life
- Improved capacity for **stress management**
- **Better sleep**
- **Enhanced interpersonal and communication abilities**
- The capacity to **recognize and alter unproductive actions** or behaviours
- **Improved capacity for time management and problem-solving**

While attending college might be thrilling, it also requires that students develop their ability to adjust to a variety of conditions, from learning to function on very little sleep to meeting people from all backgrounds to learning how to live alone for the first time. The general well-being of a student is significantly impacted by all of these changes. Because of this, there are numerous widespread causes for seeking therapy, which is something that should be encouraged.

Students frequently seek counselling for issues like melancholy, stress, and anxiety as well as issues with their families, roommates, and friends.
The problem-solving strategies used in counselling are well-established, and it is proven to be successful in treating **addiction**, **depression**, and **anxiety**. An approach to develop your daily emotional awareness is through counselling.

By working with emotion, cognition, and interpersonal interactions, students can manage their emotions and gain new perspectives through counselling. In other words, therapy is not only beneficial for students who have experienced trauma or significant life events. They can learn about how they come across to others, gain an understanding of how their emotions affect their daily life, and obtain support by speaking with a specialist.

For instance, going to a **counsellor** can help students overcome the mental barriers they have with any problem, whether they are picking the courses they want to major in or dealing with a challenging family situation.
It's simple to feel like we must do everything on our own in today's hectic and intensely competitive environment. However, studies indicate that working together makes us stronger. One of the main advantages of counselling for college students is the tremendous support it provides in terms of having someone to talk to and provide direction. Additionally, social support can help students who are in college and dealing with a variety of severe challenges develop resilience against stress, according to scientific research.

Speaking with a trained counsellor can also help students strive toward a goal, which can lead to mental clarity, self-assurance, and ultimately, a greater sense of purpose in life. The advantages of counselling for college students are numerous. A counsellor can assist kids in breaking down their issues and determining ways to resolve them independently. Counselling plays a significant role in putting everything in its proper place and developing pupils into responsible, self-assured individuals. Seeking coaching for a career or life would be of great help in charting a career. As we've already mentioned, college is a significant period in an adult's life.

A total counselling programme at the collegiate level would comprise an extension of the various services provided to the pupils at the earlier stages of their lives.
The objectives of higher education include the development of:

1. **Sound philosophy of life**
2. **An ability to enjoy life in many areas**
3. **Sensitivity to the different aspects of the environment**
4. **The capacity to be free willed individuals**

Counselling service at the collegiate level is fairly comprehensive:

- It is the culmination of the guidance the pupil receives at all the lower school levels.
- It emphasizes constructive self-guidance among students in meeting adult responsibilities.
- It provides necessary assistance to overcome academic and social deficiencies and thus helps to enrich their lives.
- Another equally important activity is to develop healthy vocational and professional interests among the students. Usually, the students are encouraged to visit the student counselling bureaux, as often as necessary, and feel free to seek assistance.

TYPES OF COUNSELLING SERVICES

1. Academic Counselling: Helping students choose courses, plan their academic path, and manage academic stress.

2. Personal Counselling: Supporting students with personal issues, such as relationships, self-esteem, and anxiety.

3. Career Counselling: Guiding students in exploring career options, resume building, and job search strategies.

4. Mental Health Counselling: Providing support for students struggling with mental health concerns, such as depression, anxiety, or trauma.

BENEFITS OF COLLEGE COUNSELLING

1. Improved Academic Performance: Counselling can help students develop better study habits, time management skills, and stress management techniques.

2. Increased Self-Awareness: Counselling can help students gain a deeper understanding of themselves, their values, and their goals.

3. Better Coping Mechanisms: Counselling can provide students with healthy coping mechanisms for managing stress, anxiety, and other emotions.4. Enhanced Career Readiness: Counselling can help students explore career options, develop job search skills, and create a plan for their future.

4. Enhanced career readiness: Counselling can help students explore career options, develop job searched skills, and create a plan for their future.

HOW COLLEGES CAN PROMOTE COUNSELLING SERVICES

1. Raise Awareness: Promote counselling services through social media, flyers, and campus events.

2. Reduce Stigma: Encourage students to seek help without fear of judgment or stigma.

3. Make Services Accessible: Offer counselling services in convenient locations, such as student unions or academic buildings.

4. Train Faculty and Staff: Educate faculty and staff on how to recognize signs of distress and refer students to counselling services.

By promoting counselling services and reducing stigma around mental health, colleges can help students thrive academically, personally, and emotionally.

ADDICTION AND HEALTH COUNSELLING

Addiction counselling or substance abuse counselling, is a specialized form of psychotherapy aimed at helping individuals overcome their addiction to substances (such as drugs or alcohol) or addictive behaviours (like gambling or overeating). This type of counselling focuses on addressing the physical, psychological, and social aspects of addiction, helping individuals understand the underlying causes of their substance or behavioural dependencies, develop coping strategies, and work toward achieving and maintaining sobriety or abstinence.

The ultimate goal is to support individuals in their journey towards recovery and a healthier, substance-free life.

Alcohol and drug use has been practiced in so called modern social groups for many years as ‘Ups’ (exciters) and ‘Downs’ (anti-anxiety/sedatives). Initially, they were used for ‘social charms’, ’social entertainment’, ‘party items’, but gradually they became all pervasive, entering schools and hostels, college education even professional/educational institutions as ‘stress relievers’. Initial experimental basis soon becomes a ‘habit

formation' and then an 'addiction', the individual is held captive by these intoxicants until he deteriorates physically, financially, and socially until the final end comes.

Addiction counselling revolves around a client-centred approach. This includes assessing the addiction's nature and severity, understanding the person's motivation for change, and recognizing the need for a personalized treatment plan. Cognitive-behavioural techniques help modify harmful thought patterns and behaviours, while relapse prevention strategies are crucial. Recognizing the significance of support systems, both from within the family and friends, or through support groups, and embracing the holistic well-being of clients, underscore the comprehensive approach that addiction counselling employs. These core concepts collectively constitute the framework for enabling individuals to regain control, sustain recovery, and achieve lasting well-being, supported by informed aftercare planning.

ROLE OF COUNSELLORS

- **PREVENTIVE ROLE**

Addiction to intoxicants is so very much damaging to individual, family and society that at any cost the spread of it should be prevented.

Some of the effective preventive programmes are:

AWARENESS PROGRAMMES:

The main 'target group' is to be made aware of 'distinctive outcomes of intoxicating effects' of addiction to alcohol and drug abuse are 'Teenagers' as they are vulnerable and easily persuaded and 'parents and family' to observe behavioural changes in their children as warming. Another group is 'peers and friendship group' to watch for symptoms and addiction and 'dissuade each other against, not persuade, toward addiction. Awareness increase is targeted as 'aversive and negative 'conditioning and 'assertiveness training' just say NO to drugs and resist any group pressure towards drugs. Effective awareness programmes can be carried out by de addiction agencies, voluntary organization, families of addicts de addicted persons by themselves.

REMEDIATION PROGRAMME

Effective remediation programme depends on relative success of 3 aspects

(a) Assessment of problem based on 'Three D's

- **Drug type**: Some are more addictive than others
- **Duration of intake and age of onset**: Longer duration and early age onset make de addiction more difficult.
- **Dosage amount, frequency and method of intake**: In case of higher dosage, withdrawal symptoms can be life threatening.

(b) Intervention programme and counselling

- **Medical help**: Pharmaco therapy is necessary for 2-3 days to take care of severe withdrawal symptoms which can threaten survival due to excess fluids discharge from body.
- **Psychological counselling**: Generally effective approaches are client cantered approach, cognitive behavioural counselling, behaviour-modification. Each of these approaches can be used as individual as well as group setting.
- **Supportive therapy**: Love and acceptance by family and friends, motivational strategies support group interaction by de addicted persons.

(c) Follow up and relapse prevention: In many cases relapse takes place when the individual goes to live in the same environment which was conducive to drug availability. In such cases agencies are found to be tracking and following up continuously with the person.

Benefits

Controlling Cravings and Triggers: Overcoming the Intensity of the Urge and Reducing the Strong Desire for Substance Addiction

Support Systems: Building a strong support network, including family, friends, and peer support, contributes to a positive and encouraging environment for recovery.

Enhanced Well-Being: The counselling process promotes overall well-being, addressing physical health, mental health, and social relationships, leading to a more fulfilling and balanced life.

Long-Term Recovery: Addiction counselling supports individuals in achieving and maintaining long-term recovery, promoting sustained sobriety and well-being.

Reduction of Harm: In some cases, harm reduction strategies may be employed, helping individuals reduce the negative consequences of their addiction if complete abstinence is not immediately achievable.

GOALS:

Sobriety: Staying away from all forms of addiction, abstaining completely from substances and actions that could endanger them, and showing no signs of addiction.

Relapse Prevention: Counselling helps clients identify high-risk situations and develop strategies to prevent relapse. The goal is to equip individuals with the tools and knowledge to maintain their recovery.

Behavioural Change: Clients work on changing their addictive behaviours and adopting healthier alternatives. This may include developing new habits and routines.

Emotional and Psychological Healing: Addiction counselling tackles the underlying emotional and psychological aspects that contribute to addiction. Clients learn to cope with emotional pain, trauma, and co-occurring mental health issues.

Positive Coping Strategies: Clients learn healthy coping mechanisms for stress, anxiety, and other emotional challenges. These strategies reduce the reliance on addictive substances as a way to cope

The dynamics of drug addiction are complex and not fully understood. However, a number of socio cultural and psychological factors have been emphasized. The young today find themselves living in a void without personal involvement and a sense of belonging. Drugs come to fill the vacuum and become a means to gain a sense of belonging, to escape from the sense of alienation.

The personality traits of addicts suggest impulsiveness, rebelliousness, dependency, etc. As a group they are characterized by low frustration tolerance, inability to endure tension, and exhibiting feelings of inadequacy and self-devaluation. Many addicts are immature and dependent individuals who have unrealistic levels of aspirations.

Addiction counselling requires a long-term treatment with rehabilitation facilities and medical help.

MARRIAGE COUNSELLING

Marriage is the basis of family life and it is to be found throughout the world. The marital relationship, as every innate human exchange, depend for its survival on the balance between love a and hate. Marriage is not just a private contract it is a covenant that affects the entire community. It is a dynamic process with the years it also grows. Every stage of marriage brings new challenges, fears and joy.

Marriage is a formalized union between two individuals that typically involves legal, social, and emotional ties. It is an institution that serves as the foundation for family structure and plays a pivotal role in shaping social norms and values. Marriage counselling encompasses a wide range of technical interventions aimed at reducing marital discord. Marriage counselling's focus and goals are generally the resolutions of the immediate presenting problems and the provision of emotional support to the spouses as well as the enhancement of their self-esteem and optimism.

Gottman's research on couples reveals three styles of conflict resolution or problem solving:

1. **Validating**- Couples compromise, work out problems calmly and accept differences.
2. **Volatile-** Couples have immense disputes, may be defensive and critical. But they seem to enjoy their intensity, which is followed by renewal, and conflict strengthens their sense of individuality
3. **Conflict avoiding couples** merely leave their disagreements alone, minimize them and use solitary activities to handle or relieve tensions.

More significant to effective functioning of the couple system is the ratio of positive feeling and interaction versus negative. Gottman found that a ratio of 5 or more positive interactions to one negative predicts marital stability, less than that tends to predict divorce.

Gottman identifies the "Four Horsemen" the warning signs that the marriage is failing and the couple is becoming increasingly preoccupied by negative.

1. **Criticism-means** attack through personalizing, blame and character attack. Whereas expressing differences is healthy.
2. **Contempt**- involves perception of the partner as devalued, as well as the desire to hurt, demean and insult the partner.
3. **Defensiveness-** involves feeling hurt and victimized and deflecting blows by refusing any responsibility for change. Defensiveness leads to intense, escalating conflict.
4. **Stonewalling**- means cutting off communication with the partner. Any communication might be cold and disapproval, which increases distress.

Once any of these horsemen arrive and predominate the relationship, negative cognition create a system which is often destined to fail.

WHEN TO SEEK MARRIAGE COUNSELLING

Every couple fight, but when the fight turns into a war or cold war between the couple, then they can take a step forward and consider marriage counselling. Some reasons could be:

- Increased frequency of arguments between partners due to poor communication pattern
- Emerging differences in opinions or value system
- Strained relationship between couple due to certain emerging familial issues
- Dissatisfaction in sexual relationship
- Feeling of being trapped in stale relationship due to lack of common interests and shared activities
- Constant dispute between the couple leading to excessive distress or couple counselling psychopathology such as depression or alcohol; abuse in one or both the partners
- Extramarital affairs
- Few or frequent instances of intimate partner violence

HISTORY

Marriage counselling emerged in the early 20th century as a response to societal shifts and the increasing recognition of marital problems. The early focus was on improving marital relationships through the guidance of clergy, who played a central role in providing counselling within their communities. In the mid-20th century, marriage counselling expanded beyond religious contexts and gained recognition as a distinct field of mental health. Pioneers like Paul Popenoe and Mollie W. Popenoe contributed to the professionalization of marriage counselling. The American Association of Marriage and Family Therapy (AAMFT) was established in 1942, marking an important milestone in the field's development.

During the mid-20th century, marriage counselling gained broader acceptance, and it became more secular in nature, emphasizing psychological and communication techniques to address relationship issues. The 1960s and 1970s saw a surge in interest, driven by the changing roles and expectations of spouses. Since the late 20th century, marriage counselling has continued to evolve with the incorporation of various therapeutic approaches, including cognitive-behavioural therapy, family systems therapy, and integrative models. It has adapted to the diverse needs of couples, addressing issues such as communication problems, infidelity, and other common challenges.

Focus theme / core-concept

Marriage counselling, also known as couples therapy, is based on several core concepts and principles aimed at helping couples improve their relationships, resolve conflicts, and build healthier, more satisfying partnerships.

The core concepts of marriage counselling include

- Communication Skills,
- Conflict Resolution,
- Building Emotional Connection,
- Building Trust and Safety.

Benefits

1. Marriage counselling can help individuals and couples address emotional distress and improve their overall mental and emotional well-being. It offers a safe space to express feelings and receive support, leading to reduced anxiety, depression, and emotional turmoil.
2. Marriage counselling encourages self-reflection and self-awareness. It enables individuals to better understand their own needs, behaviours, and patterns of interaction, which can contribute to personal growth and self-improvement.
3. Couples therapy fosters empathy and a deeper understanding of each other's perspectives and feelings. This heightened empathy can lead to greater compassion and emotional connection within the relationship.
4. Marriage counselling can reignite the physical and emotional intimacy between partners. By addressing emotional and physical closeness, couples often experience a revitalized sense of connection and affection.
5. Couples learn and develop effective conflict resolution skills in counselling, which can be applied not only in the context of the relationship but also in various other aspects of life, including work and social interactions.

LONG-TERM BENEFITS

1. **Preventing divorce**: Marital counselling can help couples work through issues, reducing the risk of divorce.
2. **Stronger relationships**: Couples develop a stronger, more resilient relationship, better equipped to handle life's challenges.
3. **Improved mental health**: Marital counselling can contribute to improved mental health and well-being for both partners.

GOALS

1. One primary goal of marriage counselling is to help couples communicate better. In order to understand each other's wants, emotions, and concerns, communication must be successful. Couples who need assistance with communication, active listening, and the capacity for truthful and polite self-expression should turn to therapists.
2. Marriage counselling seeks to help couples identify and address conflicts in a healthy and constructive manner. The goal is to teach couples how to resolve disagreements and reach compromises without damaging the relationship.

3. Trust is a fundamental component of a strong partnership. If trust has been eroded due to issues like infidelity or broken promises, marriage counselling helps couples work on rebuilding trust and re-establishing a sense of safety and security in the relationship.
4. Marriage counsellors help couples reconnect emotionally by exploring and addressing emotional needs, intimacy, and affection. The goal is to create a more emotionally fulfilling and intimate partnership.
5. Preventing future conflicts is an important objective. Marriage counselling equips couples with the skills and tools to identify potential sources of conflict and address them before they escalate.

TECHNIQUES

1. Active listening, effective need and feeling expression, and avoiding harmful communication patterns are all skills that therapists teach couples to help them communicate better.
2. Couples learn how to identify and address conflicts in a healthy and constructive manner. This includes using "I" statements, finding compromises, and understanding the underlying issues behind conflicts.
3. Cognitive-behavioural therapy (CBT) is adapted for couple's therapy, focusing on changing negative thought patterns and behaviours that contribute to relationship problems.
4. EFT helps couples understand and express their emotions and attachment needs, leading to increased emotional connection and intimacy.
5. Couples explore the stories and narratives that shape their relationship, helping them reframe negative narratives and create more positive, empowering stories.
6. This approach helps couples understand their unconscious patterns and past experiences that influence their current relationship dynamics.
7. Developed by John Gottman, this method focuses on strengthening friendship, managing conflict, and creating shared meaning within the relationship. The "Four Horsemen of the Apocalypse" (criticism, contempt, defensiveness, and stonewalling) are addressed to improve communication.
8. This technique emphasizes identifying solutions and building on strengths rather than dwelling on problems and conflicts.
9. Couples work on specific issues using problem-solving techniques, creating action plans and commitments to address and resolve those issues.
10. Couples may engage in role-playing exercises to practice new communication and problem-solving techniques in a safe and guided environment.

1. Pre-marital counselling
2. Post marital counselling

Pre-marital counselling: Pre marital counselling can be opted by couples who are in a relationship and want to take their relationship to the next level, marriage.
Post marital counselling: This type of counselling is for couples who are already married. There is no bar for years, which a couple is married for or type of marriage when it comes to post marital therapy sessions.
The Gottman gave Seven Principles for Making Marriage Work are a set of evidence-based principles developed by Dr. John Gottman and Dr. Julie Schwartz Gottman. These principles are designed to help couples build a stronger, more resilient relationship. Here are the seven principles:
1. Enhance your love maps

- Create a "love map" by asking open-ended questions and actively listening to each other.
- Develop a deep understanding of each other's thoughts, feelings and desires

2. Nurture Fondness and Admiration

- Cultivate a culture of appreciation and respect.
- Regularly express gratitude, admiration, and affection for each other.

3. Turn towards each other Instead of Away

- Respond to each other's bids for connection and intimacy.

- Practice empathy and understanding to strengthen your bond.

4. Let your partner influence you
    - Don't argue back to statements which are harshly phrased, conflicting with one's own agenda
    - The issue is not to express or not express negative emotions, but it is how one would accommodate to them.
5. Solve your solvable problems
    - Soften your startup
    - Learn to make and receive repair attempts
    - Soothe yourself, and each other
    - Compromise, be tolerant to each other's fault
6. Overcoming gridlocks
    - Support each other's goals, aspirations, and dreams.
    - Create a shared vision for your future together.
    - Become a dream detective-even if someone gives up a dream for the marriage
    - Work on a gridlock issue-listening, financial support and taking part
    - Soothe each other
    - End the gridlock-you will never be able to fully resolve it but reduce some of its tension
    - Say thank you-it is difficult to do after a gridlock session but it's important to highlight and thank the positives in the relationship as well
7. Creating shared meaning
    - Find meaning in the togetherness beyond the mere joint tasks of family life
    - Foster a culture of respect, appreciation, and empathy.
    - Regularly express gratitude and admiration for each other.

    By following these seven principles, couples can build a stronger, more resilient relationship and create a lifelong connection.

GRIDLOCK

Gridlock happens when people's life dreams (hopes, aspirations, and wishes) for their life are not being addressed/respected by each other. Such deep dreams could include

- Sense of freedom
- Experience of peace
- Unity with nature
- Exploration of who am I
- Justice
- Honour
- Unity with the past
- Healing
- Spiritual journal

COUNSELLING ON PREGNANCY AND CHILDBIRTH, REARING OF INFANT AND CHILDREN

Counselling in pregnancy and childbirth encompasses a broad range of support and information designed to help individuals and couples navigate the physical and emotional aspects of this life stage.

KEY AREAS OF COUNSELLING:

PRE-NATAL COUNSELLING

- This focuses on providing information and support during pregnancy
- Healthy lifestyle choices
- Managing pregnancy related symptoms
- Preparing for childbirth
- Addressing potential complications
- Emotional and psychological well being
- Genetic counselling

CHILDBIRTH COUNSELLING

- Stages of labour
- Pain management techniques
- Breathing exercises
- Different birthing options
- What to expect during and after delivery

POSTPARTUM COUNSELLING

- Emotional support for postpartum depression or anxiety
- Guidance on new-born care
- Support with breastfeeding
- Addressing relationship changes

PRECONCEPTION COUNSELLING

This happens before conception

- Reviewing medical history
- Evaluating lifestyle choices
- Discussing any potential risks
- Genetic risk assessments

EMOTIONAL AND PSYCHOLOGICAL SUPPORT

- Pregnancy and childbirth can bring about significant emotional changes
- Counselling can provide a safe place to discuss about anxiety and stress, relationship issues, concerns about parenthood and dealing with pregnancy loss

WHO CAN PROVIDE COUNSELLING

- Doctors and nurses
- Licensed therapist and counsellors
- Social workers
- Childbirth educators

TECHNIQUES USED IN COUNSELLING

1. **Active Listening**: Encourages expectant parents to express their concerns and feelings.
2. **Open-Ended Questions**: Encourages expectant parents to share their thoughts and feelings.
3. **Education and Information**: Provides expectant parents with accurate and unbiased information.
4. **Support and Reassurance**: Offers emotional support and reassurance to expectant parents.

BENEFITS OF COUNSELLING

1. Reduced Anxiety: Counselling can help reduce anxiety and stress related to pregnancy and childbirth.

2. Increased Confidence: Counselling can empower expectant parents to feel more confident and prepared for parenthood.

3. Improved Relationships: Counselling can strengthen relationships between expectant parents and their healthcare providers.

4. Better Birth Outcomes: Counselling can lead to better birth outcomes, such as lower rates of caesarean sections and instrument-assisted deliveries.

WHEN TO SEEK COUNSELLING

1. Early Pregnancy: Seek counselling early in pregnancy to address concerns and develop a birth plan.

2. High-Risk Pregnancy: Seek counselling if experiencing a high-risk pregnancy or complications.

3. Previous Traumatic Birth: Seek counselling if experiencing anxiety or trauma related to a previous birth.

4. Postpartum Concerns: Seek counselling if experiencing postpartum depression, anxiety, or other concerns.

REARING OF INFANT AND CHILD

Rearing of infants involves providing care, nutrition, and stimulation to promote healthy growth and development.

Here are some key aspects of rearing infants:

PHYSICAL CARE

1. Feeding: Breast milk or formula, burping, and introducing solid foods.

2. Bathing: Regular bathing, skin care, and hygiene practices.

3. Sleep: Establishing a sleep routine, creating a sleep-conducive environment, and addressing sleep issues.

4. Health checks: Regular health checks, vaccinations, and monitoring for signs of illness.

EMOTIONAL AND SOCIAL DEVELOPMENT

1. Attachment: Building a secure attachment through responsive parenting, skin-to-skin contact, and emotional support.

2. Stimulation: Providing sensory stimulation, play, and interactive activities to promote cognitive development.

3. Social interaction: Encouraging social interaction, smiling, and responding to infant cues.

4. Emotional regulation: Helping infants regulate their emotions, manage stress, and develop self-soothing skills.

COGNITIVE DEVELOPMENT

1. Sensory development: Providing opportunities for sensory exploration, such as texture, taste, and smell.

2. Motor skills: Encouraging motor skill development, such as grasping, rolling, and crawling.

3. Language development: Talking, reading, and singing to promote language skills and literacy.

4. Problem-solving: Encouraging problem-solving skills through play and exploration.

SAFETY AND ENVIRONMENT

1. Safety-proofing: Ensuring a safe environment, free from hazards and toxins.

2. Environmental stimulation: Providing a stimulating environment, with opportunities for exploration and discovery.

3. Caregiver support: Ensuring caregivers are supported, rested, and able to provide quality care.

4. Community resources: Accessing community resources, such as parenting groups and support services.

PARENT-INFANT RELATIONSHIP

1. Responsive parenting: Responding to infant cues, such as crying, cooing, and gesturing.

2. Emotional support: Providing emotional support, reassurance, and comfort.

3. Play and interaction: Engaging in play and interactive activities to promote bonding and attachment.

4. Parental self-care: Prioritizing parental self-care, rest, and stress management to ensure quality care.

REARING OF YOUNG CHILDREN

Young children require emotional nourishment while growing up. They need to feel secure, not just physically but also for emotional security. Another way of approaching the concept of secure base is to emphasize the growing persons need for empathetic understanding. Through being sensitively heard by an attachment figure children not only experience and acknowledge their own feelings but also feel confident to engage in exploratory behaviour. In such cases relationship involves might be viewed as more person than problem oriented. Here the major aim to foster the overall development of a child. Apart from these psychological needs, the physiological needs should be taken care of. Proper nutrition, diet, activities, health checking should be looked after in each developmental stage.

The human baby at birth is quite helpless, left to himself the baby will perish without care. It is the parents who take care of all the needs of the baby such as feeding, clothing, personal cleanliness and health care. Besides taking care of the physical needs of the baby, parents also fulfil the psychological needs such as love, affection and feeling of security. From the time the baby reaches the age of simple understanding, the parents prepare him to be a member of the society by teaching him rules and behaviour. Practices such as feeding, weaning, toilet training, health care, love, affection and security feeling such as cuddling, soothing are called child rearing.

Child rearing practices plays an important role in the development of the personality of an individual. The components of personality of an individual such as habits, attitudes, interests, aspiration, values, socio-emotional behaviour and intellectual performance are much influenced by the way in which a child has been reached. The process of child rearing process is also known as *"parenting"*.

OBJECTIVES

By learning about the styles and areas of child rearing practices students learn about:

- Meaning and importance of child rearing practices
- Styles and areas of child rearing practices
- Influence of child rearing practices on the development of children

2 Styles of child rearing practices

Parental styles are defined as set of attitudes, beliefs and goals of parents, have put into practice in their daily interactions with their children. Parents adopt many styles, from quite strict to a very permissive one and a child reared in one type of family may be markedly different from a child reared in another type of the family. Styles of child rearing adopted by the parents is determined by many factors.

2.1 Factors determining child rearing practices

- Social class
- Family size
- Educational status of the parents
- Occupation of the parent
- Traditional practices of the society
- Culture

- Religion
- Gender
- Number of siblings
- Ordinal position of the child v social status

Stressful social expectations, economic conditions have great effect on child rearing practices. Parents having greater marital conflicts, suffering from debts and single parent households show their sufferings on their innocent children. Child abuse is most frequent in families living in stressful environment. Researchers have proved that the children of middle class are said to be honest, happy, well-mannered and considerate.
A major goal for middle class parents is to teach the children to be self-disciplined and self-directed who think for themselves and who want to act in a socially accepted manner. On the other hand, working and lower-class parents tend to be more interested in conformity, obedience, and respect for authority, neatness and cleanliness. In poor families' children's needs may not be fulfilled, hence they may be malnourished. In some family's children are child labourers.

- **Family size**

The nuclear family in which father, mother and the child live together. In extended families' parents, brothers with their families, unmarried sisters, widowed sisters and grandparents live together. When the size and characteristics of families varies, has an effect on the level of affection and stimulation, opportunities for peer play and the number of adult models' children have to imitate and learn. Due to divorce, separation or death of any one parent, the family becomes a one-parent family/ single parent family. The chronic stress and practical problems experienced by parents in such families are reflected in child rearing practices. It is very difficult to fulfil the needs of the children in such families and very much insecure or over dependent.

- **Educational Status of the parents**

In India majority of the people live in rural areas. Child rearing practices are followed what was practiced by the parents and grandparents. The educated women follow the practices what is ideal as per doctor's advice.

- **Occupation of the parent**

Due to modernization, and improved women employment, both the mother and father are working in most of the families. Thus, the occupation keep away the parents from the child, the child is left in the hands of ahya's/ servants. These children feel insecure, rejected and have no proper role model for the ideal behaviour. Sometimes these children get into bad company; the negative occupation of the parents such as smugglers, alcohol production pushes the child to acquire bad values.

- **Traditional practices of the society**

In this 21st century also in remote villages/tribal areas, parents exercise the rearing practices that are followed by their mothers/grandmothers. For example, the practice of feeding colostrum to the new born baby may not be there, instead sugar water is given; parents pamper their children very much. Whereas in urban area, due to women education, awareness programme through mass media about the significance of colostrum and the facilities available, parents follow the ideal rearing practices.

- **Culture**

Child rearing practices are embedded in the culture and determine to a large extent, the behaviours and expectations surrounding a child's birth and infancy. Cultural practices are followed to rear the child in tribal areas and remote villages; children are breast feed for longer period, in some families even till 5 or 6 years. In some society the child is fed at any time they wake up, due to this sleep pattern of the child is affected. Toilet

practices are started very later. Culture influences child development by creating an environment of values and beliefs that shapes parenting.

- **Religion**

Various religious beliefs lead differences in methods and goals of child rearing and training. The differences may vary from degrees of punishments and disciplinary practices used by the parents to emphasis on self – reliance. And also difference in attitude towards achievements among children have been linked to the religion of their parents.

- **Gender**

From the moment of birth, girls and boys are treated differently. Boys are fed for longer duration, later favourable foods are provided, allowed to go out often than the girls. Boys' health care is taken in the best hospital and sent to the reputed school. Research evidences prove that the mortality and morbidity rates are higher for girls, and the academic achievements is lower for girls, which is the impact of gender disparity shown in child rearing practices.

- **Number of siblings**
-

Number of children in the family determines the kind of child rearing process. The only child, only girl child among many boys and only boy child among many girls are taken care in a better way than the other children in the family. Sometimes parents may pamper too much, the result is the child may be a dependent one.

- **Ordinal position of the child**

The first born and the last born are reared very carefully by the parents without any hesitations. This may develop the superior attitude among them and inferior complex among the other children.

STYLES OF CHILD REARING

Parents adopt many parenting styles from quite strict to very permissive one and a child reared in one type of family may markedly different from a child reared in another type. There are three parenting styles. Good knowledge about the parenting styles and the impact of adopting specific parenting style will help to confine to the appropriate one.

Very prominent styles are:

- Authoritarian
- Democratic
- Permissive

Authoritarian technique

Characteristics

- Rigid
- Punitive
- Cold
- Lack of freedom for expression of thought and action
- Constant criticisms
- Expects unattainable standards
- Pays little recognition
- Deprives opportunities
- Adopts corporal punishments
- Demands unquestioning obedience
- Emphasizes on perfection

Effect on children

* Introverted
* Anxious
* Uncertain
* Sensitive
* Fantasies
* Lacks curiosity
* Lacks originality and creativity
* Feels insecure
* Lacks self- confidence
* Fear of Punishment
* Unsociable
* Unfriendly
* Withdrawn
* Hostile
* Rebellious
* Shy
* Suspicious
* Dishonest

Democratic technique

Characteristics

- Firm
- Sets limits and goals
- Uses reasoning
- Encourages independence
- More receptive to disagreement
- Explains rules and regulations clearly
- Punishes appropriately
- Communicates rationale for punishment
- Rewards with praise
- Expresses signs of approval
- Educates to behave appropriately
- Plans for fostering self – discipline
- Motivates child to live up to expectation

Effects on children

- Self-reliant
- Independent
- Assertive
- Co-operative
- Socially adjustable
- Exhibits positive attitude
- Self-control
- Spontaneous

Permissive technique

Characteristics

- No control
- Non demanding
- Warm
- Inconsistent
- Un-involvement
- Lack of interest and concern
- No punishment for wrong doings
- No role model

Effects on children

* Immature
* Dependent
* Confused
* Fearful
* Anxiety
* Aggressive
* Lack of conformity to social rules
* Feels insecure
* Unable to differentiate between right and wrong
* Develops illusion
* Resentfulness

From this we can understand that affection-oriented parenting style is more effective than power – oriented parenting style.

To discipline children, parents may attempt the following:

- Become an attached parent
- Know the child well
- Guide the child respect others
- Talk and listen to the child
- Be a positive role model
- Provide clear and adequate information
- Teach the child prosocial behaviour and attitudes
- Adopt an instrumental approach
- Avoid corporal punishments
- Redirect positively
- Verbalize feelings
- Suggest natural consequences
- Give choices
- Physically guide
- Maintain eye contact
- Withdraw privileges for a short while
- Practice temporary isolation and
- Distract

EATING DISORDER

Eating disorders are behavioural conditions characterized by severe and persistent disturbance in eating behaviours and associated distressing thoughts and emotions. They can be very serious conditions affecting physical, psychological and social function. Types of eating disorders include anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant restrictive food intake disorder, other specified feeding and eating disorder, pica and rumination disorder.

Taken together, eating disorders affect up to 5% of the population, most often develop in adolescence and young adulthood. Several, especially anorexia nervosa and bulimia nervosa are more common in women, but they can all occur at any age and affect any gender. Eating disorders are often associated with preoccupations with food, weight or shape or with anxiety about eating or the consequences of eating certain foods. Behaviours associated with eating disorders including restrictive eating or avoidance of certain foods, binge eating, purging by vomiting or laxative misuse or compulsive exercise. These behaviours can become driven in ways that appear similar to an addiction.

1. Anorexia nervosa

Anorexia often involves:

- severely restricted calorie intake, which may include avoiding certain types of foods
- intense fear of gaining weight
- distorted body image

It's important to know that weight is not necessarily indicative of whether someone is living with an eating disorder.

In atypical anorexia, for example, a person may not be underweight despite experiencing significant weight loss.

Anorexia is officially categorized into two subtypes: the restricting type and the binge eating and purging type.

People with the restricting type lose weight solely through dieting, fasting, or excessive exercise.

People with the binge eating and purging type may binge on large amounts of food or eat very little. Purging may involve vomiting, taking laxatives or diuretics, or exercising excessively.

Obsessive-compulsive symptoms are often present. For instance, many people with anorexia are preoccupied with constant thoughts about food. Some may obsessively collect recipes or hoard food.

They may also have difficulty eating in public and have a strong desire to control their environment, limiting their ability to be spontaneous.

Over time, people living with anorexia may experience brittle hair and nails, thinning bones, and infertility. In severe cases, anorexia can result in heart, brain, or multi-organ failure and death.

2. Bulimia nervosa

People with bulimia often eat large amounts of food in a limited period of time.

A binge eating episode usually continues until they become painfully full. During a binge, they may feel that they cannot stop eating or control how much they are eating.

Binges can happen with any type of food but most commonly occur with foods the individual would usually avoid. People with bulimia then attempt to purge to compensate for the calories consumed and to relieve gut discomfort.

Common purging behaviours include:

- forced vomiting
- fasting
- using laxatives
- using diuretics
- using enemas
- excessive exercise

Symptoms may appear very similar to those of the binge eating or purging subtypes of anorexia nervosa.

Side effects of bulimia may include:

- an inflamed and sore throat
- swollen salivary glands
- worn tooth enamel
- tooth decay
- acid reflux
- gut irritation
- dehydration

In severe cases, bulimia can also create an imbalance in levels of electrolytes, such as sodium, potassium, and calcium. This can cause a stroke or heart attack.

3. Binge eating disorder (BED)

BED often involves eating large amounts of food rapidly, in secret, and until uncomfortably full, despite not feeling hungry. Feelings of distress, such as shame, disgust, or guilt, may occur when thinking about binge eating behaviour.

People with BED have symptoms similar to those of bulimia or the binge eating subtype of anorexia. This includes eating large amounts of food in relatively short periods of time and feeling a lack of control during these episodes.

However, people with BED do not restrict calories or use purging behaviours, such as vomiting or excessive exercise, after a binge eating episode.

People with BED may eat more ultra-processed foods than whole foods. This may increase the risk of complications such as heart disease, stroke, and type 2 diabetes.

4. Pica

Pica involves eating things that are not considered food and that do not provide nutritional value. This may include:

- ice
- dirt
- soil
- chalk
- soap
- paper
- hair
- cloth
- wool
- pebbles
- laundry detergent
- corn starch

However, for the condition to be considered pica, the eating of non-food substances must not be a typical part of someone's culture or religion.

Pica is most frequently seen in individuals with conditions that affect daily functioning, such as:

- intellectual disabilities
- neurodevelopmental conditions, such as autism spectrum disorder
- mental health conditions, such as schizophrenia

People with pica may have an increased risk of:

- poisoning
- infections
- gut injuries
- nutritional deficiencies

Depending on the substances ingested, pica may be fatal.

5. Rumination disorder

Rumination disorder occurs when a person routinely regurgitates food they have previously chewed and swallowed, re-chews it, and then either re-swallows it or spits it out. This typically occurs within 30 minutes after a meal.

In infants, rumination disorder tends to develop between 3 and 12 months old and often disappears on its own. In children and adults with the condition, therapy can resolve it.

If not resolved in infants, rumination disorder can result in weight loss and severe malnutrition that can be fatal. Adults with this disorder may restrict the amount of food they eat, especially in public.

6. Avoidant/restrictive food intake disorder (ARFID)

People with ARFID experience a lack of interest in eating or a distaste for certain smells, tastes, colours, textures, or temperatures.

Common symptoms include:

- avoidance or restriction of food that prevents the person from eating enough calories or nutrients
- eating habits that interfere with typical social functions, such as eating with others
- weight loss or poor development for age and height
- nutrient deficiencies or dependence on supplements or tube feeding

ARFID goes beyond common behaviours such as picky eating in toddlers or lower food intake in older adults. Moreover, it does not include the avoidance or restriction of foods due to lack of availability or religious or cultural practices.

Other eating disorders

In addition to the six eating disorders mentioned, other less known or less common eating disorders also exist.

These include:

- **Purging disorder:** People with purging disorder use vomiting, laxatives, diuretics, or excessive exercise to control their weight or shape. However, they do not binge eat.
- **Night eating syndrome:** People with this syndrome frequently eat excessively at night, often after awakening from sleep.
- **Other specified feeding or eating disorder (OSFED):** This is an umbrella term for conditions that have symptoms similar to those of an eating disorder but don't fit any of the disorders above.

One disorder that may currently fall under OSFED is orthorexia.

Although orthorexia is increasingly mentioned in the media and in scientific studies, the Diagnostic and Statistical Manual of Mental Disorders, 5th edition, text revision (DSM-5-TR) does not yet recognize it as a separate eating disorder.

People with orthorexia tend to have an obsessive focus on healthy eating to an extent that disrupts their daily lives. They may compulsively check ingredient lists and nutritional labels and obsessively follow “healthy lifestyle” accounts on social media.

Someone with this condition may eliminate entire food groups, fearing that they’re unhealthy. This can lead to malnutrition, severe weight loss, difficulty eating outside the home, and emotional distress.

There is no single cause of eating disorders.

Many people with eating disorders also have body image disturbance and a comorbid body dysmorphic disorder (BDD), leading them to an altered perception of their body. Studies have found that a high proportion of individuals diagnosed with body dysmorphic disorder also had some type of eating disorder, with 15% of individuals having either anorexia nervosa or bulimia nervosa. This link between body dysmorphic disorder and anorexia stems from the fact that both BDD and anorexia nervosa are characterized by a preoccupation with physical appearance and a distortion of body image.

There are also many other possibilities such as environmental, social and interpersonal issues that could promote and sustain these illnesses. Also, the media are oftentimes blamed for the rise in the incidence of eating disorders due to the fact that media images of idealized slim physical shape of people such as models and celebrities motivate or even force people to attempt to achieve slimness themselves. The media are accused of distorting reality, in the sense that people portrayed in the media are either naturally thin and thus unrepresentative of normality or unnaturally thin by forcing their bodies to look like the ideal image by putting excessive pressure on themselves to look a certain way. While past findings have described eating disorders as primarily psychological, environmental, and sociocultural, further studies have uncovered evidence that there is a genetic component.

Genetics

Numerous studies show a genetic predisposition toward eating disorders. Twin studies have found a slight instances of genetic variance when considering the different criterion of both anorexia nervosa and bulimia nervosa as endophenotypes contributing to the disorders as a whole.

Psychological

Eating disorders are classified as Axis I disorders in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-IV) published by the American Psychiatric Association. There are various other psychological issues that may factor into eating disorders, some fulfil the criteria for a separate Axis I diagnosis or a personality disorder which is coded Axis II and thus are considered comorbid to the diagnosed eating disorder. Axis II disorders are subtyped into 3 "clusters": A, B and C. The causality between personality disorders and eating disorders has yet to be fully established. Some people have a previous disorder which may increase their vulnerability to developing an eating disorder. Some develop them afterwards. The severity and type of eating disorder symptoms have been shown to affect comorbidity.

Attentional bias may have an effect on eating disorders. Attentional bias is the preferential attention toward certain types of information in the environment while simultaneously ignoring others. Individuals with eating disorders can be thought to have schemas, knowledge structures, which are dysfunctional as they may bias judgement, thought, and behaviour in a manner that is self-destructive or maladaptive. They may have developed a disordered schema which focuses on body size and eating. Thus, this information is given the highest level of importance and overvalued among other cognitive structures. Researchers have found that

people who have eating disorders tend to pay more attention to stimuli related to food. For people struggling to recover from an eating disorder or addiction, this tendency to pay attention to certain signals while discounting others can make recovery that much more difficult.

Personality traits

There are various childhood personality traits associated with the development of eating disorders, such as perfectionism and neuroticism. These personality traits are found to link eating disorders and OCD. During adolescence these traits may become intensified due to a variety of physiological and cultural influences such as the hormonal changes associated with puberty, stress related to the approaching demands of maturity and socio-cultural influences and perceived expectations, especially in areas that concern body image. Eating disorders have been associated with a fragile sense of self and with disordered metallization. Many personality traits have a genetic component and are highly heritable.

Celiac disease

People with gastrointestinal disorders may be more risk of developing disordered eating practices than the general population, principally restrictive eating disturbances. An association of anorexia nervosa with celiac disease has been found.] The role that gastrointestinal symptoms play in the development of eating disorders seems rather complex.

Child maltreatment

Child abuse which encompasses physical, psychological, and sexual abuse, as well as neglect, has been shown to approximately triple the risk of an eating disorder. Sexual abuse appears to double the risk of bulimia; however, the association is less clear for anorexia. The risk for individuals developing eating disorders increases if the individual grew up in an invalidating environment where displays of emotions were often punished. Abuse that has also occurred in childhood produces intolerable difficult emotions that cannot be expressed in a healthy manner. Eating disorders come in as an escape coping mechanism, as a means to control and avoid overwhelming negative emotions and feelings. Those who report physical or sexual maltreatment as a child are at an increased risk of developing an eating disorder.

Social isolation

Social isolation has been shown to have a deleterious effect on an individual's physical and emotional well-being. Those that are socially isolated have a higher mortality rate in general as compared to individuals that have established social relationships. This effect on mortality is markedly increased in those with pre-existing medical or psychiatric conditions, and has been especially noted in cases of coronary heart disease. "The magnitude of risk associated with social isolation is comparable with that of cigarette smoking and other major bio-medical and psychosocial risk factors." (Brummett *et al.*)

Social isolation can be inherently stressful, depressing and anxiety-provoking. In an attempt to ameliorate these distressful feelings an individual may engage in emotional eating in which food serves as a source of comfort. The loneliness of social isolation and the inherent stressors thus associated have been implicated as parental influence.

Parental influence

Parental influence has been shown to be an intrinsic component in the development of eating behaviours of children. This influence is manifested and shaped by a variety of diverse factors such as familial genetic predisposition, dietary choices as dictated by cultural or ethnic preferences, the parents' own body shape, how they talk about their own body, and eating patterns, the degree of involvement and expectations of their children's eating behaviour as well as the interpersonal relationship of parent and child. It is also influenced by

the general psychosocial climate of the home and whether a nurturing stable environment is present. It has been shown that maladaptive parental behaviour has an important role in the development of eating disorders. As to the more subtle aspects of parental influence, it has been shown that eating patterns are established in early childhood and that children should be allowed to decide when their appetite is satisfied as early as the age of two. A direct link has been shown between obesity and parental pressure to eat more.

Peer pressure

In various studies such as one conducted by The McKnight Investigators, peer pressure was shown to be a significant contributor to body image concerns and attitudes toward eating among subjects in their teens and early twenties.

Eleanor Mackey and co-author, Annette M. La Greca of the University of Miami, studied 236 teen girls from public high schools in southeast Florida. "Teen girls' concerns about their own weight, about how they appear to others and their perceptions that their peers want them to be thin are significantly related to weight-control behaviour", says psychologist Eleanor Mackey of the Children's National Medical Centre in Washington and lead author of the study. "Those are really important. Other psychological problems that could possibly create an eating disorder such as Anorexia Nervosa are depression, and low self-esteem. Depression is a state of mind where emotions are unstable causing a person's eating habits to change due to sadness and no interest of doing anything. According to PSYCOM "Studies show that a high percentage of people with an eating disorder will experience depression. Depression is a state of mind where people seem to refuge without being able to get out of it. A big factor of this can affect people with their eating and this can mostly affect teenagers. Teenagers are big candidates for Anorexia for the reason that during the teenage years, many things start changing and they start to think certain ways.

It's essential to remember that eating disorders are complex and multifaceted. Each individual's experience is unique, and treatment should address the specific causes and risk factors involved.

TREATMENT

Counselling plays a crucial role in the treatment of eating disorders, helping individuals develop a healthier relationship with food and their body. Here are some key aspects of counselling in eating disorders:

TYPES OF COUNSELLING

1. Cognitive-Behavioural Therapy (CBT): Helps individuals identify and challenge negative thought patterns and behaviours associated with their eating disorder.

2. Family-Based Therapy (FBT): Involves the individual with the eating disorder and their family members in the treatment process, focusing on family dynamics and communication.

3. Dialectical Behaviour Therapy (DBT): Emphasizes mindfulness, emotional regulation, and coping skills to manage emotions and behaviours associated with eating disorders.

4. Psychodynamic Therapy: Explores the underlying emotional and psychological issues that contribute to the eating disorder.

GOALS OF COUNSELLING

1. Weight restoration: Helping individuals achieve a healthy weight and develop a positive body image.

2. Improved eating habits: Encouraging healthy eating patterns and reducing restrictive eating or bingeing behaviours.

3. Emotional regulation: Teaching individuals skills to manage emotions and reduce stress.

4. Self-esteem enhancement: Helping individuals develop a positive self-image and improve self-esteem.

5. Family support: Educating family members on how to support their loved one's recovery.

TECHNIQUES USED IN COUNSELLING

1. Food diaries: Encouraging individuals to keep a record of their eating habits and emotions.
2. Cognitive restructuring: Helping individuals challenge and reframe negative thought patterns.
3. Mindfulness techniques: Teaching individuals mindfulness skills to manage emotions and behaviours.
4. Exposure therapy: Helping individuals gradually confront feared foods or eating situations.
5. Family therapy: Working with family members to improve communication and support.

BENEFITS OF COUNSELLING

1. Improved mental health: Counselling can help individuals manage symptoms of anxiety, depression, and other mental health conditions.
2. Increased self-awareness: Counselling helps individuals understand their thoughts, feelings, and behaviours associated with their eating disorder.
3. Better coping skills: Counselling teaches individuals effective coping skills to manage emotions and behaviours.
4. Supportive relationships: Counselling provides individuals with a supportive and non-judgmental relationship.
5. Long-term recovery: Counselling can help individuals achieve long-term recovery from their eating disorder.

COUNSELLING INDIVIDUALS WITH COMMUNICATION DISORDER

Communication disorders are a group of conditions involving problems with receiving, processing, sending, and comprehending various forms of information and communication, including:

- concepts
- verbal
- nonverbal
- graphic language
- speech

They can result from any condition that affects hearing, speech, and language to the extent that it can disrupt a person's ability to communicate properly. A communication disorder can manifest early in a child's development, or a medical condition can cause it to develop at an older age.
It can be a stand-alone condition or co-occur with other communication and developmental disorders.
The severity of communication disorders can range from mild to profound.

Types of communication disorders

Speech disorder

Speech disorders affect a person's ability to articulate speech sounds. These conditions can affect fluency, meaning the rate, rhythm, and flow of speech, or voice, meaning the pitch, volume, or length of speech.

Language disorder

Language disorders impair a person's ability to comprehend or use spoken, written, or other symbol systems.

They may involve problems with:

- **Phonology:** This term refers to the sounds that make up language systems and the rules governing sound combinations.
- **Morphology:** Morphology describes the structure and construction of words.
- **Syntax:** People who have difficulties with syntax may make errors relating to the relationship, order, and combination of words in sentences.
- **Language content:** This term refers to the meaning of words and sentences, or semantics.

- **Language function:** Language function means using and understanding language based on interactional context and beyond its literal meaning.

Hearing disorder

Hearing disorders result from an impaired sensitivity of the auditory system. They involve difficulties detecting, recognizing, discriminating, comprehending, and perceiving auditory information.

A person with a hearing disorder may be deaf or have partial hearing loss.

Central auditory processing disorder (CAPD)

CAPD results from problems in processing auditory information in the brain area responsible for interpreting auditory signals. These problems are not due to an intellectual impairment or hearing sensitivity problems of the ear.

Other classifications

The *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* classifies communication disorders into four categories:

- **Language disorder:** A person has difficulty acquiring and using spoken, written, or sign language or other language modalities.
- **Speech sound disorder:** These disorders involve difficulty producing speech sounds, which can make sounds challenging to understand or prevent effective communication.
- **Child-onset fluency disorder (stuttering):** This term refers to speech flow and fluency problems that are not appropriate for a child's age.
- **Social (pragmatic) communication disorder:** A person has trouble understanding and using verbal and nonverbal communication for social purposes.

What causes communication disorders?

Most communication disorders have an unknown cause, but they may be developmental or acquired. Possible causes include:

- exposure to toxins and substances while in the womb
- traumatic brain injuries or tumours in the brain area responsible for communication
- stroke and other neurological disorders
- structural impairments, such as cleft lip or cleft palate
- vocal cord injury due to misuse and abuse
- viral disease

Symptoms

The type of communication disorder will determine the possible symptoms:

Speech disorder symptoms

Symptoms of speech disorders include:

- repeating words, vowels, or sounds
- difficulty making sounds, even when the person knows what they want to say
- elongating or stretching words
- adding, omitting, or substituting words or sounds
- jerky head movements or excessive blinking while talking
- frequently pausing while talking

Language disorder symptoms

Symptoms of language disorders include:

- overusing fillers such as "um" and "uh" because of the inability to recall words

- knowing and using fewer words than their peers
- trouble understanding concepts and ideas
- difficulty learning new words
- problems using words and forming sentences to explain or describe something
- saying words in the wrong order
- difficulty understanding instructions and answering questions

Hearing disorder symptoms

Symptoms of hearing disorders include:

- being behind their peers in terms of oral communication
- asking others to repeat what they said in a slower, clearer manner
- talking louder than is typical
- muffled speech and other sounds
- withdrawal from social settings and conversations
- difficulty understanding words, especially in noisy environments

CAPD disorder symptoms

Symptoms of CAPD include:

- difficulty localizing sounds
- difficulty understanding words that people say too fast or against a noisy background
- problems understanding and following rapid speech
- difficulty learning songs
- lack of musical and singing skills
- difficulty learning a new language
- problems paying attention
- getting easily distracted

Counselling individuals with communication disorders requires a unique approach that addresses their specific needs and challenges. Here are some key considerations:

Counselling Strategies

1. Establish Trust: Build a rapport with the individual, ensuring they feel comfortable and supported.

2. Assess Communication Needs: Evaluate the individual's communication strengths, challenges, and goals.

3. Use Alternative Communication Methods: Incorporate alternative methods, such as visual aids, gestures, or augmentative and alternative communication (AAC) devices.

4. Focus on Strengths: Emphasize the individual's strengths and abilities, rather than their communication challenges.

5. Involve Family and Caregivers: Educate and involve family members and caregivers in the counselling process to ensure a supportive environment.

6. Address Emotional and Psychological Needs: Help the individual cope with emotions related to their communication disorder, such as frustration, anxiety, or low self-esteem.

Specific Counselling Techniques

1. Speech-Generating Devices: Use devices that generate speech, such as text-to-speech software or devices.

2. **Picture Communication Symbols**: Utilize pictures or symbols to support communication.

3. **Sign Language:** Incorporate sign language into counselling sessions, if applicable.

4. Cognitive-Behavioural Therapy (CBT): Adapt CBT techniques to address communication-related anxiety, frustration, or low self-esteem.

5. Support Groups: Facilitate support groups for individuals with communication disorders to share experiences, receive support, and build connections.

Cultural Considerations

1. Cultural Sensitivity: Be aware of cultural differences in communication styles and adapt counselling approaches accordingly.

2. Language Accessibility: Ensure that counselling materials and communication methods are accessible and understandable for individuals with diverse language backgrounds.

By tailoring counselling approaches to the unique needs of individuals with communication disorders, counsellors can help them build confidence, develop effective communication strategies, and improve their overall quality of life.

COUNSELLING FOR OBSESSIVE COMPULSIVE DISORDER (OCD)

Obsession is a type of thought, which keeps coming back in the minds of the victims of OCD, though they want to avoid it. He/she knows that the thought is meaningless, unnecessary, unreasonable, and they want to eradicate the thought from the mind but cannot. Consequently, they suffer a painful and frustrating situation, eventually cannot concentrate on any important matter.

Compulsion is the reflection of obsession. A person who is victimized by OCD, is bound to do a certain work like cleaning of the hands, rubbing, counting, washing, etc., repetitively. Victims of OCD always think if he/she doesn't repeat the actions, then it will harm him/her or someone close to them.

Obsessive-Compulsive Disorder (OCD) is a complex mental health condition characterized by recurring, intrusive thoughts (obsessions) and repetitive behaviours (compulsions). The exact causes of OCD are still not fully understood, but research suggests that it is a multifactorial disorder, involving a combination of genetic, neurobiological, environmental, and psychological factors.

Individuals with OCD usually experience both obsessions and compulsions that can present a long list of challenges. However, some people may experience only obsessions or only compulsions. The severity of symptoms may change over time but often worsens during excessive periods of high stress and anxiety. Below the difference between obsessions and compulsions is explained.

Obsessions are repeated thoughts, urges, or mental images that create anxiety. Common obsessions include:

- Fear of germs or contamination
- Unwanted or taboo thoughts involving sex, religion, and harm
- Aggressive thoughts towards others or self
- Having things symmetrical or in a perfect order

Compulsions are repetitive behaviours that a person with OCD urges to do in response to an obsessive thought. Common compulsions include:

- Excessive cleaning or hand washing
- Ordering and arranging things in a particular, precise way
- Repeatedly checking on things, like checking to see if the door is locked or the oven is off
- Compulsive counting

Many People with OCD can relate to one of the following behaviour categories:

Hand Washing ›

Counting and Fixing

Having Doubts or Negative Thoughts

Re-checking

Hoarding items

Repetitive behaviours

Treatment for (OCD) Obsessive-Compulsive Disorder

Individuals that face the symptoms of OCD daily can find relief through a combination of psychotherapy, medication and self-help strategies. Choosing the right therapist to get optimal results in the short and long term is essential. This means only relying on therapists with the expertise and previous training to accurately diagnose and treat OCD.

Treatment options for OCD typically include:

Medication for OCD

Medications called serotonin reuptake inhibitors (SRIs), selective SRIs (SSRIs) and tricyclic antidepressants may help treat OCD

Psychotherapy

In addition to medication, many healthcare providers recommend psychotherapy or OCD Counselling to minimize the impact of OCD on your daily life. Knowing some of the various forms of effective psychotherapy may be helpful when looking for OCD treatment:

- **Cognitive-behavioural therapy (CBT):** This treatment method can benefit people suffering from OCD. In CBT, you will work on identifying obsessive thoughts that may lead to having increased feelings of anxiety, and you will work on replacing this mode of thinking with a more realistic one. Working closely with a therapist to obtain the desired results during this process is important.
- **Exposure Therapy (ET):** Allowing individuals to confront their fears in an environment that is both safe and controlled can be helpful when it comes to reducing the impact of OCD. This therapy may encourage individuals to become more desensitized to specific situations that commonly trigger their anxiety.
- **Acceptance and commitment therapy (ACT)**: ACT helps you learn to accept obsessive thoughts as just thoughts, taking the power away from them.

Studies show that a combination of medication, CBT, and ET are the best remedies for OCD. A combination treatment is often the recommendation of OCD specialists because of the fast and efficient results obtained. Getting better requires the right amount of effort, discipline, and time. This is all possible with professional guidance and motivation. Working closely with a therapist can be the key to helping you have a better quality of life.

Self-Care Strategies

Self-care can significantly reduce the symptoms of OCD and can allow for a better quality of life. Many valuable treatments and complementary self-help strategies help deal with OCD.

Deep Breathing: Taking control of the day can often begin by becoming more attuned with mind and body. A great way to accomplish this is by taking deep breaths and focusing on breathing throughout the day. Mind-fulness helps with remaining focused and keeping from getting off track by the obsessive thoughts. Learning meditation can be a great way to handle OCD better.

Keeping a Journal: Maintaining a record of what's happening daily is an ideal way to feel more attuned to mind and body. This will only take a few minutes to accomplish and may be extremely helpful in reducing many of the common obsessions for people with OCD. To be successful with this self-help strategy, one must be consistent in his/her efforts. Doing this can provide a thorough record of what's going on each day and may

be extremely helpful in living with OCD. In addition to its practical purposes, journaling is an enjoyable activity that many people find useful in reducing the stress and anxiety accompanying OCD.

Sleeping Well: Getting into the habit of sleeping enough each night can be beneficial for coping with OCD. Being well-rested can contribute to a calmer mind, which is helpful for anyone with OCD.

Joining a Support Group: Communicating with others that struggle with the challenges of OCD can be a great way to manage this condition. Having a group that is accessible and willing to provide the necessary support can be extremely helpful for any individual with OCD.

Individuals with OCD usually experience both obsessions and compulsions that can present a long list of challenges. However, some people may experience only obsessions or only compulsions. The severity of symptoms may change over time but often worsens during excessive periods of high stress and anxiety. Below the difference between obsessions and compulsions is explained.

What causes OCD?

- **Genetics**: Studies show that people who have a first-degree relative (biological parent or sibling) with OCD are at a higher risk for developing the condition. The risk increases if the relative developed OCD as a child or teen.
- **Brain changes**: Imaging studies have shown differences in the frontal cortex and subcortical structures of the brain in people who have OCD. OCD is also associated with other neurological conditions that affect similar areas of your brain, including Parkinson's disease, Tourette's syndrome and epilepsy.
- **PANDAS syndrome**: PANDAS is short for "pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections." It describes a group of conditions that can affect children who have had strep infections, such as strep throat or scarlet fever. OCD is one of these conditions.
- **Childhood trauma**: Some studies show an association between childhood trauma, such as abuse or neglect, and the development of OCD.
- **Neurotransmitter imbalance**: Imbalances in neurotransmitters, such as serotonin, dopamine, and glutamate, may contribute to the development of OCD.

- **ENVIRONMENTAL FACTORS**
    1. **Stress:** Stressful life events, such as trauma or significant changes, can trigger the onset of OCD symptoms.
    2. **Learning and conditioning**: OCD symptoms can be learned and reinforced through classical conditioning, operant conditioning, and social learning.
- **PSYCHOLOGICAL FACTORS**
    1. **Cognitive distortions**: Individuals with OCD often experience cognitive distortions, such as overestimation of threat, exaggerated sense of responsibility, and intolerance of uncertainty.
    2. **Anxiety and fear**: OCD symptoms are often driven by anxiety and fear, which can be triggered by specific stimuli or situations.

- **OTHER FACTORS**
    1. **Infections**: Certain infections, such as streptococcal infections, may trigger the onset of OCD symptoms in some individuals.
    2. **Hormonal changes**: Hormonal changes, such as those experienced during pregnancy or puberty, may contribute to the development of OCD symptoms.
    3. **Neurodevelopmental factors**: OCD may be associated with neurodevelopmental factors, such as abnormalities in brain development or function.

It's essential to note that OCD is a complex condition, and each individual's experience is unique. A comprehensive understanding of the causes of OCD can help healthcare professionals develop effective treatment plans and provide better support for individuals with OCD.

PHOBIC AND OTHER PANIC VICTIMS

PHOBIC DISORDER

Phobia is defined as an irrational fear of specific object, situation or activity, often leading to persistent avoidance of the feared object, situation or activity. The common types of phobias are:

1. Agoraphobia
2. Social phobia
3. Specific(simple) phobia

Some characteristic features of phobia:

- Presence of the fear of an object, situation or activity
- The fear is out of proportion to the dangerousness perceived
- Patient recognizes the fear as irrational and unjustified (insight is present)
- Patient is unable to control the fear and is very distressed by it
- This leads to persistent avoidance of the particular object, situation or activity
- Gradually, the phobia and the phobic object become a preoccupation with the patient, resulting in marked distress and rejection of the freedom of mobility

1. Agoraphobia

Agoraphobia is an example of irrational fear of situations. It is the commonest type of phobia. It is characterised by the irrational fear of being in places away from the familiar setting of home. Although it was earlier thought to be fear of open spaces only, now it includes fear of open spaces, public places, crowded places, and any other place from where there is no easy escape to a safe place.

Social phobia

This is an example of irrational fear of activities or social interaction, characterised by an irrational fear of performing activities in the presence of other people or interacting with others. The patient is afraid of his own actions being viewed by others critically, resulting in embarrassment or humiliation.

There is marked distress and disturbance in routine daily functioning. Some of the examples include fear of blushing (erythrophobia), eating in company of others, public speaking, stage performance, participating in groups, writing in public (signing a cheque) dating, speaking to authority figures, and urinating in a public lavatory (shy bladder).

Specific (Simple) phobia

In contrast to agoraphobia and social phobia where the stimuli are generalised, in specie phobia the stimulus is usually well circumscribed. Specific phobia is characterised by an irrational fear of a specified object or situation. Anticipatory anxiety leads to persistent avoidant behaviour, while confrontation with the avoided object or situation leads to panic attacks. Gradually the phobia usually spreads to other objects and situations. This disorder is diagnosed only if there is marked distress or disturbance in daily functioning, in addition to fear and avoidance of the specified object or situation. Some of the examples are acrophobia (fear of height), zoophobia (fear of animals), xenophobia (fear of strangers) algophobia (fear of pain), and claustrophobia (fear of closed places).

The list of specific phobias is virtually endless.

While the exact causes can vary, several factors are believed to contribute to their development:

A significant traumatic event involving the feared object or situation can trigger a phobia. For example, a dog attack can lead to cynophobia (fear of dogs). Even witnessing a traumatic event can have a similar effect.

Phobias can be learned through observation. If a child sees a parent exhibiting intense fear of something, they may develop the same fear. This can also involve receiving excessive warnings about potential dangers.
There's evidence that some people may be genetically predisposed to anxiety disorders, making them more susceptible to developing phobias. Having a family history of anxiety disorders increases the risk.
Sometimes, simply hearing or reading about frightening events can lead to the development of a phobia. For instance, news reports about plane crashes could contribute to a fear of flying.
Research suggests that certain areas of the brain, particularly those involved in fear responses, may function differently in people with phobias. Chemical imbalances in the brain may also play a role.
General stressful life situations can increase a person's likely hood of developing phobias.
It's important to note that phobias can develop at any age, although some, like animal phobias, often begin in childhood.
Anxiety is a normal reaction to stress. Mild levels of anxiety can be beneficial in some situations. It can alert us to dangers and help us prepare and pay attention. Anxiety disorders differ from normal feelings of nervousness or anxiousness and involve excessive fear or anxiety. Anxiety disorders are the most common of mental disorders. They affect nearly 30% of adults at some point in their lives. However, anxiety disorders are treatable with a number of psychotherapeutic treatments. Treatment helps most people lead normal productive lives.
Anxiety refers to anticipation of a future concern and is more associated with muscle tension and avoidance behaviour.
Fear is an emotional response to an immediate threat and is more associated with a fight or flight reaction – either staying to fight or leaving to escape danger.
Anxiety disorders can cause people to try to avoid situations that trigger or worsen their symptoms. Job performance, schoolwork and personal relationships can be affected. In general, for a person to be diagnosed with an anxiety disorder, the fear or anxiety must:

- Be out of proportion to the situation or be age-inappropriate
- Hinder their ability to function normally

There are several types of anxiety disorders: generalized anxiety disorder, panic disorder with or without agoraphobia, specific phobias, agoraphobia, social anxiety disorder, separation anxiety disorder and selective mutism.

Types:

Generalized Anxiety Disorder

Generalized anxiety disorder involves persistent and excessive worry that interferes with daily activities. This ongoing worry and tension may be accompanied by physical symptoms, such as restlessness, feeling on edge or easily fatigued, difficulty concentrating, muscle tension or problems sleeping. Often the worries focus on everyday things such as job responsibilities, family health or minor matters such as chores, car repairs, or appointments.

Panic Disorder

The core symptom of panic disorder is recurrent panic attacks, an overwhelming combination of physical and psychological distress. During an attack, several of these symptoms occur in combination:
Panic Disorder Symptoms
During an attack, several of these symptoms occur in combination.
Palpitations, pounding heart or rapid heart rate
Numbness or tingling
Sweating
Chills or hot flashes

Trembling or shaking
Nausea or abdominal pains
Feeling of shortness of breath or smothering sensations
Feeling detached
Chest pain
Fear of losing control
Feeling dizzy, light-headed or faint
Fear of dying
Feeling of choking

Because the symptoms can be quite severe, some people who experience a panic attack may believe they are having a heart attack or some other life-threatening illness. They may go to a hospital emergency department. Panic attacks may be expected, such as a response to a feared object, or unexpected, apparently occurring for no reason. The mean age for onset of panic disorder is 20-24. Panic attacks may occur with other mental disorders such as depression or PTSD.

Phobias, Specific Phobia

A specific phobia is excessive and persistent fear of a specific object, situation or activity that is generally not harmful. Patients know their fear is excessive, but they can't overcome it. These fears cause such distress that some people go to extreme lengths to avoid what they fear. Examples are public speaking, fear of flying or fear of spiders.

Agoraphobia

Agoraphobia is the fear of being in situations where escape may be difficult or embarrassing, or help might not be available in the event of panic symptoms. The fear is out of proportion to the actual situation and lasts generally six months or more and causes problems in functioning. A person with agoraphobia experiences this fear in two or more of the following situations:

- Using public transportation
- Being in open spaces
- Being in enclosed places
- Standing in line or being in a crowd
- Being outside the home alone

The individual actively avoids the situation, requires a companion or endures with intense fear or anxiety. Untreated agoraphobia can become so serious that a person may be unable to leave the house. A person can only be diagnosed with agoraphobia if the fear is intensely upsetting, or if it significantly interferes with normal daily activities.

Social Anxiety Disorder (previously called social phobia)

A person with social anxiety disorder has significant anxiety and discomfort about being embarrassed, humiliated, rejected or looked down on in social interactions. People with this disorder will try to avoid the situation or endure it with great anxiety. Common examples are extreme fear of public speaking, meeting new people or eating/drinking in public. The fear or anxiety causes problems with daily functioning and lasts at least six months.

Separation Anxiety Disorder

A person with separation anxiety disorder is excessively fearful or anxious about separation from those with whom he or she is attached. The feeling is beyond what is appropriate for the person's age, persists (at least four weeks in children and six months in adults) and causes problems functioning. A person with separation anxiety disorder may be persistently worried about losing the person closest to him or her, may be reluctant or refuse to go out or sleep away from home or without that person, or may experience nightmares about

separation. Physical symptoms of distress often develop in childhood, but symptoms can carry though adulthood.

Selective Mutism

Children with selective mutism do not speak in some social situations where they are expected to speak, such as school, even though they speak in other situations. They will speak in their home around immediate family members, but often will not speak even in front of others, such as close friends or grandparents.

The lack of speech may interfere with social communication, although children with this disorder sometimes use non-spoken or nonverbal means (e.g., grunting, pointing, and writing). The lack of speech can also have significant consequences in school, leading to academic problems and social isolation. Many children with selective mutism also experience excessive shyness, fear of social embarrassment and high social anxiety. However, they typically have normal language skills.

Selective mutism usually begins before age 5, but it may not be formally identified until the child enters school. Many children will outgrow selective mutism. For children who also have social anxiety disorder, selective mutism may disappear, but symptoms of social anxiety disorder may remain.

The causes of anxiety disorders are currently unknown but likely involve a combination of factors including genetic, environmental, psychological and developmental. Anxiety disorders can run in families, suggesting that a combination of genes and environmental stresses can produce the disorders.

Although each anxiety disorder has unique characteristics, most respond well to two types of treatment: psychotherapy or "talk-therapy," and medications. These treatments can be given alone or in combination. Cognitive behaviour therapy (CBT), a type of talk therapy, can help a person learn a different way of thinking, reacting and behaving to help feel less anxious. Medications will not cure anxiety disorders, but can provide significant relief from symptoms. The most commonly used medications are anti-anxiety medications (generally prescribed only for a short period of time) and antidepressants. Beta-blockers, used for heart conditions, are sometimes used to control physical symptoms of anxiety.

There are a number of things people do to help cope with symptoms of anxiety disorders and make treatment more effective. Stress management techniques and meditation can be helpful. Support groups (in-person or online) can provide an opportunity to share experiences and coping strategies. Learning more about the specifics of a disorder and helping family and friends to understand the condition better can also be helpful. Avoid caffeine, which can worsen symptoms, and check with your doctor about any medications.

Types of Anxiety Therapy

The goal of all therapeutic approaches is to help you understand why you feel the way you feel, what your triggers are, and how you might change your reaction to them. Some types of therapy even teach practical techniques to help reframe your negative thinking and change your behaviours.

Anxiety disorders differ considerably, so therapy should be tailored to your specific symptoms and diagnosis. It can be conducted in an individual, family, couples, or group setting. How often you meet with your therapist and for how long will depend on your specific symptoms and diagnosis.

Psychiatrists, psychologists, and other mental health professionals use several types of anxiety therapy. The choice of therapy also depends on your diagnosis and the severity of your symptoms.

Cognitive Behavioural Therapy

Cognitive behavioral therapy (CBT) is the most widely-used therapy for anxiety disorders. Research has found it to be effective in treating SAD, GAD, phobias, and panic disorders, among other conditions.

The premise of CBT is that your thoughts—not your current situation—affect how you feel and subsequently behave. So, the goal of CBT is to identify and understand your negative thinking and ineffective behaviour patterns and replace them with more realistic thoughts and effective actions and coping mechanisms.

During this process, your therapist acts like a coach, teaching you helpful strategies. For example, you might do a lot of "black-and-white" thinking, where you assume that things are all bad or all good. Instead, you would replace those thoughts with the more realistic perception that there are many shades of grey in between.

Exposure Therapy

Exposure therapy is one of the most common CBT methods used to treat a variety of anxiety disorders, including specific phobias, SAD, and PTSD. The basic premise behind exposure therapy is that if you're afraid of something, the best way to conquer it is head-on.

During exposure therapy, your therapist will slowly introduce you to anxiety-producing objects or situations. This is often done using a technique known as "systematic desensitization," which involves three steps:

1. **Relax**: Your therapist will teach you relaxation training to help combat your anxiety. Examples of relaxation training include progressive muscle relaxation, deep breathing, meditation, and guided imagery.
2. **List**: Create a list of your anxiety-provoking triggers, ranking them in intensity.
3. **Expose**: In this final step, you'll gradually work through your listed anxiety-provoking objects or situations, using relaxation techniques when necessary.

There are several ways your psychologist may expose you to anxiety-provoking stimuli. Here are the most common:

- **Imaginal exposure**: In this type of exposure, you'll be instructed to imagine your anxiety-provoking object or situation vividly.
- **In vivo exposure**: In this method, you'll face your anxiety-provoking object or situation in real life. So with this type of exposure, a person with social anxiety might be instructed to give a speech in front of an audience.
- **Virtual reality exposure**: In some cases, virtual reality can be used when in vivo exposure isn't possible. Virtual reality therapy uses technology to combine elements of in vivo and imaginal exposure. This method has proven especially helpful for soldiers and others with PTSD.

Dialectical Behaviour Therapy

Dialectical behaviour therapy (DBT) is a highly effective type of CBT. Originally used to treat borderline personality disorder (BPD), DBT is now used to treat a variety of conditions, including anxiety.

DBT focuses on helping to develop what seems like a "dialectical" (opposite) outlook, practice acceptance, and embrace change. During DBT treatment, the client will learn to accept your anxiety while actively working to change it. It's similar to the notion of loving oneself the way one is while still trying to change for the better.

DBT treatment teaches four powerful skills:

- **Mindfulness**: Connecting with the present moment and notice passing thoughts (like anxiety) without being ruled by them
- **Distress tolerance**: Managing anxiety when faced with a stressful situation
- **Interpersonal effectiveness**: Learning how to say no or to ask for what you need
- **Emotion regulation**: Managing anxiety before it gets out of control

Acceptance and Commitment Therapy

Acceptance and commitment therapy (ACT) is another form of therapy that has been shown effective for a variety of anxiety disorders. ACT involves identifying life values and acting in ways that match values.

ACT has two main components:

- Accepting that thoughts and feelings don't necessarily need to be controlled
- Making a commitment to take actions that help a person live life according to their values

ACT helps people learn to accept the uncomfortable, anxious feelings they have. Instead of trying to suppress or change these feelings, they learn emotional strategies to help them tolerate discomfort.

Art Therapy

Art therapy is an experience-oriented therapy. It involves either using visual art (such as painting, drawing, and sculpting) to express and process emotion or using art to practice mindfulness and relaxation. Although it can be provided as a standalone therapy, it's commonly used in combination with other treatment methods such as CBT.

Psychoanalytic Therapy

According to this Freudian model, anxiety symptoms reflect unconscious conflicts. The purpose of psychoanalytic therapy is to resolve them. In psychoanalysis both client and therapist examine thoughts, fears, and desires to better understand how the client view themselves and to reduce anxiety. This is one of the most intensive forms of treatment; it can take years to identify patterns the ways of thinking.

The terms "psychoanalysis" and "psychodynamic therapy" are often used interchangeably, but psychoanalysis is actually a subset of psychodynamic therapy.

Interpersonal Therapy

Interpersonal therapy (IPT) focuses on social roles and relationships. In IPT, the client work with the therapist to identify any interpersonal issues, such as unresolved grief, conflicts with family or friends, changes in work or social roles, and problems relating to others. The client then learns healthy ways to express emotions and ways to improve communication with others.

PERSONALITY DISORDER

A person's characteristic ways of responding are often referred to as his/her personality. Personality is a combination of thoughts, emotions and behaviour that makes a person unique.

It's the way we view, understand and relate to the outside world as well as how we see ourselves.

Personality disorders result when personality traits or patterns become abnormal, become inflexible, repetitive maladaptive and significantly impairs social and work functioning.

These patterns deviate from cultural norms and expectations, causing distress and impairment in social, occupational, and personal relationships.

CHARACTERISTICS OF PERSONALITY DISORDER

- Markedly disharmonious behaviour and attitudes covering several areas of functioning, effectively arousal, impulse control, ways of perceiving and thinking, style of relating to others.
- Abnormal behavioural pattern enduring of long standing and not limited to episodes of mental illness.
- The abnormal behaviour is pervasive and maladaptive to a broad range of personal and social situations.
- The above manifestations always appear in the childhood and continue into adulthood.
- The disorder leads to considerable personal distress but this may only become apparent late.
- The disorder is usually but not invariably associated with social or occupational disturbance.

TYPES OF PERSONALITY DISORDERS

The Personal Disorder is classified into 3 broad categories:

Cluster A-Odd and eccentric behaviour, this consists of those personality disorders which are thought to be on a “schizophrenic continuum” , these are:

- Paranoid PD
- Schizoid PD
- Schizotypal PD

Cluster B- Dramatic, emotional and erratic behaviour, this consists of those personality disorders which are thought to be on a “psychopathic continuum”, these are:

- Antisocial PD
- Borderline PD
- Histrionic PD
- Narcissistic PD

Cluster C- Anxious and fearful behaviour consists of “introversion continuum” these are:

- Avoidant PD
- Dependent PD
- Obsessive compulsive PD

CLUSTER A

1. Paranoid Personality Disorder: Characterized by pervasive distrust, suspiciousness, and hostility towards others. A person having at least 4 of these characteristics might be considered to have a Paranoid PD:

- Expects, without sufficient basis, to be exploited by others.
- Questions, without justifications, loyalty or trustworthiness of peers and associates.
- Reads hidden, demeaning or threatening meanings into benign remarks and events.
- Bears grudges or is unforgiving of insults.
- Is reluctant to share anything with others because of unwarranted fear that the information will be used against him/her.
- Perceives, attack on his/her character or reputation that are not apparent to others and is quick to react with anger or to counterattack.
- Has recurrent suspicious without justification regarding fidelity of spouse or sexual partner.

2. Schizoid Personality Disorder: Marked by social isolation, emotional coldness, and a lack of interest in social relationships. A person having at least 4 of these characteristics:

- Neither desires nor enjoys close relationships, including being part of a family.
- Almost always chooses solitary activities.
- Obtains pleasure from any activity.
- Indicates, if any, desire to have sexual experiences or to have a partner.
- Appears indifferent to the praise criticism of others.
- Has no close friends or confidants.
- Shows emotional coldness, detachment, and little variations in emotions.

3. Schizotypal Personality Disorder: Characterized by eccentric behaviour, unusual thinking, and difficulty forming close relationships. A person having at least 5 of these characteristics:

- Inappropriate ideas of reference(the belief that other peoples conversation, smile have reference to oneself)
- Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgements.

- Odd beliefs or thinking that one has magical powers, others can understand my feelings, they have the sixth sense.
- Unusual perceptual experiences including bodily illusions.
- Odd speech and thinking
- Paranoid ideas or suspiciousness
- Odd acentric behaviour or appurtenance, unusual mannerism, talking to self
- No close friends or confidants or perhaps only one primarily because of lack of desire for contact, pervasive discomfort with others
- Inappropriate or constricted effect-coldness or aloofness

CLUSTER B

1. Antisocial Personality Disorder: Marked by a disregard for others' rights, feelings, and safety, often accompanied by impulsivity and aggression. A person having at least 3 of these characteristics if she/he is at least 18 years of age and has shown evidence of conduct disorder before age 15:

- Failure to confirm to social norms (violating laws)
- Deceitfulness, manipulativeness
- Impulsivity, failure to plan ahead
- Irritability, aggressiveness
- Reckless, disregard for the safety of self and others.
- Consistent irresponsibility
- Lack of remorse after having hurt, mistreated or stolen from another person.

2. Borderline Personality Disorder: Characterized by instability in relationships, emotions, and self-image, often accompanied by impulsivity and self-destructive behaviours. A person having at least 5 of these characteristics:

- Employment of frantic efforts to avoid real or imagined abandonment
- Unstable or intense interpersonal relationship
- Persistent and markedly disturbed, distorted or unstable sense of self- a feeling that one does not exist
- Impulsiveness in such areas as sex, substance use, crying and reckless driving
- Recurrent suicidal thoughts, gestures and behaviours
- Emotional instability with periods of extreme depression, irritability or anxiety
- Chronic feelings of emptiness
- Inappropriate intense anger or lack of control of anger
- Stress related paranoid thoughts of dissociative symptoms (It's not me, it's somebody else)

3. Histrionic Personality Disorder: Marked by excessive emotionality, attention-seeking behaviour, and a need for constant approval. A person is having at least 5 of these characteristics:

- Rapidly shifting but basically shallow expressions of emotions
- Over concerned with physical attractiveness
- Inappropriate sexual seductiveness in appearance or behaviour
- Discomfort when not the centre of attraction
- Intolerance of , or excessive frustration over situation that do not work out exactly as desire
- Apparent view of relationship as possessing greater intimacy then is actually the case
- Exaggerative expressions or emotion with much self-dramatization

4. Narcissistic Personality Disorder: Characterized by a grandiose sense of self-importance, a need for admiration, and a lack of empathy for others. A person having at least 5 of these characteristics:

- Grandiose sense of self-importance, exaggeration of self-achievements and talents, need for recognition of one's superiority by others
- Preoccupation with fantasies with unlimited success, power and beauty.

- Sense that one's specialness or uniqueness can be appreciated only by other special or high-status people or institutions
- Need for excessive admiration and attention
- Sense of entitlement, expects especially favourable treatment or automatic compliance with personal expectations
- Exploitation of other people and takes advantage of them
- Lack of empathy for other people's needs and feelings
- Often envy of others or believe that others are envious of him or her
- Arrogance or haughtier behaviour or attitude

CLUSTER C

1. Avoidant Personality Disorder: Marked by social inhibition, feelings of inadequacy, and a fear of rejection or criticism. A person having at least 4 out of these characteristics:

- Anticipates and worries about being rejected or criticized in social situations.
- Has few friends, despite the desire for them
- Unwilling to get involved with people unless certain of being liked
- Avoids social or occupational activities that involve significant interpersonal contact
- Inhibits development of intimate relationships because of seeming foolish, being ridiculed and feeling ashamed
- Possesses low self-worth because of self-perceived social ineptness lack of personal appealing qualities
- Unusually reluctant to engage in new situations or activities for fear of embarrassment

2. Dependent Personality Disorder: Characterized by a need for others to take responsibility, make decisions, and provide emotional support. A person having at least 5 out of these characteristics:

- Unable to make everyday decisions without advice and reassurance from others
- Allows or encourages others to make important life decisions for them
- Has difficulty expressing disagreement with others because of fear of their anger or loss of support
- Has difficulty independently initiating activities because of lack of confidence in personal judgement or abilities
- Goes to excessive length to obtain nurturance and support from others
- Feels uncomfortable or helpless when alone because of exaggerate fears of inability to care for himself or herself
- Indiscriminately seeks another relationship to provide nurturing and support when a close relationship ends
- Frequently pre occupied of fears of being left to care for himself/herself

3. Obsessive-Compulsive Personality Disorder: Marked by a preoccupation with orderliness, perfectionism, and control, often accompanied by rigidity and inflexibility. A person having at least 4 out of these characteristics:

- Perfectionism that interferes with completing tasks
- Pre occupation with details rules, lists and schedules
- Reluctant to delegate tasks or to work with others unless they follow exactly his/her way of doing things
- Excessive devotion to work and productivity to the exclusion of lazier activities and friendships
- Over consciousness or inflexibility of others morality
- Perception of money is something to be saved for future catastrophes, miserliness regarding spending themselves and others
- Inability to discard worn out or worthless objects even when they don't have any sentimental values
- Behaviour is typically rigid and stubborn

CAUSES:

Scientists are still researching to determine the causes of personality disorder, as it is one of the least understood mental health conditions. However, scientists do believe that the following factors can contribute to whether someone develops a personality disorder:

- **Genetic factors –** Scientists have found a malfunctioning gene that may potentially be a mark for obsessive-compulsive personality disorder. They are also exploring genetic connections to other traits associated with personality disorders, such as anxiety, fear, and aggression.
- **Childhood trauma** – There might be a link between childhood trauma and personality disorders developing. For example, people with borderline personality disorder are known to have high rates of childhood sexual trauma.
- **Verbal abuse** – People who have experienced extreme verbal abuse as a child are three times as likely to have personality disorders such as borderline personality disorder, narcissistic personality disorder, obsessive-compulsive personality disorder, or paranoid personality disorder in adulthood.
- **Brain changes** – There has been an identification of slight brain differences within people that have certain personality disorders. Studies on paranoid personality disorder have found that there is altered amygdala functioning, which is the part of your brain involved with processing threats and fearful stimuli.

Symptoms of Personality Disorder

Each personality disorder type has unique symptoms or signs. It is essential first to determine whether an individual has the condition. Once someone realizes they have a personality disorder, it is easier to seek out and follow treatment to see improvement.

As a general rule of thumb, most personality disorders typically involve issues with the following:

- **Relationships –** People with personality disorders tend to be unable to form stable and close relationships with others because of their disordered beliefs and behaviours. They might be emotionally detached, overly in need of attention, or lack empathy and respect for others.
- **Identity and a sense of self** – People with personality disorders typically lack a stable or realistic image of themselves. How they view themselves can change depending on their situation or who they are with. As a result, their self-esteem can be unnaturally low or high.

Lack of self-awareness – People with personality disorders often have no insight or awareness of how their problematic thoughts and behaviours affect their relationships with others.

COUNSELLING STRATEGIES:

Counselling for personality disorders can be challenging, but with a compassionate and non-judgmental approach, individuals can learn to manage their symptoms and improve their relationships and overall well-being. Here are some key aspects of counselling for personality disorders:

Personality disorders can be challenging to treat because people who have personality disorders don't always believe they have problematic behaviour. As a result, they often do not seek treatment. There are a few different treatments that can be successful in managing personality disorders, including:

Psychotherapy

Psychotherapy (talk-therapy) involves working with a mental health professional who can provide guidance, education, and support to help manage personality disorders. This type of therapy uses techniques to identify and change problem behaviours, thoughts, and emotions. Psychotherapy is typically the most recommended borderline personality disorder treatment.

The main goals of psychotherapy in treating personality disorders include the following:

- Reducing distress
- Helping the person understand that their problems are internal and not caused by others
- Treating unhealthy behaviour
- Modifying personality traits to ease difficulties experienced

Medication

While no medications are used to treat personality disorders specifically, there are some cases when certain medications prove to help reduce personality disorder symptoms. Medications such as antidepressants, anti-anxiety medications, or mood-stabilizing medications might help treat some symptoms seen in those with personality disorders.

Those experiencing severe or long-term symptoms typically require a team consisting of a psychologist, social worker, family members, psychiatrist, and primary care doctor to determine the best treatment plan.

Self-care and coping strategies

While actively participating in a treatment plan, some people with personality disorders might find the addition of self-care and coping strategies helpful. Some of these strategies include:

- **Become more physically active** – Exercise can help in managing symptoms such as stress, anxiety, and depression.
- **Learn more about personality disorders** – Gaining more knowledge about your condition can empower and motivate you to get the help you need.
- **Avoid alcohol and drugs** – Substances such as drugs or alcohol can cause symptoms to worsen or negatively interact with medications.
- **Find a support group** – It can be helpful to speak with others who also have personality disorders.
- **Journal** – Writing in a journal to express emotions and track how you feel daily can be helpful in pinpointing symptoms.
- **Socialize** – Staying connected with family and friends is essential to overall mental wellness.
- **Use relaxation and stress management techniques** – Incorporating yoga, meditation, and walks outside can help man

TYPES OF COUNSELLING

1. Psychodynamic Therapy: Explores the underlying causes of personality disorders, focusing on childhood experiences, relationships, and unconscious thoughts and feelings.

2. Cognitive-Behavioural Therapy (CBT): Helps individuals identify and challenge negative thought patterns and behaviours, replacing them with more adaptive ones.

3. Dialectical Behaviour Therapy (DBT): Combines CBT with mindfulness techniques to manage emotions, reduce self-destructive behaviours, and improve relationships.

4. Schema Therapy: Focuses on identifying and changing negative patterns or schemas that contribute to personality disorders.

GOALS OF COUNSELLING

1. Symptom reduction: Manage symptoms such as anxiety, depression, or impulsivity.

2. Improved relationships: Develop healthier relationships with family, friends, and romantic partners.

3. Increased self-awareness: Understand the underlying causes of personality disorder symptoms and how they impact daily life.

4. Development of coping skills: Learn effective coping strategies to manage emotions, behaviors, and relationships.

TECHNIQUES USED IN COUNSELLING

1. Mindfulness techniques: Encourage individuals to be present in the moment, reducing emotional reactivity.

2. Cognitive restructuring: Help individuals challenge and reframe negative thought patterns.

3. Emotional regulation: Teach individuals to manage and regulate their emotions.

4. Role-playing: Practice social skills and relationships through role-playing exercises.

BENEFITS OF COUNSELLING

1. Improved symptom management: Reduce symptoms of personality disorders, such as anxiety, depression, or impulsivity.

2. Increased self-awareness: Develop a better understanding of oneself, including strengths, weaknesses, and areas for improvement.

3. Healthier relationships: Improve relationships with family, friends, and romantic partners.

4. Enhanced coping skills: Develop effective coping strategies to manage emotions, behaviours, and relationships.

CHALLENGES AND CONSIDERATIONS

1. Establishing trust: Building trust with individuals with personality disorders can be challenging due to their difficulties with intimacy and emotional regulation.

2. Managing emotional reactivity: Counsellors must be prepared to manage their own emotional reactivity when working with individuals with personality disorders.

3. Setting boundaries: Establishing clear boundaries and expectations is essential when working with individuals with personality disorders.

4. Collaboration with other professionals: Counsellors may need to collaborate with other professionals, such as psychiatrists or social workers, to provide comprehensive care.

ORGANIC MENTAL DISORDER

It is assumed that that all psychological and behavioural processes, whether normal or abnormal, are a result of normal or deranged brain function. A rational theory would be that all psychiatric disorders are due to abnormal brain functioning and are therefore organic. However, this would be a gross oversimplification. According to the present knowledge, there are broadly three types of psychiatric disorders:

1. Those due to a known organic cause
2. Those in whose causation an organic factor has not yet found or proven.
3. Those primarily due to psychosocial factors.

Only disorders with a known organic cause are called organic mental disorders. The use of term organic here does not imply that other psychiatric disorders are 'non organic' in the sense of having no biological basis. It simply means that the organic mental disorders have a demonstrable and independently diagnosable cerebral disease or disorder, unlike other psychiatric disorders that do not at present. Organic disorder should be the first consideration in evaluating a patient with ant psychological or behavioural clinical syndrome. The presence of following features requires a high index of suspicion for an organic mental disorder:

1. First episode
2. Sudden onset
3. Older age of onset
4. History of drug/alcohol use disorder
5. Concurrent medical or neurological illness
6. Neurological symptoms or signs such as, seizures, impairment of conscious, head injury, sensory or motor disturbance
7. Presence of confusion, disorientation, memory impairment, or soft neurological signs
8. Prominent visual or other non-auditory (olfactory, gustatory or tactile) hallucinations.

What are the Symptoms of Organic Mental Disorder

Organic Mental Disorder typically involves a range of symptoms that affect cognitive functioning. These symptoms can vary in severity and may impact memory, attention, language skills, and overall mental clarity. Additionally, individuals with this disorder may experience changes in mood, behaviour, and perception. It is

important to seek medical evaluation and support if you or someone you know is displaying symptoms of Organic Mental Disorder.

- Memory problems
- Confusion
- Changes in mood or behaviour
- Disorientation
- Difficulty concentrating
- Impaired judgment
- Hallucinations
- Delusions
- Personality changes
- Difficulty in performing daily tasks

Get a second opinion from trusted experts and informed decisions.

Causes of Organic Mental Disorder

Organic Mental Disorder, also known as organic brain syndrome, is caused by physical changes in the brain's structure or function. Common causes include brain injuries, infections, substance abuse, and metabolic imbalances. Additionally, genetic factors, nutritional deficiencies, and vascular issues can contribute to the development of this disorder. Understanding these underlying causes is crucial for proper diagnosis and treatment of Organic Mental Disorder.

- Traumatic brain injury
- Stroke
- Brain tumours
- Infections such as meningitis
- Neurodegenerative disorders like Alzheimer's disease
- Seizure disorders
- Substance abuse
- Metabolic disorders like hypothyroidism
- Vitamin deficiencies
- Autoimmune disorders

Risk Factors

Organic Mental Disorder can be influenced by various risk factors that may contribute to its development. These factors can affect an individual's brain function and overall mental well-being, potentially leading to cognitive impairment and other symptoms associated with the disorder. Understanding these risk factors is essential in identifying potential triggers for the condition and implementing appropriate preventive measures.

- Age
- Genetic factors
- Traumatic brain injury
- Substance abuse
- Chronic medical conditions
- Use of certain medications
- Family history of mental disorders

These disorders can be broadly subcategorized into the following categories:

1. Delirium
2. Dementia

3. Organic amnestic syndrome
4. Other organic mental disorders

Delirium is a serious change in mental abilities. It results in confused thinking and a lack of awareness of someone's surroundings. The disorder usually comes on fast — within hours or a few days.

Delirium can often be traced to one or more factors. Factors may include a severe or long illness or an imbalance in the body, such as low sodium. The disorder also may be caused by certain medicines, infection, surgery, or alcohol or drug use or withdrawal.

Symptoms of delirium are sometimes confused with symptoms of dementia. Health care providers may rely on input from a family member or caregiver to diagnose the disorder.

Symptoms

Symptoms of delirium usually begin over a few hours or a few days. They typically occur with a medical problem. Symptoms often come and go during the day. There may be periods of no symptoms. Symptoms tend to be worse at night when it's dark and things look less familiar. They also tend to be worse in settings that aren't familiar, such as in a hospital.

Primary symptoms include the following.

Reduced awareness of surroundings

This may result in:

- Trouble focusing on a topic or changing topics
- Getting stuck on an idea rather than responding to questions
- Being easily distracted
- Being withdrawn, with little or no activity or little response to surroundings

Poor thinking skills

This may appear as:

- Poor memory, such as forgetting recent events
- Not knowing where they are or who they are
- Trouble with speech or recalling words
- Rambling or nonsense speech
- Trouble understanding speech
- Trouble reading or writing

Behaviour and emotional changes

These may include:

- Anxiety, fear or distrust of others
- Depression
- A short temper or anger
- A sense of feeling elated
- Lack of interest and emotion
- Quick changes in mood
- Personality changes
- Seeing things that others don't see
- Being restless, anxious or combative
- Calling out, moaning or making other sounds
- Being quiet and withdrawn — especially in older adults

- Slowed movement or being sluggish
- Changes in sleep habits
- A switched night-day sleep-wake cycle

Types of delirium

Experts have identified three types:

- **Hyperactive delirium.** This may be the easiest type to recognize. People with this type may be restless and pace the room. They also may be anxious, have rapid mood swings or see things that aren't there. People with this type often resist care.
- **Hypoactive delirium.** People with this type may be inactive or have reduced activity. They tend to be sluggish or drowsy. They might seem to be in a daze. They don't interact with family or others.
- **Mixed delirium.** Symptoms involve both types of delirium. The person may quickly switch back and forth from being restless and sluggish.

Delirium and dementia

Delirium and dementia may be hard to tell apart, and a person may have both. Someone with dementia has a gradual decline of memory and other thinking skills due to damage or loss of brain cells. The most common cause of dementia is Alzheimer's disease, which comes on slowly over months or years.

Delirium often occurs in people with dementia. However, episodes of delirium don't always mean a person has dementia. Tests for dementia shouldn't be done during a delirium episode because the results could be misleading.

Some differences between the symptoms of delirium and dementia include:

- **Onset.** The onset of delirium occurs within a short time — within a day or two. Dementia usually begins with minor symptoms that get worse over time.
- **Attention.** The ability to stay focused or maintain focus is impaired with delirium. A person in the early stages of dementia remains generally alert. Someone with dementia often isn't sluggish or agitated.
- **Rapid changes in symptoms.** Delirium symptoms can come and go several times during the day. While people with dementia have better and worse times of day, their memory and thinking skills typically stay at a constant level.

Dementia is a syndrome associated with many neurodegenerative diseases, characterized by a general decline in cognitive abilities that affects a person's ability to perform everyday activities. This typically involves problems with memory, thinking, behaviour, and motor control. Aside from memory impairment and a disruption in thought patterns, the most common symptoms of dementia include emotional problems, difficulties with language, and decreased motivation. The symptoms may be described as occurring in a continuum over several stages.[11][a] Dementia ultimately has a significant effect on the individual, their caregivers, and their social relationships in general. A diagnosis of dementia requires the observation of a change from a person's usual mental functioning and a greater cognitive decline than might be caused by the normal aging process. Difficulty with communication, problem-solving, and other thinking abilities. This decline is significant enough to interfere with daily life and is not a normal part of aging.

Dementia types

There are several types of dementia. They include but are not limited to the following:

Alzheimer's disease

Alzheimer's disease is the most common cause of dementia, accounting more than half of cases. In Alzheimer's disease, "plaques" and "tangles" develop in and between the brain cells. Both are due to changes in proteins.

A person may have short-term memory problems, difficulty finding words and making decisions, and difficulty seeing things in three dimensions.

Lewy body dementia

Lewy body dementia are unusual structures known as Lewy bodies develop in the brain. These brain changes involve a protein called alpha-synuclein.

In the early stages, there may be fluctuations in alertness, hallucinations, and difficulty judging distance. The impact on short-term memory may be less severe than it is with Alzheimer's disease.

People with Parkinson's disease may also have Lewy bodies. Although doctors often consider Parkinson's disease a disorder of movement, symptoms of dementia can also appear.

Frontotemporal dementia

This condition involves damage to the brain. It happens when brain cells die due to clumps of protein developing inside them.

Depending on the part of the brain the condition affects, the person may have difficulty with behaviour, speech and communication, or both.

Huntington's disease

Huntington's disease is an inherited genetic condition. The main symptoms are uncontrolled movements, but dementia can also occur.

Early symptoms are difficulty focusing, irritability, and impulsivity. Depression may also be present. The person may have difficulty with organizing, multitasking, and planning. These symptoms may appear before movement changes develop.

Mixed dementia

When this happens, a person has a diagnosis of two or three types together. For instance, a person may have both Alzheimer's disease and vascular dementia at the same time.

Behavioural Changes:

Alzheimer's and other dementias can lead to a range of behavioural changes, including:

- Agitation and aggression
- Wandering
- Sleep disturbances
- Repetitive behaviours
- Hallucinations and delusions
- Changes in mood (depression, anxiety)

Your health is everything - prioritize your well-being today.

Diagnosis of Organic Mental Disorder

Organic Mental Disorder is typically diagnosed through a comprehensive evaluation that involves assessing a person's medical history, symptoms, and behaviour. Healthcare providers may also conduct physical exams, laboratory tests, and imaging studies to rule out other potential causes of the symptoms.

Additionally, cognitive assessments and psychiatric evaluations can help in understanding the individual's mental functioning. The diagnosis of Organic Mental Disorder is made when there is evidence of cognitive impairment that is directly related to a medical condition or substance use. It is essential for healthcare professionals to consider all possible factors that may contribute to the symptoms before confirming the diagnosis of Organic Mental Disorder.

- Physical examination
- Neurological evaluation
- Cognitive testing
- Laboratory tests
- Brain imaging studies

Treatment for Organic Mental Disorder

Organic Mental Disorder, also known as organic brain syndrome or organic brain disease, refers to a range of conditions that cause cognitive impairment due to physical changes in the brain. Treatment for Organic Mental Disorder aims to manage symptoms, slow down the progression of the disease, and improve overall quality of life. Treatment options may include medication, psychotherapy, occupational therapy, cognitive rehabilitation, and lifestyle modifications. It is essential for individuals with this condition to work closely with healthcare professionals to develop a comprehensive treatment plan tailored

- Medication: Prescription drugs may be used to manage symptoms such as mood swings, aggression, or hallucinations in Organic Mental Disorder.
- Psychotherapy: Therapy sessions can help individuals cope with the emotional and behavioural challenges associated with Organic Mental Disorder, providing support and teaching coping strategies.
- Lifestyle modifications: Healthy lifestyle choices, such as regular exercise, balanced nutrition, and adequate sleep, can support overall wellbeing and potentially improve symptoms of Organic Mental Disorder.
- Occupational therapy: Occupational therapists can assist individuals in developing skills and strategies to manage daily activities and routines, promoting independence and quality of life.
- Support groups: Joining support groups for individuals with Organic Mental Disorder can offer a sense of community, understanding, and encouragement, helping individuals feel less isolated and more empowered in their journey towards recovery.

Counselling Strategies:

For Caregivers:

Education and Support:

Counselling provides caregivers with education about the disease and its effects on behaviour.

It offers emotional support, helping caregivers cope with the stress and challenges of caregiving.

Behavioural Management Techniques:

Counsellors can teach caregivers strategies for managing difficult behaviours, such as:

- Creating a calm and predictable environment.
- Using redirection and distraction.
- Communicating effectively.
- Identifying and addressing triggers.

Stress Management:

Caregiver burnout is common. Counselling can help caregivers develop stress-reduction techniques and access respite care.

For Individuals in Early Stages:

Cognitive Behavioural Therapy (CBT):

In the early stages, CBT can help individuals cope with anxiety and depression related to their diagnosis.

Support and emotional processing:

Talking therapies can help the individual process the changes they are going through.

Environmental Adjustments:

Counselling often includes assessing the individual's environment and recommending modifications to improve safety and reduce triggers for behavioural problems.

Considerations:

Team Approach:

Effective management requires a team approach involving doctors, nurses, social workers, and counsellors.

Individualized Care:

Treatment plans should be tailored to the individual's specific needs and behaviours.

Medication:

In some cases, medication may be necessary to manage severe behavioural symptoms. A physician will determine if this is appropriate.

By combining counselling, medication and other forms of support, it's possible to improve the quality of life for individuals with Alzheimer's and other organic mental disorders, as well as their caregivers.

VISION IMPAIRMENT AND HEARING PROBLEMS

Impaired vision can range from poor vision to blindness. People whose vision cannot be corrected by ordinary glasses, contact lenses, medication, or surgery have visual impairments. People with visual impairments have difficulty with routine tasks, such as reading a newspaper, even with glasses or lenses.

Key facts

- Globally, at least 2.2 billion people have a near or distance vision impairment. In at least 1 billion of these, vision impairment could have been prevented or is yet to be addressed.
- The leading causes of vision impairment and blindness at a global level are refractive errors and cataracts.
- It is estimated that globally only 36% of people with a distance vision impairment due to refractive error and only 17% of people with vision impairment due to cataract have received access to an appropriate intervention.
- Vision impairment poses an enormous global financial burden, with the annual global cost of productivity estimated to be US$ 411 billion.
- Vision loss can affect people of all ages; however, most people with vision impairment and blindness are over the age of 50 years.

Vision, the most dominant of our senses, plays a critical role in every facet and stage of our lives. We take vision for granted, but without vision, we struggle to learn, to walk, to read, to participate in school and to work. Vision impairment occurs when an eye condition affects the visual system and its vision functions. Everyone, if they live long enough, will experience at least one eye condition in their lifetime that will require appropriate care.

Vision impairment has serious consequences for the individual across the life course. Many of these consequences can be mitigated by timely access to quality eye care. Eye conditions that can cause vision impairment and blindness – such as cataract or refractive error – are, for good reasons, the main focus of eye care strategies; nevertheless, the importance of eye conditions that do not typically cause vision impairment – such as dry eye or conjunctivitis – must not be overlooked. These conditions are frequently among the leading reasons for presentation to eye care services.

Causes

Globally, the leading causes of vision impairment and blindness are:

- Refractive errors
- Cataract
- Diabetic retinopathy
- Glaucoma
- Age-related macular degeneration.

There is substantial variation in the causes of vision impairment between and within countries according to the availability of eye care services, their affordability, and the education of the population. For example, the proportion of vision impairment attributable to un-operated cataract is higher in low- and middle-income countries. In high income countries, diseases such as glaucoma and age-related macular degeneration are more common.

Among children, congenital cataract is a leading cause of vision impairment in low-income countries, whereas in middle-income countries it is more likely to be retinopathy of prematurity.

Uncorrected refractive error remains a leading cause of vision impairment in all countries amongst children and adult populations.

HEARING IMPAIRMENT

Hearing loss is defined as diminished acuity to sounds which would otherwise be heard normally. The terms hearing impaired or hard of hearing are usually reserved for people who have relative inability to hear sound in the speech frequencies. Hearing loss occurs when sound waves enter the ears and damage the sensitive tissues[21] The severity of hearing loss is categorized according to the increase in intensity of sound above the usual level required for the listener to detect it.

Deafness is defined as a degree of loss such that a person is unable to understand speech, even in the presence of amplification. In profound deafness, even the highest intensity sounds produced by an audiometer (an instrument used to measure hearing by producing pure tone sounds through a range of frequencies) may not be detected. In total deafness, no sounds at all, regardless of amplification or method of production, can be heard.

Speech perception is another aspect of hearing which involves the perceived clarity of a word rather than the intensity of sound made by the word. In humans, this is usually measured with speech discrimination tests, which measure not only the ability to detect sound, but also the ability to understand speech. There are very rare types of hearing loss that affect speech discrimination alone. One example is auditory neuropathy, a variety of hearing loss in which the outer hair cells of the cochlea are intact and functioning, but sound information is not faithfully transmitted by the auditory nerve to the brain.

Use of the terms "hearing impaired", "deaf-mute", or "deaf and dumb" to describe deaf and hard of hearing people is discouraged by many in the deaf community as well as advocacy organizations, as they are offensive to many deaf and hard of hearing people.

Types of Hearing Impairment

Conductive Hearing Loss:

Conductive hearing loss results from defects in the outer or middle ear. The sound is not conducted efficiently to the inner ear. All sounds heard thus become weak and/or muffled. Usually such individuals speak softly irrespective of the surrounding environmental noise.

Conditions that cause conductive hearing loss are:

- Wax in the ear canal.
- Diseases of the outer and middle ear associated with symptoms like ear ache and ear discharge.

- Congenital defects in the outer or middle ear – defect and damage to the outer or middle ear.
- Upper respiratory tract infections.
- Neglect of care of ears and oral cavity (mouth).

Sensorineural Hearing Loss:

Sensorineural hearing loss is caused due to damage or disease of the inner ear or auditory nerve. It could also result as an after effect of infectious diseases like measles, mumps, meningitis and T.B.

Some conditions that may cause congenital sensorineural hearing loss are:

- Hereditary childhood deafness
- Rh incompatibility
- Premature birth – birth before due time
- Birth Asphyxia (lack of oxygen supply to the new born due to inability to breathe normally resulting in blueness of baby due to various reasons).
- Viral infections in pregnancy
- Exposure to X–rays in the first trimester of pregnancy – taking X–ray within the first three months
- Harmful drugs of mycin variety e.g. streptomycin
- Acoustic neuroma (Tumour of the auditory nerve)

Mixed Hearing Loss:

Mixed hearing loss is the combination of conductive and sensorineural hearing loss. One of the main causes of this type of loss is the long-standing ear infection known as Chronic Suppurative Otitis Media (CSOM). In CSOM, ear discharge in the form of pus, blood or clear water is seen. This starts with conductive loss yielding to sensorineural impairment, if not treated immediately and regularly.

Central Hearing Loss:

Central hearing loss is due to a damage, malformation or infections of the neural pathways and the hearing centres in the brain. The child may hear but has difficulty in understanding what he hears. Some of the children classified as learning disabled or slow learners may have this type of hearing loss.

Functional Hearing Loss:

Functional hearing loss is due to some psychogenic condition or maybe due to deliberate exaggeration of hearing thresholds for personal gains.

Counselling for vision impairment and hearing problems addresses the unique emotional, social, and practical challenges that individuals with these conditions face.

Vision Impairment Counselling:

- The counsellor has to empathise with the patient's problem and help him/her come to terms with the fact that their vision loss is permanent and beyond repair.
- Though visual loss is permanent, the patient with low vision can still function with the remaining vision to continue his profession and daily activities, within certain limits. The counsellor encourage the patent to understand this.
- The counsellor can cite various examples of people with low vision/blindness who have achieved so much, despite their handicap and gently try to inspire the patient.
- The counsellor also puts forward the various options available to the low vision patients, in terms of low vision aids and profession and help them select whatever is suitable to their needs.
- The counsellor can guide the persons to get various concessions, scholarships etc. available for them.
- When it comes to parents of children with low vision/blindness the counsellor has to assume the role of a caring friend who helps the family come to terms with their children's disability. She also encourages them to be positive and assist the child's development, through various rehabilitation programmes available.

Counselling a permanently blind person

In the case of a person who had good vision but has lost vision due to disease, the counsellor gently but persistently assists him/her to accept reality and start rehabilitation. The counsellor may have to work with the family of the patient to make the patient achieve the maximum possible independence. The social surrounding of the patient also has to be involved, to assist the patient, so that they can resume some mobility, daily activities, and some income generating work.

Rehabilitating a blind person is a team work which should involve the patient, the counsellor, the patient's family and the community.

Emotional Support:

Coping with the emotional impact of vision loss, including feelings of grief, frustration, and anxiety, addressing concerns about independence, self-esteem, and social isolation.

Helping individuals and their families adjust to changes in lifestyle and daily routines.

Practical Guidance:

Providing information about available resources, such as assistive technology, rehabilitation services, and support groups.

Offering strategies for adapting to daily tasks, such as cooking, shopping, and navigating public spaces.

Assisting with vocational counselling and career planning.

Rehabilitation Counselling:

Vision rehabilitation specialists can help individuals maximize their remaining vision and learn new skills, such as using adaptive equipment and orientation and mobility techniques.

Helping to gain information on available concessions from governmental agencies.

Hearing impairment counselling

Emotional Support:

Addressing the emotional impact of hearing loss, including feelings of isolation, frustration, and difficulty communicating.

Helping individuals and their families cope with the challenges of communication breakdowns.

Providing support for individuals who experience tinnitus (ringing in the ears).

Practical Guidance:

Providing information about hearing aids, cochlear implants, and other assistive listening devices.

Offering communication strategies, such as lip-reading and using sign language.

Assisting with navigating social situations and workplace accommodations.

Audio logical Counselling:

Audiologists provide counselling on hearing loss management, including how to use hearing aids effectively and how to protect remaining hearing.

Combined Vision and Hearing Impairment (Deaf blindness) Counselling:

Individuals with combined vision and hearing loss face unique challenges and require specialized support. Counselling for deaf blindness focuses on developing effective communication strategies, such as tactile sign language, promoting independence and mobility and providing emotional support and addressing social isolation.

Considerations:

Counselling services should be accessible to individuals with vision and hearing impairments, including providing information in accessible formats (e.g., Braille, large print, audio) and using effective communication strategies. It's important to seek counseling from professionals who have specialized training in working with individuals with vision and hearing impairments.

Counselling should be tailored to the individual's specific needs and circumstances.

DEATH AND DYING COUNSELLING

Terminal illness is used to describe patients with advanced disease and a drastically reduced lifespan, with perhaps months or weeks to live. Inevitably the range and severity of physical symptoms will have increased, and will be having a profound effect on how the patient lives his life. General symptoms such as fatigue, pain and sleeplessness will all be taking their toll, and even patients who have coped well find the final insidious decline taxing their psychological reserve. How well a patient copes is dependent on a number of variables, age of patient, level of education, religion, previous experience of illness, social support, personality and medical factors such as pain to name but a few. An optimal adjustment also depends on how bad news is delivered, and how the various reactions to this are managed. In many cases, but not all, the patient will only have reached the terminal phase of the illness after a period of declining health and failed treatment. Both the patient and his family may well be aware of the possibility that the prognosis is grave, but this is different to being told that death is certain in so many months.

There are also cases where the patient may present with metastatic disease, and the diagnosis and prognosis may come as an enormous shock to patient and family alike. Psychotherapy with dying patients shares many features with all other psychotherapy. However, the unique status of the dying person presents special problems for the mental health professional. Clearly, everyone will die, and in this sense all therapy is done with patients of a limited life span. The labelling of a person as a “dying patient”, identifies that person as belonging to a special category of humanity, and creates profound changes in the emotional, social, and spiritual climate of therapy.

The dying person is one who is seen to be in a life-threatening condition with relatively little remaining time with little or no hope of recovery. This unique existential position of the dying person necessitates some adaptations of the typical psychotherapeutic attitudes and strategies. The goals, structure, and process of therapy must change to meet the special needs and circumstances of the dying patient. There are several features which distinguish therapy with a dying person from “typical therapy”.
They are:
First, therapy is more time-limited and time-focused. The dimension of time takes on special urgency with the dying patient. While many therapies are time-limited, often they proceed as if time were an inexhaustible resource. The brief remaining time for the dying patient intensifies the therapy process, and accelerates it.
Second, the goals of therapy with dying patients are often more modest. Recognising the limits of possible change is an essential feature of therapy with the dying. What can be accomplished is quite restricted by time, disability, and other aspects of the patient’s condition.
Third, the treatment of the dying patient often requires careful coordination with a variety of medical, nursing, and religious professionals. The physical condition, medical treatments, and institutional settings of the patient complicate the practical and psychological context of therapy.

GOALS OF THERAPY WITH DYING PERSONS The major goals of therapy with the dying patient can be summarized in a few simple statements:

- To allow open communication with patients regarding their conditions, and to provide honest, factual information about those conditions.
- To facilitate the expression of important emotions and to help patients learn to manage these emotions as well possible under the circumstances.
- To provide a relationship in which patients can experience support in the confrontation with death.
- To intervene between patients and other significant people such as family, friends, and medical staff.

Psychotherapy is beginning to be incorporated into the more general and growing field of clinical thanatology, which is concerned with the overall care and treatment of the dying person - mind, body, and spirit. Modern psychotherapies are divided into four main groups – psychodynamic, humanistic, behavioural, and family therapy. The main features of these therapies as used with all patients are preserved in the treatment of the dying, but each has been modified somewhat to fit the unique needs of dying persons.

The Psychodynamic Approach-

The psychodynamic approaches are primarily concerned with the emotional conflicts and defense mechanisms of the individual. Special issues of conflict and defense arise in the dying person, and this approach addresses them in the hope of resolving the psychic crisis to the fullest extent possible. Dying is the ultimate crisis of ego development, and as such is associated with intense intrapsychic turmoil. Psychoanalyst Erik Erickson labels the last stage of ego development, “ego integrity versus despair”, and identifies it with the crisis. The fear of death may precipitate a breakdown of previously integrated ego functioning, and result in an attitude of despair and disgust. In most people the threat of death generates powerful defensive reactions, and although these defences provide some limited relief of emotional distress, in the end they prohibit the person from effectively coping with the death crisis. Common defences which are found in the dying person include denial, displacement, projection, and regression.

As Kubler-Ross pointed out, denial is a very typical reaction of the dying person. The refusal to accept the reality of death makes it impossible for people to prepare themselves and their families adequately for it. Through the displacement defence the fear of dying is channelled into other, “substitute” fears. For example, one may become preoccupied with anxiety about family members, personal business, household jobs, or other matters, and, thus, obtain partial release of one’s death anxiety. The dying person’s projection defence typically expresses itself in hostility and resentment toward others, e.g., doctors, nurses, and family. The person may irrationally blame others for the illness, or accuse them of not doing enough to cure or help. Regression in the dying person is often manifested in increasingly immature, dependent, and occasionally self-threatening behaviours and attitudes.

A major goal of dynamic therapy with the dying is to help the person recognise, confront, and replace the defences which run counter to an emotionally healthy attitude toward death. In the process it may be necessary to try to work through some long-standing problems and fixations which are intensified by the death crisis. For instance, a patient with a history of anxiety over separation from family members may be more distressed over the issue of loss/separation than by other death-related concerns. Dynamic therapy with dying patients is not directed as much toward the goal of insight, as it is with others. Time limits the course of therapy with the dying, and the goals are therefore more short-term changes; rather than long-term personality change. Another significant concern which has been addressed by the psychodynamic approach is countertransference, the emotional reactions of the therapist. The therapist must be particularly careful to avoid letting personal fears and conflicts over death interfere with helping the patient. The three potential negative results of countertransference are:

1) The therapist unwittingly supports the patient’s denial of death by avoiding the issue. 2) The therapist regresses to a helpless position in doing therapy with the patient. 3) The therapist engages in an anxious avoidance of the patient and his concerns

In order to minimize the effects of the therapist’s own attitudes toward death on the therapy, the therapist should explore and confront personal death attitudes before initiating treatment.

The Humanistic Approach

More than other approaches the humanistic view of therapy clearly integrates a philosophy of human nature in which death plays an essential role. Existentialism is a philosophy which has had a significant effect on the humanistic approach, and in this philosophy living the "good life" demand a confrontation with the reality of death. Death awareness helps us to clarify our values and purpose in life, and motivates us to live our lives with fullness and meaning. Death is the absolute existential threat, and it forces us to acknowledge the limit of our life plans and face "nothingness".

Humanistic therapy aims to help the dying patient live as full a life as possible in the face of death. Without giving false hope or optimism, the therapist attempts to mobilise the patient's will to live, to encourage the expression and growth of the self, and to facilitate the patient's self-actualisation. LeShan, an advocate of this approach, expresses his view of humanistic therapy with the dying in the following remark: "Help is really needed in terms of how to live, not how to die." With the dying patient humanistic therapy is more intensely focused than with others. According to LeShan psychotherapy should "move strongly" with the dying patient.

Feigenberg describes the main features of his humanistic, "patient-centred" approach in the following way:

1) It emphasises building a strong, supportive, and empathic relationship with the client.
2) It allows the client to set the pace of the treatment.
3) It enables the client to actively and positively participate in the process of dying.

The Behavioural Approach

The behavioural approach to therapy relies on educating patients about more adequate coping skills to help deal better with the death crisis. Impending death is a terribly stressful situation, and it produces extreme emotional reactions like anxiety and depression, which inhibit patients from living out the remainder of their lives in a satisfactory way. The symptoms of the dying patient are partially manageable through some standard behavioural techniques. For example, relaxation training and desensitisation can help to alleviate excessive fear and tension. Other self-management skills, like biofeedback and self-hypnosis, are also useful in controlling the distressing emotions of the patient. One example of a valuable behaviour therapy technique is "stress inoculation training". With the dying patient this strategy may be used to help cope with the physical and emotional aspects of pain. In this approach the patient is taught how to employ cognitive and behavioural skills in preparing for pain and managing pain.

A basic goal of behaviour therapy is to provide some Coping skills so that the patient can reduce discomfort and gain a measure of control over life. The loss of control over one's body, one's actions, and one's future which is experienced by the dying patient can lead to emotional distress and to feelings of helplessness and passivity. The behavioural approach to therapy tends to focus on specific and concrete symptoms. It does not directly attend to the developmental and personality issues which are so important in dynamic or humanistic approaches.

The goal of the therapy is primarily to relieve negative emotions and to enable the patient to cope more effectively in the remaining time.

Family Approach

The impending death of a family member places the entire family in a state of crisis. Death presents a threatening situation for each member of the dying person's family. The degree of disturbance in the family depends on many factors such as the role of the dying member, the stage of development of the family, and the quality of relationships among family members. A family systems approach conceives of the entire family, not just the dying person, as the recipient of therapy.

This approach seeks to provide the family unit the opportunity to learn to deal with the tragedy. Some therapists will continue treatment beyond the death, offering grief counselling for the survivors. Though family therapy may be integrated into therapies of various types, there are several issues on which family therapists are more likely to focus. Dying patients often experience a need to feel the closeness and support of their families in facing the death crisis. In families where past conflicts have interfered with relationships between the patient and others, family therapy can facilitate more open and productive communication. This can benefit all members concerned in terms of finding closure for "unfinished business". The defences of family members can make it very difficult for the dying patient to confront death. It often happens that family members share the defensive reactions of the dying person, such as denial of the facts and displaced anger.

An advantage of the family approach to therapy is that it offers an experience that may enable everyone to accept the facts and to work together to enhance the quality of life for the dying person. Families generally experience a range of intense emotions regarding the dying patient, including anger, guilt, fear, and depression. In family therapy members are encouraged to understand and express these feelings in anticipation of the death of their loved

MAJOR THERAPY ISSUES

The Psychology of Dying Person

The best-known theory of the dying process is that of Kubler-Ross, who proposes that many dying people progress through five stages of dying, described below:

Stage 1: Denial: Initially the reaction is "No! Not me!" Though the denial is rarely complete, most people respond with disbelief in the seriousness of their illness.

Stage 2: Anger: In this stage the dying person expresses anger, resentment, and hostility at the "injustice" of dying, and often projects these attitudes onto others.

Stage 3: Bargaining: The dying person tries to "make deals" to prolong life, e.g., making promises to God.

Stage 4: Depression: Here the individual may become overwhelmed with feelings of loss, hopelessness, shame and guilt, and may experience "preparatory grief".

Stage 5: Acceptance: In the final stage one comes to terms with death, not necessarily happily, but with a feeling of readiness to meet it.

Some researchers have questioned the generality of Kubler-Ross' five stages, pointing out that they do not necessarily apply to all dying people and that the therapeutic implications of the theory are not necessarily appropriate for everyone. An alternate view of the "trajectory" of the dying person is offered by the psychiatrist, Avery Weisman. He believes that Kubler-Ross' theory describes some common reactions to loss, rather than general stages of dying.

Weisman proposes four very flexible stages:

Weisman's Four Stages of Dying 1) Existential Plight: The dying person experiences an extreme emotional shock at the awareness of his/her own mortality. 2) Mitigation and Accommodation: The individual attempts to resume a "normal" life after first learning of the terminal nature of the illness. 3) Decline and Deterioration: When illness and its treatment begin to take full control over one's life and normal living is no longer possible, this stage begins. 4) Pre-Terminally and Terminally: This final stage refers to the very end of life, when treatment is no longer helpful and the "death watch" begins.

Whether they accept stage theories or not, most researchers and practitioners recognise that there are many common features in the emotional reactions of dying people. The core emotions on which therapies focus include depression, anxiety and anger.

EXAMPLES OF TERMINAL ILLNESSES

1. Cancer: Advanced stages of cancer, such as stage IV cancer, that have spread to multiple parts of the body.

2. Amyotrophic Lateral Sclerosis (ALS): A progressive neurological disease that affects nerve cells responsible for controlling voluntary muscle movement.

3. Chronic Obstructive Pulmonary Disease (COPD): A progressive lung disease that makes it difficult to breathe.

4. Heart Failure: Advanced stages of heart failure, where the heart is unable to pump enough blood to meet the body's needs.

5. Alzheimer's Disease: A progressive neurological disease that affects memory, thinking, and behaviour.

6. HIV/AIDS: Advanced stages of HIV/AIDS, where the immune system is severely compromised.

7. Kidney Failure: End-stage renal disease, where the kidneys are no longer able to filter waste and excess fluids.

BENEFITS OF COUNSELING

1. Improved Quality of Life: Counselling can help patients manage symptoms, reduce pain, and improve their overall quality of life.

2. Emotional Support: Counselling provides emotional support and validation, helping patients cope with their terminal illness.

3. Increased Sense of Control: Counselling can help patients feel more in control of their life and care.

4. Support for Family Members: Counselling can also provide support and guidance for family members and caregivers.

CHALLENGES AND CONSIDERATIONS

1. Time Constraints: Counselling may be limited by the patient's prognosis and remaining lifespan.

2. Emotional Intensity: Counselling for terminally ill patients can be emotionally intense and challenging for both the patient and the counsellor.

3. Cultural and Spiritual Sensitivity: Counsellors must be sensitive to patients' cultural and spiritual beliefs and values.

4. Collaboration with Healthcare Team: Counsellors must work collaboratively with the patient's healthcare team to provide comprehensive care.

COUNSELLING THE ELDERLY

"Not much is done for' old people in our culture, many persons seem to be changed when they are older and this is mainly due to the fact that they feel futile and useless. They try to prove their worth and value again in the same way as adolescents do, they interfere and want to show in many ways that. They are not old and will not be overlooked or else they become disappointed and depressed. Adler, 1956.

Besides this statement, Adler wrote little about the elderly. Even contemporary Adlerians have written little about aging compared to what has been published on issues of childhood, adolescence and adulthood. But one should not conclude that Individual Psychology has little relevance to the problem of aging.
The purpose here is to identify some of the challenges involved in the treatment of elderly and to offer several applications of theory of Individual Psychology in their treatment.

A major challenge for professionals working with the elderly is their attitudes about the aged. Gerontophobia refers to the professional's pessimistic outlook about achieving therapeutic successes with people older

than 65. Professionals who believe that only a YAVIS patient- Young. Attractive in terms of having similar values as the therapist; Verbal, Intelligent and Successful- is treatable will likely be disappointed with the elderly' patient. Further the professional is likely to expect less progress, to assume responsibility for things the individual is indeed capable of, and approach the relationship with an attitude of sympathy, rather than empathy. Besides a different attitude- that is a more realistic attitude- towards the elderly, a somewhat different set of skills is needed to be a geriatric counsellor or psychotherapist.
Adler described community feelings as a sense of harmony and connectedness with the universe and a form of self-transcendence. Social interest is also a form of transcendence which connotes a more proactive stance of cooperation, contribution and generativity. Ansbatcher (1992) notes that the concept of community feeling is more germane in that the elderly become less physically capable of the activity that social interest requires. It is rather the spiritual transcendence of community feelings that is required of the elderly person. In short, community feelings means "to identify with the mysterious phenomenon of life that existed before and will continue long after one dies, to accept cheerfully the inevitability of death and make the best use of what is still left for one."

THERAPEUTIC ISSUES UNIQUE TO THE ELDERLY:

For Adler, the life tasks of work, love and friendship embraced all human desires and activities. He believed that all human sufferings originated from difficulties that complicate the tasks, whereas happiness and balanced personality were the results of successfully meeting the tasks of life with an attitude of social interest. Meeting the tasks of life is different for the elderly individual compared with the child or young adult. Where attending school or working at a job or at home are the usual ways of meeting the task of work, how does the elderly person contribute to the welfare of others? How does one meet the tasks of love when one's spouse has died? What about the task of friendship when one is bedridden or wheelchair-bound?

Physical decline, loss of sensory function resulting in social isolation, chronic degenerative disease, and economic deprivation, the loss of friends and spouse, and retirement are some of the factors that lead to widespread feelings of inferiority among the elderly. Thus, old age is an especially difficult period of life because factors that cause inferiority feelings and loss of self-adequacy are on the rise while means of compensating for these feelings by the former means one used to meet the life tasks are decreasing.

A basic challenge for the counsellor is to undercut inferiority feelings by helping the person find different means of meeting the tasks of life. This means cultivating independent behaviour and facilitating mental, emotional and physical development and whatever else develops rather than shrinks social interest. Recent evidence increasingly suggest that many elderly have the ability to further develop, their potential in many physical, mental and emotional areas. This research evidence indicates that even when some declines are noted in certain body systems, there are usually accommodative mechanisms that permit varying degree of adaptation.

With the advancing age, the cardiovascular and the respiratory system do show lowered efficiency, but are capable of continued development and exercise endurance. Many of the declines in the auditory, visual and endocrine systems can also be accommodated, Physiological changes do occur in the sexual system but these in no way preclude sexual functioning. Finally, the only normal changes in cognitive functioning are decreases in speed and abstract reasoning, whereas memory loss and concentration difficulties are abnormal. Thus even amid physical decline there is potential for development in the physical and the emotional realms. Continued development depends on a growing sense of belonging and self-respect, and on the desire and opportunities for elderly individuals to maintain a sense or independence as long as possible. Finally, it means accepting the inevitability of death calmly and cheerfully.

COUNSELLING AND CONSULTING WITHTHEELDERLY:

The most common mental health problems of the elderly involve problem of daily living. In whatever capacity the professional encounters the elderly person - as legal aid, psychologist, nurse, physician, paraprofessional or administrator- an effective counselling relation or consulting intervention may take place in a formal one-to-one setting or in a group. Most often it will occur informally, usually in the context of some ongoing daily activity that would not normally be associated with "counselling". Most often, these counselling interventions will involve encouragement, information or goal disclosure. At other times more specialized techniques may be needed or a specific consultation must be sought.

Following are some guidelines in each of the three phases that have been found helpful in counselling and consulting with the elderly:

(1) Relationship

a) Attitude — The professional's attitude should be one of respect at all times. This is shown verbally by use of the person's surname, unless invited by the person to do otherwise and non-verbally, by an unhurried and interested manner and showing empathy with feelings, beliefs and attitudes.

b) Voice — Emphasis should be, on speaking slowly, distinctly and louder if is any indication of hearing loss.

c) Touch — Touch whether through handshake, hug or pat on the shoulder communicates caring and concern. Most elderly are comfortable with a smaller space,

d) Time — Keep intervals short, especially if the person is easily fatigued. Several short sessions are better than one long session.

e) Focus- Be supportive and issue- oriented-, especially in the first encounter, Encourage the person to express themselves about general issues such as grief, loneliness, helplessness and guilt.

(2) Assessment

a) Always assess the individual's behaviour in terms of the four goals of unproductive behaviour and their styles of coping. When possible, and as time permits, perform a brief lifestyle assessment. Family constellation material is especially valuable in understanding the person's, functioning in group settings.

(3) The four goals of Misbehaviour (Dreikurs, 1953) have proved to be a valuable tool for assessing and intervening with child-adult relationship issues. Dreikurs describes a method for understanding children's misbehaviour in terms of the goals of attention seeking, power, revenge and inadequacy or physical disability. Shulman and Berman (1988) have developed a scheme that is loosely based on the four goals, but focused on aging parent-adult- child relationship patterns. They designate these four patterns-

(i) Status equality (control)
(ii) Status quo (comfort)
(iii) Status conflict (seniority)
(iv) status reversal (pleasing attitude)

COUNSELLING STRATEGIES

1) Be available to the clients and their families if you are functioning in the -counselling role-, or to the staff if you are in the consultant's role. Be reachable by phone. If the counselling or consultation is a one-shot, informal event, make it known that you will be available for formal follow-up if desired.

2) Always encourage social interest- Help the individual identify the possible ways the life tasks in question could be met. Emphasize the individual's strengths and potentials for development that exists at this stage of their life. Help them identify they can still do for themselves and for others, and encourage them to keep doing them. Challenge them to do things they have not believed are possible or did not want to do, but of which they are physically capable.

3) Encourage self-esteem- This can be facilitated in many ways, but the technique of reminiscence and life review are particularly valuable with the elderly. Clients are helped to review the events of their life and see it as complete. This review reminds them that life is a series of crisis and struggles as well as accomplishments and that they have persevered and triumphed. To the extent that the counsellor aids them in framing their past in this way, it can serve as a powerful motivation for elderly clients to try or to persevere in coping with the demands of the present.

4) The generic technique of encouragement is unquestionably the most important with the elderly. Encouragement is the primary antidote for inferiority feelings. When people encourage,i,e, share their courage and the belief that the other person is important and worthwhile — elderly individuals are empowered in their quest to reconsider and relinquish feelings of inferiority in favour of feelings and behaviours more consistent with social interest.

5) Involve the family as fully as possible. It is usually necessary to teach them appropriate skills for dealing with their elderly relatives as well as for their own personal coping. With few exceptions, family members need help in adjusting their expectation for the functioning of the elderly person. Often

family expectations are unrealistically low, such as their efforts to help actually results an decreasing adaptation, self-responsibility and independence in their elderly relative. Standard counseling techniques are useful in helping the family to deal with the-anger, frustration and resentment related to the caring for the elderly.

6) Develop a good working knowledge of available community resource and policies, especially regarding legal and financial issues involving the elderly.

SPECIFICTECHNIQUES

I) **Reminiscence exercise:** The reminiscence technique involves the calling to mind of an experience or facts from the past to reconstruct and find added meaning in the past and subsequently in the present. This exercise can be done individually but is particularly valuable when used as a structured group activity. The technique usually involves a minimal amount of written response to stimulus items- " How old were you when you first saw a T. V? When you first saw a Radio? Name the first person you dated" This is followed by a group discussion. These exercises have been shown to stimulate cognitive processes, reduce depressive mood, stimulate common bonds, experiences and beliefs among group members, and stimulate a person's interest and motivate them to engage in activities in which they were previously uninvolved.

2) Contracting: Behavioural contracts are particularly suitable for dealing with the goals of power and revenge in the elderly. Contracts can promote desirable behaviour while extinguishing undesirable patterns. The consequences of the desirable behaviour are defined, clearly specified and then agreed upon by both. It is extremely important to specify the particular undesirable behaviour as well as the expected desirable behaviour e.g; it is too vague to say, "She is uncooperative... work at cooperating with others." Rather, state specific examples of undesirable behaviour such as, “She refuses to carry out morning household duties", He makes critical remarks to group members." Examples of desirable behaviour might be, “He will make at least three encouraging remarks a day to other residents for the next five days."

3. **Group Assembly:** This group method is a derivation from Dreikurs' family, counsel concept. The assembly involves regular meetings of residents to foster personal independence and social interest within a democratic environment. If possible, the assembly is chaired by a resident who keeps order and allows everyone an opportunity to speak. Staff may need to organize the first meeting.

4) Couple conference- It can structure respect and self-dignity of spouses who live in their own homes. It ensures that each elderly spouse has equal access to the marriage rule making and goal setting process. The counsellor helps both spouses develop skills such as active listening, I-messages and basic conflict

resolution skills so that the couple meet weekly outside their home and discuss mutual concerns in their relationship.

COUNSELLING FOR HIV AND AIDS PATIENTS

Acquired Immune Deficiency Syndrome (AIDS) is caused by the Human Immunodeficiency Virus (HIV). It is a serious disorder of the immune system in which the body's normal defences against infections break down, leaving it vulnerable to a host of life-threatening infections, including unusual malignancies.

HIV is found in the blood and other body fluids (particularly semen, pre-ejaculatory secretions, vaginal secretions, saliva, and breast milk) of persons infected with the virus. A person can be infected with HIV and not know it. It is currently believed that most people infected with HIV will develop AIDS over a period of time depending on their general health and natural defence mechanisms of the body. AIDS is the most advanced stage of the HIV infection. Some people develop the primary symptoms of HIV shortly after being infected. Most of the HIV infected people develop symptoms of AIDS after about 6 to 12 years. HIV is transmitted through specific bodily fluids from a person with HIV that can get into the bloodstream of another person. Here's a breakdown of the primary ways HIV is transmitted:

SEXUAL TRANSMISSION:

This is the most common way HIV is spread. It can occur during vaginal or anal sex with someone who has HIV. HIV can be present in semen, vaginal fluids, and pre-seminal fluid.

SHARING NEEDLES:

Sharing needles, syringes, or other drug injection equipment with someone who has HIV can transmit the virus. This is because these items can carry infected blood.

MOTHER TO CHILD (PERINATAL TRANSMISSION):

A pregnant person with HIV can transmit the virus to their child during pregnancy, childbirth, or breastfeeding.

BLOOD TRANSFUSIONS:

While rare in countries with thorough blood screening, HIV can be transmitted through transfusions of infected blood.

OTHER BODILY FLUIDS:

HIV can also be transmitted through other bodily fluids such as breast milk.

A PERSON CANNOT GET INFECTED WITH HIV FROM

Casual contact, such as hugging, shaking hands, or sharing food.

Kissing, unless there is blood present.

Sharing toilets or swimming pools.

Insect bites.

Counsellors, medical practitioners, social workers, need to be trained and made aware of the situation. Lack of basic knowledge of HIV / AIDS as, a disease limited scope for open discussion and harsh laws and regulations has created a negative attitude towards the prevailing problems.

Recommended Interventions For The Counsellors

A comprehensive strategy that promotes behaviour change is essential to prevent HIV transmission and other negative health consequences from injecting drug use. The ability to halt -the epidemic requires a four-part strategy-

I. Preventing drug abuse especially among young people

2. Facilitating entry into drug abuse treatment;

3. Establishing effective outreach for better awareness among the masses.
4 Encourage the uptake of treatment and medical care for the infected.

Interventions

The following interventions may be proposed

Recommendation 1- Reach out to any suspected drug user and provide information. This involves (a) identifying and making contact with target population in their natural environment; (b) Establishing rapport with the target group; (c) Enlisting commitment to behavioural change; (d) Providing information about unsafe as well as risk behaviours; (e) Strategies to reduce risk behaviours; (f) Promotion of safe behaviours.

Recommendation 2 - Educate one self and get rid of misbelieves about the illness. HIV /AIDS is an infected disease only. There is no oral transmission. So do not treat a suspected or infected person as an untouchable.

Recommendation 3 - Impart proper sex education to pre — adolescence and adolescence. As studies have found that lack of proper knowledge and maturity has aroused inquisitiveness in sexual conduct among very young children.

Recommendation 4-- Encourage treatment to all drug abusers. As a counsellor one can make an effort to lead a client towards drug substitution. The aim of drug substitution is -

- To switch from an injected to a non-injected substance;
- To reduce the risk., of contacting or transmitting HIV / AIDS and other blood borne pathogens;
- To minimize the risk of overdose and other medical complications;
- To reduce hazardous drug use;

Recommendation 5- Establish a hierarchy of risk reduction strategies to prevent HIV among IDUs (Intravenous Drug User.) The same typology could encourage people to -

- Think before they start using drugs.
- Think before they start injecting.
- Think before they start sharing injecting equipment.

Users should —

- Never re-use or share syringes.
- Use only syringes obtained from reliable sources.
- Only use new sterile syringes.
- Clean the injecting site prior to injecting with a new alcohol swab.
- Safely dispose off syringes after one use.

Recommendation 6- Reduce risky sexual behaviour among drug users and the link between drug use and sex risk is often ignored. In order that interventions have desirable impact on the sexual behaviour, the following issues have to be addressed -

- Consistency of condom use with regular partners should be stressed.
- STIs (Sexual Transmitted Infection) should be assessed early and treated appropriately and adequately.
- Sex work and drug use among women need to be specifically addressed.

Counselling before and after testing should be an integral part of the HIV testing procedures. During counselling, vital information is made available to those who test positive to prevent subsequent transmission to their partner(s), to prevent acquiring other STDs, to identify links to social and health resources, and to receive guidance for maintaining health through a healthy lifestyle. For those who test negative, counselling information can be critical in helping to prevent future infections.

COUNSELLING FOR GAY MEN AND LESBIANS

Sexual orientation refers to an enduring pattern of romantic or sexual attraction to people of the opposite sex or gender, the same sex or gender, or both sexes or more than one gender. It's a complex and multifaceted concept that encompasses emotional, romantic, and/or sexual attractions. The most commonly recognised sexual orientations are heterosexuality, homosexuality and bisexuality.

It's essential to note that sexual orientation is distinct from gender identity, which refers to a person's internal sense of their own gender. Additionally, sexual orientation is not a choice, and research suggests that it's influenced by a combination of genetic, hormonal, and environmental factors.

Homosexuality refers to romantic or sexual attraction between people of the same sex or gender. It's a natural and normal variation in human sexuality, and researchers believe that it's influenced by a combination of biological, hormonal, and environmental factors.

In simpler terms, homosexuality is when a person is emotionally, romantically, or sexually attracted to someone of the same sex. This can include men who are attracted to men, women who are attracted to women, or people who are attracted to both men and women.

It's essential to note that homosexuality is not a choice, and it's not something that can be changed or "cured." The American Psychological Association and other reputable health organizations have stated that homosexuality is a normal and healthy part of human diversity.

Throughout history, homosexuality has been documented in many cultures around the world, including ancient Greece, Rome, China, and Egypt. However, the way homosexuality has been perceived and treated has varied greatly across different cultures and time periods.

Gay and lesbian are terms used to describe individuals who identify as homosexual, meaning they are emotionally, romantically, or sexually attracted to people of the same sex. Gay typically refers to men who are attracted to men, while lesbian refers to women who are attracted to women.

These terms are part of the broader LGBTQ+ community, which encompasses individuals who identify as lesbian, gay, bisexual, transgender, queer, or questioning, among others. The LGBTQ+ community has a rich history and culture, with various events and celebrations around the world, such as the Sydney Gay and Lesbian Mardi Gras.
Counselling for homosexuality and their families can be a supportive and non-judgmental space to explore feelings, concerns, and experiences.

Counselling helps individuals accept and love themselves for who they are, support the families in accepting their LGBTQ+ relative. Counselling helps in developing strategies to cope with stigma, discrimination and social pressures.

Signs and symptoms of LGBTQ+ issues may include:
a. Feeling isolated or misunderstood: LGBTQ+ individuals may feel isolated from their peers or family members due to their sexual orientation or gender identity.
b. Fear of discrimination or rejection: LGBTQ+ individuals may experience discrimination or rejection from others, which can lead to fears of being open about their sexual orientation or gender identity.

c. Low self-esteem or self-worth: LGBTQ+ individuals may struggle with low self-esteem or self-worth due to negative messages they have received about their sexual orientation or gender identity.
d. Anxiety or depression: LGBTQ+ individuals may experience higher rates of anxiety or depression due to the stressors associated with discrimination or rejection.
e. Difficulty coming out: LGBTQ+ individuals may struggle with the decision to come out to family members or peers, which can lead to stress and anxiety.
f. Relationship difficulties: LGBTQ+ individuals may experience challenges in forming and maintaining relationships due to discrimination or lack of acceptance.
g. Gender dysphoria: Transgender individuals may experience gender dysphoria, which refers to the distress caused by the discrepancy between their gender identity and their biological sex.

It is important to note that experiencing some or all of these signs and symptoms does not necessarily mean an individual has LGBTQ+ issues. However, if these symptoms persist or interfere with daily functioning, it may be helpful to seek support from a mental health professional or an online counsellor who can provide guidance and support in coping with these challenges.

It is important to note that being LGBTQ+ is not a problem or an issue, but rather it is a natural and valid aspect of human diversity. However, members of the LGBTQ+ community may face discrimination, stigmatization, and marginalization, which can lead to mental health issues and other challenges. Some causes of these challenges may include:

1. Heteronormativity: Heteronormativity is the assumption that heterosexuality is the norm, and anything outside of that is abnormal or unnatural. This can lead to discrimination against LGBTQ+ individuals and a lack of representation in media, education, and society in general.

2. Prejudice and discrimination: LGBTQ+ individuals may face prejudice and discrimination in their daily lives, such as discrimination in the workplace, housing, healthcare, and education. This can lead to feelings of isolation, depression, and anxiety.

3. Family rejection: Family rejection can have a significant impact on LGBTQ+ individuals, particularly if it occurs during childhood or adolescence. This can lead to low self-esteem, depression, and even suicidal thoughts.

4. Lack of legal protections: In many parts of the world, LGBTQ+ individuals do not have legal protections against discrimination, and may face legal barriers to accessing healthcare, marriage, and other basic rights.

5. Intersectionality: Intersectionality refers to the intersection of different marginalized identities, such as race, gender, and socioeconomic status. LGBTQ+ individuals who belong to other marginalized groups may face additional challenges, such as racism or poverty.

It is important to recognize and address these challenges in order to create a more inclusive and equitable society for all individuals, regardless of their sexual orientation or gender identity.

LGBTQ+ individuals continue to face numerous challenges and issues in various areas of life, including the following:

Discrimination and violence: LGBTQ+ people may face discrimination, harassment, and violence in employment, housing, and other areas of life. This can lead to feelings of isolation, alienation, and fear.

Mental health concerns: LGBTQ+ individuals are at a higher risk of experiencing depression, anxiety, and suicide compared to the general population due to stigma, discrimination, and lack of support.

Legal inequalities: Despite progress made in recent years, many countries still do not afford LGBTQ+ individuals the same legal protections as those offered to heterosexual and cisgender people.

Healthcare access: LGBTQ+ individuals may face barriers to accessing adequate healthcare, including discrimination, lack of specialized care, and financial obstacles.

Family and relational issues: LGBTQ+ individuals may face challenges in building and maintaining familial relationships, such as coming out to family and friends, legal and financial issues in formalizing relationships, and parenting hurdles.
It is important to address and actively work on solutions to these issues to ensure that LGBTQ+ individuals can live full and equitable lives, free from discrimination and violence.

Family members of LGBTQ+ individuals may also face a range of issues and challenges:
Family rejection: LGBTQ+ individuals may be rejected by their families due to their sexual orientation or gender identity, which can cause significant distress and lead to family conflict.
Lack of knowledge and understanding: Family members may not have a clear understanding of what it means to be LGBTQ+ and may struggle to support their loved ones appropriately.
Stigma and discrimination: Family members may experience discrimination or stigma due to their association with an LGBTQ+ loved one.
Mental health concerns: Family members may experience stress, anxiety, and depression related to their loved one's identity and the challenges they may face due to discrimination or lack of acceptance.
Relationship issues: Family members may struggle with how to navigate relationships with their LGBTQ+ loved one and their loved one's partner or spouse.
It is important for family members to seek support and resources to address these challenges and learn how to support their LGBTQ+ loved ones effectively. Online Counselling, support groups, and education programs can all be helpful in this regard.

FACED BY- THE PERSON-
Workplace Conflicts
Conflicts in School
Bullying
Depression
Anxiety
Social Isolation
Suicidal ideation
Low self-confidence

FACED BY- THE FAMILY-
Social Alienation
Abuse
Guilt
Hostility
Anger
Shame

Treatment
They should not be subjected to discrimination, prejudice, or mistreatment based on their sexual orientation, gender identity, or any other characteristic.
When it comes to healthcare, including mental health, it is essential that LGBTQ+ individuals receive appropriate and affirming care.

Here are some important considerations for LGBTQ+ treatment:

Affirming language: Healthcare providers should use affirming and respectful language that respects an individual's self-identified gender and sexual orientation. Using correct names and pronouns, as well as avoiding heteronormative assumptions, can help create a safe and inclusive environment for LGBTQ+ individuals.

Culturally competent care: Healthcare providers should be knowledgeable about the unique health needs and disparities faced by LGBTQ+ individuals, and provide culturally competent care. This includes understanding the specific health risks, mental health challenges, and barriers to care that LGBTQ+ individuals may face and tailoring care accordingly.

Informed consent: LGBTQ+ individuals have the right to make informed decisions about their healthcare, including their gender-affirming care, without discrimination or gatekeeping. Informed consent models, where individuals are fully informed about the risks and benefits of medical interventions, should be followed.

Confidentiality and privacy: Healthcare providers should respect the privacy and confidentiality of LGBTQ+ individuals, as disclosure of their sexual orientation or gender identity may have serious consequences for their safety, well-being, and livelihood.

Mental health support: LGBTQ+ individuals may face unique mental health challenges, including stigma, discrimination, and rejection. Access to LGBTQ+-affirming mental health care, including online therapy and online counselling, can be crucial in promoting mental well-being.

Social support: social support networks, including LGBTQ+ organizations and communities, can provide invaluable support for individuals navigating their gender identity or sexual orientation. Healthcare providers should be aware of and connect individuals with appropriate social support resources.

Anti-discrimination: LGBTQ+ individuals have the right to be free from discrimination in healthcare settings. Healthcare providers should advocate against discrimination and provide a safe and inclusive environment for all patients, regardless of their sexual orientation, gender identity, or any other characteristic.

Therapies:

- ***Acceptance and Commitment Therapy (ACT)***
- ***Anger Management Therapy***
- ***Psychodynamic Therapy***
- ***Cognitive Behavioural Therapy (CBT)***
- ***Interpersonal Therapy (IPT)***

Benefits:

1. It helps with exploring gender identity and expression
2. It helps with exploring sexual and/or romantic preferences
3. It helps to choose whether to come out
4. It helps to recognize and treat depression, anxiety, or gender dysphoria
5. It helps in dealing with bullying or discrimination in family, neighbourhood, or place of worship or among peers
6. It helps in overcoming the worries about STDs, HIV, or sexually transmitted diseases
7. LGTQ+ counsellor can also help with relationship issues
8. LGTQ+ counsellor can also help with sexual problems
9. LGTQ+ counsellor can also help with all the parenting difficulties
10. LGTQ+ counsellor can also help with addiction

TYPES OF COUNSELLING:

Gay affirmative psychotherapy is a form of psychotherapy for non-heterosexual people, specifically gay and lesbian clients, which focuses on client comfort in working towards authenticity and self-acceptance

regarding sexual orientation, and does not attempt to "change" them to heterosexual, or to "eliminate or diminish" same-sex "desires and behaviours". Affirmative psychotherapy affirms that homosexuality or bisexuality is not a mental disorder, in accordance with global scientific consensus. In fact, embracing and affirming gay identity can be a key component to recovery from other mental illnesses or substance abuse. Clients whose religious beliefs are interpreted as teaching against homosexual behaviour may require some other method of integration of their possibly conflicting religious and sexual selves.

1. Individual counselling: One-on-one counselling for individuals to explore their feelings, concerns, and experiences.

2. Family counselling: Counselling for family members to understand, accept, and support their LGBTQ+ relative.

3. Group counselling: Group counselling for LGBTQ+ individuals to connect with others who share similar experiences.

4. Couple counselling: Counselling for LGBTQ+ couples to strengthen their relationship and navigate challenges.

Techniques and Strategies

1. Affirmative therapy: A supportive and non-judgmental approach that affirms LGBTQ+ identities.

2. Cognitive-behavioural therapy (CBT): Helps individuals identify and challenge negative thought patterns and behaviours.

3. Family systems therapy: Helps family members understand and improve their relationships and communication.

4. Supportive listening: Provides a safe and supportive space for individuals to share their experiences and feelings.

While counselling for homosexuality can be incredibly beneficial, there are some limitations to consider:

LIMITATIONS OF COUNSELLING

1. Lack of trained therapists: Not all therapists have received training or have experience working with LGBTQ+ individuals, which can limit access to effective counselling.

2. Societal stigma: Homophobia and transphobia can still be prevalent in some societies, making it difficult for individuals to seek counselling without fear of judgment or rejection.

3. Internalized homophobia: Some individuals may struggle with internalized homophobia, making it challenging to accept themselves and seek counselling.

4. Limited cultural competence: Therapists may not always have the cultural competence to work effectively with LGBTQ+ individuals from diverse backgrounds.

PARAPHILIA

SEXUAL DISORDER

Sexual disorders, also known as sexual dysfunctions, are conditions that affect an individual's ability to experience sexual pleasure, desire, or intimacy. Here are some common types of sexual disorders:

- Gender Identity Disorder
- Psychological And Behavioural Disorder Associated With Sexual Development And Maturation
- Paraphylies
- Sexual Dysfunction

WHAT IS GENDER IDENTITY

The sense of belonging to a particular sex, not only biologically but also psychologically and socially is called gender identity. Sex refers to our biological sex, as determined by our chromosomes and sexual organs. Sexual orientation refers to our attraction to others of the same or opposite gender. Gender identity, on the other hand, refers to an individual's identification with male or female gender roles and behaviours.

GENDER IDENTITY DISORDER (GID)

- **Transsexualism**
- **Transgender**
- **Gender dysphoria**

Most biological men (XY) identify as male and most biological women (XX) identify as female. However, there are minority of individuals who feel that their biological sex and their gender do not match.

PSYCHOLOGICAL AND BEHAVIOUR DISORDER ASSICIATED WITH SEXUAL DEVELOPMENT

It generally begins at adolescence and is characterised by uncertain about the gender identity or sexual orientation (homosexual, Heterosexual or Bisexual)

PARAPHILIES

Paraphilia is a disorder of sexual preference where sexual arousement occurs significantly and persistently in response to the objects which are not a part of normal sexual arousal (non-human objects, humiliation of self or sexual partner, children or non-consenting partner) and cause clinically significant distress or impairment in social, occupational and other areas of functioning.

Some paraphilias are as follows:

Exhibitionism ("Flashing")

Exhibitionism involves someone exposing their genitals to an unsuspecting stranger. The individual with this problem, sometimes called a "flasher," feels a need to surprise, shock, or impress their victims. The condition is usually limited to the exposure with no other harmful advances being made. Nevertheless, "indecent exposure" is illegal. Actual sexual contact with the victim is rare. However, the person may masturbate while exposing themselves or while fantasizing about exposing themselves.

Fetishism

People with fetishes have sexual urges associated with non-living objects. The person becomes sexually aroused by wearing or touching the object. For example, the object of a fetish could be an article of clothing, such as underwear, rubber clothing, women's shoes, women's underwear, or lingerie. The fetish may replace sexual activity with a partner or may be integrated into sexual activity with a willing partner. When the fetish becomes the sole object of sexual desire, sexual relationships often are avoided. A related disorder, called partialism, involves becoming sexually aroused by a body part, such as the feet, breasts, or buttocks.

Frotteurism

With this problem, the focus of the person's sexual urges is on touching or rubbing their genitals against the body of a non-consenting, unfamiliar person. In most cases of frotteurism, males rub their genital area against a female, often in a crowded public location. The contact made with the other person is illegal.

Paedophilia

People with paedophilia have fantasies, urges, or behaviours that involve illegal sexual activity with a child or children. The children involved are generally 13 years of age or younger. The behaviour includes undressing the child, encouraging the child to watch the abuser masturbate, touching or fondling the child's genitals, and forcefully performing sexual acts on the child.

Some paedophiles, known as exclusive paedophiles, are sexually attracted only to children and are not attracted to adults. Some limit their activity to incest, involving only their own children or close relatives. Others victimize other children. Predatory paedophiles may use force or threaten their victims with what will happen if they disclose the abuse. Health care providers are legally bound to report such abuse of minors.
Paedophile activity constitutes rape and is a felony offense punishable by imprisonment.

Sexual Masochism

Individuals with this disorder use the act -- real, not simulated -- of being humiliated, beaten, or otherwise made to suffer in order to achieve sexual excitement and climax. These acts may be limited to verbal humiliation, or they may involve being beaten, bound, or otherwise abused. Masochists may act out their fantasies on themselves by such acts as cutting or piercing their skin or burning themselves. Or they may seek out a partner who enjoys inflicting pain or humiliation on others. Activities with a partner include bondage, spanking, and simulated rape.
Sadomasochistic fantasies and activities are not uncommon among consenting adults. In most of these cases, however, the humiliation and abuse are acted out in fantasy. The participants are aware that the behaviour is a "game" and actual pain and injury is avoided.
A potentially dangerous, sometimes fatal, masochistic activity is autoerotic partial asphyxiation. With this activity, a person uses ropes, nooses, or plastic bags to induce a state of asphyxia (interruption of breathing) at the point of orgasm. This is done to enhance orgasm, but accidental deaths sometimes occur.

Sexual Sadism

Individuals with this disorder have persistent fantasies in which sexual excitement results from inflicting psychological or physical suffering (including humiliation and terror) on a sexual partner. This disorder is different from minor acts of aggression in normal sexual activity -- for example, rough sex. In some cases, sexual sadists are able to find willing partners to participate in the sadistic activities.
At its most extreme, sexual sadism involves illegal activities such as rape, torture, and even murder, in which case the death of the victim produces sexual excitement. It should be noted that while rape may be an expression of sexual sadism, the infliction of suffering is not the motive for most rapists, and the victim's pain generally does not increase the rapist's sexual excitement. Rather, rape involves a combination of sex and gaining power over the victim. These individuals need intensive psychiatric treatment and may be jailed for these activities.

Transvestitism

Transvestitism, or transvestism fetishism, refers to the practice by heterosexual males of dressing in female clothes to produce or enhance sexual arousal. The sexual arousal usually does not involve a real partner but includes the fantasy that the individual is the female partner as well. Some men wear only one special piece of female clothing, such as underwear, while others fully dress as female, including hair style and make-up. Cross-dressing as a transvestite is not a problem unless it is necessary for the individual to become sexually aroused or experience sexual climax.

Voyeurism

This disorder involves achieving sexual arousal by observing an unsuspecting and non-consenting person who is undressing or unclothed or engaged in sexual activity. This behaviour may conclude with masturbation by the voyeur. The voyeur does not seek sexual contact with the person they are observing.
Counselling for paraphilias is a complex and sensitive process, requiring a non-judgmental and empathetic approach.

Here are some key aspects of counselling for paraphilias:

Treatment / Management

Most clinicians and researchers believe that paraphilic sexual interests cannot be altered, although evidence is needed to support this. Instead, the goal of therapy is normally to reduce the person's discomfort with their paraphilia and limit the risk of any harmful, anti-social, or criminal behaviour.

Both psychotherapeutic and pharmacological methods are available to these ends.] Cognitive behavioural therapy, at times, can help people with extreme paraphilic disorders develop strategies to avoid acting on their interests.[72] Patients are taught to identify and cope with factors that make acting on their interests more likely, such as stress. It is currently the only form of psychotherapy for paraphilic disorders supported by randomized double-blind trials, as opposed to case studies and consensus of expert opinion.

The treatment and management of paraphilia's and paraphilic disorders pose extreme difficulty due to a multitude of factors. Despite the ego syntonic and ego dystonic dual nature of paraphilia in general, the overall majority of patients rarely seek treatment voluntarily. Many individuals may feel indignity, culpability, or discomfiture, while others focus on the difficulty and lack of desire to halt efforts to achieve intense sexual pleasure and ultimate satisfaction. Furthermore, many may fear the legal repercussions of coming forward for treatment. Those patients in treatment or seeking treatment are often either mandated legally or convinced by family, friends, or sexual partners.

The management of paraphilic disorders falls into two main categories, incorporating both psychological and biological constituents. The psychological approach, which includes psychotherapy, but more importantly, cognitive behavioural therapy (CBT), yields an overall positive outcome in terms of efficacy, regardless of the type of diagnosed paraphilic disorder. However, due to the patient's reluctance to seek treatment or the legal obligation to obtain treatment, psychiatrists are often forced to exceed the call of duty to the patient to reduce distress but rather focus efforts on protection against potential victimization. The predisposition of committing sexual offenses demonstrates the significance of biological treatments for paraphilic disorders for the suffering individual and the greater good of society. However, specialized management, with a comprehensive treatment plan encompassing both psychological and pharmacological components, proves to be the optimal therapeutic option overall.

The three main classifications of pharmacological agents used in managing paraphilic disorders involve selective serotonin reuptake inhibitors (SSRIs), synthetic steroidal analogs, and antiandrogens. Despite limited support in the literature and the demand for further definitive research, treatment algorithms for varying severity of illness have been devised, offering useful and rational approaches to treating paraphilic disorders. The therapeutic choice depends on previous medical history and medication compliance, along with the intensity of both the sexual fantasy and the risk of sexual violence.

TYPES OF COUNSELLING

1. Cognitive-Behavioural Therapy (CBT): Helps individuals identify and challenge negative thought patterns and behaviours associated with their paraphilia.

2. Psychodynamic Therapy: Explores the underlying causes of the paraphilia, focusing on childhood experiences, relationships, and unconscious thoughts and feelings.

3. Dialectical Behaviour Therapy (DBT): Combines CBT with mindfulness techniques to manage emotions, reduce self-destructive behaviours, and improve relationships.

4. Group Therapy: Provides a supportive environment for individuals with paraphilias to share their experiences, receive support, and learn from others.

GOALS OF COUNSELLING

1. Reduce deviant sexual behaviours: Help individuals manage and reduce their paraphilic behaviours.
2. Improve emotional regulation: Teach individuals skills to manage emotions, reduce stress, and improve overall well-being.
3. Enhance relationships: Improve relationships with family, friends, and romantic partners.
4. Increase self-awareness: Help individuals understand the underlying causes of their paraphilia and develop a more positive self-image.

What Causes Paraphilia?

It is not clear what causes paraphilia. Some experts believe it is caused by a childhood trauma, such as sexual abuse. Others suggest that objects or situations can become sexually arousing if they are frequently and repeatedly associated with a pleasurable sexual activity. In most cases, the individual with a paraphilia has difficulty developing personal and sexual relationships with others.
Many paraphilias begin during adolescence and continue into adulthood. The intensity and occurrence of the fantasies associated with paraphilia vary with the individual, but they usually decrease as the person ages.

TECHNIQUES USED IN COUNSELLING

1. Mindfulness techniques: Encourage individuals to be present in the moment, reducing emotional reactivity.
2. Cognitive restructuring (CBT): Help individuals challenge and reframe negative thought patterns.
3. Exposure therapy: Gradually expose individuals to situations or stimuli that trigger their paraphilia behaviours, while teaching coping skills.
4. Relapse prevention: Teach individuals strategies to maintain treatment gains and prevent relapse.

CHALLENGES AND CONSIDERATIONS

1. Establishing trust: Building trust with individuals with paraphilias can be challenging due to their difficulties with intimacy and emotional regulation.
2. Managing emotional reactivity: Counsellors must be prepared to manage their own emotional reactivity when working with individuals with paraphilias.
3. Confidentiality and boundaries: Establishing clear boundaries and maintaining confidentiality is essential when working with individuals with paraphilias.
4. Collaboration with other professionals: Counsellors may need to collaborate with other professionals, such as psychiatrists or law enforcement, to provide comprehensive care.

CONCLUSION

Paraphilic disorders are rarely encountered in general psychiatric practice and pose numerous challenges for the treating clinician. Patients may be hesitant to seek or engage in treatment for atypical sexual interests; there is limited evidence by which to guide treatment decisions and medication selection; and the use of hormone-altering agents can have severe adverse effects that require patient education and careful informed consent procedures prior to implementation.

For difficult or high-risk cases, consultation with or referral to a sexual disorders' specialist is essential. Despite these concerns, both patients and society at large can benefit from the effective management of paraphilic disorders. Treatment can curb patients' unwanted, distressing sexual urges and fantasies and reduce the risk of harmful sexual behaviour. Psychiatrists should therefore be aware of this class of disorders, feel comfortable conducting a complete sexual behaviours history, and be able to discuss treatment options, even if the patient ultimately receives care elsewhere.

QUESTIONS

UNIT-1 COUNSELLING BASICS / MENTAL HEALTH

10 MCQs with 4 options

1. What is counselling NOT?
A) A supportive relationship between counsellor and client
B) An advice-giving process where the counsellor tells the client what to do
C) A collaborative process to explore client concerns
D) A medical treatment for mental health issues
Answer: B

2. In Psychodynamic Therapy, which of the following defense mechanisms is characterized by attributing unacceptable thoughts or feelings to someone else?
A) Repression
B) Denial
C) Projection
D) Rationalization
Answer: C

3. Which of the following models of mental health emphasizes the interplay between biological, psychological, and social factors that contribute to an individual's mental health?
A) Biomedical Model
B) Psychodynamic Model
C) Cognitive-Behavioural Model
D) Biopsychosocial Model
Answer: D

4. What is empathy in counselling?
A) The counsellor's emotional reaction to the client's situation
B) The counsellor's ability to understand and share the client's feelings
C) The counsellor's advice-giving and problem-solving skills
D) The counsellor's assessment and diagnosis of the client's mental health
Answer: B

5. What is a crucial aspect of LGBTQ+ affirmative counselling?
A) Focusing solely on the client's sexual orientation or gender identity
B) Avoiding discussions about the client's sexual orientation or gender identity
C) Creating a safe, non-judgmental space that acknowledges and respects the client's identity
D) Providing information about conversion therapy
Answer: C

6. Which of the following symptoms is a characteristic of the "hyperarousal" cluster in post-traumatic stress disorder (PTSD)?
A) Flashbacks and nightmares
B) Avoidance of triggers and memories
C) Difficulty sleeping and exaggerated
startle response
D) Feelings of guilt and shame
Answer: C

7. Why are psychological tests used in counselling?
A) To provide a definitive diagnosis and treatment plan
B) To understand the client's personality, strengths, and challenges
C) To predict the client's future behaviour and outcomes
D) To replace the counselling process with a quicker, more efficient assessment
Answer: B

8. In a school setting, which of the following is a primary goal of student health counselling?
A) To provide medical treatment for illnesses and injuries
B) To promote healthy behaviours and prevent health problems
C) To provide academic advising and career guidance
D) To discipline students for unhealthy behaviours
Answer: B

9. A client expresses suicidal ideation during a counselling session. What should the counsellor do FIRST?
A) Ask the client to contract for safety
B) Inform the client's family members or emergency services
C) Assess the client's level of suicidal intent and risk
D) Provide the client with coping skills and resources
Answer: B

10. A client presents with negative self-statements, such as "I'm a failure" and "I'll never succeed." Which cognitive-behavioural technique would the counsellor most likely use to address these statements?
A) Exposure therapy
B) Cognitive restructuring
C) Mindfulness-based intervention
D) Behavioural activation
Answer: B

Unit 1 - SHORT ANSWER TYPE QUESTIONS

1. Define counselling
2. What is unconditioned positive regard?
3. Goal of CBT
4. Bio psycho social model of mental health
5. What is PTSD?

UNIT- 2 COUNSELLING FOR YOUNG PEOPLE

10 MCQs with 4 options

1. What is a primary goal of teaching children self-control through counselling?

a) To punish bad behaviour
b) To develop self-regulation skills
c) To make decisions for them
d) To ignore their emotions

Answer: B

2. Which strategy can help children develop self-control?

a) Setting clear boundaries
b) Ignoring misbehaviour
c) Using punishment
d) Modelling self-control

Answer: D

3. What is an essential aspect of counselling for families affected by child abuse?

a) Confrontation
b) Family dynamics
c) Secrecy
d) Punishment

Answer: B

4. What is a crucial consideration when counselling victims of child abuse?

a) Avoiding emotional expression
b) Building trust
c) Rushing through sessions
d) Focusing on the perpetrator

Answer: B

5. What is a primary challenge faced by adolescents that counselling can address?

a) Financial stability
b) Career establishment
c) Identity formation
d) Retirement planning

Answer: C

6. What is an effective counselling approach for adolescents?

a) Directive approach
b) Non- directive approach
c) Cognitive behavioural therapy
d) Family therapy

Answer: C

7. What is a common issue that college students may seek counselling for?

a) Career advancement

b) Academic pressure

c) Financial planning

d) Both a and b

Answer: D

8. What is an effective counselling approach for college students?

a) Solution focused therapy

b) Psychodynamic therapy

c) Cognitive behavioural therapy

d) All of the above

Answer: D

9. The fundamental part of special education is:

a) Play therapy

b) Assessment tests

c) Individual Education Programme

d) Cognitive behavioural therapy

Answer: B

10. Learning disability falls under:

a) Psychological issues

b) Neurodevelopment problems

c) Sensory impairment needs

d) Behavioural problem

Answer: B

Unit 2 - SHORT ANSWER TYPE QUESTIONS

1. How colleges can promote counselling services?

2. What are the assessment tools and strategies in special education?

3. What are the effects of problems in adolescents?

4. What are the factors that may be considered in determining child abuse?

5. Explain marshmallow test for teaching self-control in children.

UNIT - 3 COUNSELLING FOR DIFFERENT DISORDERS

10 MCQs with 4 options

1. What are the primary characteristics of anorexia nervosa?

a) Bingeing and purging

b) Restrictive eating

c) Excessive exercise

d) Emotional eating

Answer: B

2. Pica involves eating things like:

a) Rice

b) Dirt

c) Junk food

d) Fruits only

Answer: B

3. Which of the following is an example of a speech disorder?

a) Stuttering

b) Apraxia

c) Dysarthria

d) All of the above

Answer: D

4. What is a primary characteristics of a communication disorder?

a) Difficulty with speech articulation

b) Difficulty with language comprehension

c) Difficulty with social interactions

d) All of the above

Answer: D

5. Which of the following is an example of OCD compulsion?

a) Excessive hand washing

b) Checking locks repeatedly

c) Counting objects

d) All of the above

Answer: D

6. What is a common treatment approach for OCD?

a) Cognitive Behavioural Therapy

b) Exposure and response prevention

c) Medication

d) All of the above

Answer: A

7. Which of the following personality disorders is characterized by a pervasive pattern of disregard for others rights?

a) Borderline personality disorder

b) Narcissistic personality disorder

c) Antisocial personality disorder

d) Avoidant personality disorder

Answer: C

8. What is a common challenge in treating personality disorders?

a) Resistance to change

b) Lack of motivation

c) Comorbid conditions

d) All of the above

Answer: D

9. What is the primary goal of exposure therapy in treating phobias?

a) Avoiding the feared stimulus

b) Reducing anxiety symptoms

c) Gradual exposure to the feared stimulus

d) Cognitive restructuring

Answer:C

10. Which of the following is a common technique used in CBT for panic disorder

a) Deep breathing exercise

b) Cognitive restructuring

c) Exposure to feared situations

d) All of the above

Answer: B

Unit 3 - SHORT ANSWER TYPE QUESTIONS

1. Write down the types of eating disorders.
2. What are the types of communication disorder?
3. Write in short, the treatment for OCD.
4. Write down the Cluster –A personality disorder.
5. What do you understand by GAD?

UNIT 4 – SPECIFIC COUNSELLING

10 MCQs with 4 options

1. Which of the following is a common issue addressed in marriage counselling?

a) Financial disagreements

b) Intimacy issues

c) Communication problems

d) All of the above

Answer: C

2. What is the primary mode of HIV transmission?

a) Sexual contact

b) Blood transfusions

c) Mother-to-child transmission

d) all of the above

Answer: D

3. What is the difference between HIV and AIDS?

a) HIV is a virus, while AID is a disease

b) HIV is a disease, while AIDS is a virus

c) HIV and AIDS are interchangeable terms

d) HIV is curable, while AIDS is not

Answer: A

4. What do you understand by paedophilia?

a) Sexual desire between same genders

b) Sexual desire between opposite genders

c) Sexually attracted only to children

d) Sexual urges associated with non- living objects

Answer: C

5. What does the term "gay" typically refer to?

a) A man who is attracted to women

b) A woman who is attracted to women

c) A man who is attracted to men

d) A person who is not attracted to anyone

Answer: C

6. What is an important aspect of promoting inclusivity for gay men and lesbians?

a) Promoting social awareness

b) Respecting individuals' identity

c) Ignoring their experiences

d) Promoting stereotypes

Answer: B

7. What is a common challenge faced by gay men and lesbians?

a) Discrimination and stigma

b) Lack of community

c) Mental health issues

d) All of the above

Answer: A

8. What are the characteristics of authoritative parenting?

a) Strict rules and punishments

b) Warmth and responsiveness

c) Laissez-fair approaches

d) Neglectful parenting

Answer: B

9. Which parenting style is associated with increased risk of behavioural problems in children?

a) Authoritative parenting

b) Authoritarian parenting

c) Permissive parenting

d) Both b and c

Answer: D

10. What is a key aspect of positive parenting?

a) Using physical punishment

b) Setting clear boundaries

c) Ignoring misbehaviour

d) Praising effort, not outcome

Correct answer-d) Praising effort not outcome

Unit 4 - SHORT ANSWER TYPE QUESTIONS

1. Explain Gottman's "Four Horsemen"
2. What is postpartum counselling?
3. How HIV is transmitted?
4. What are the types of paraphilia?
5. What are the signs of LGBTQ+?

UNIT- 5 – ELDERLY CARE & ADDICTION COUNSELLING

10 MCQs with 4 options

1. What is primary goal of geriatric counselling?

a) Improving physical heath

b) Addressing mental health concerns

c) Enhancing social connections

d) All of the above

Answer: B

2. What is the common challenge faced by older adults?

a) Career transitions

b) Loss and grief

c) Parenting concerns

d) All of the above

Answer: B

3. What is an important aspect of death and dying counselling?

a) Avoiding discussions about death

b) Encouraging hope

c) Empathy and active listening

d) Giving advice

Answer: C

4. What is a common challenge faced by individuals who are dying?

a) Loss of identity

b) Fear of the unknown

c) Unfinished business

d) All of the above

Answer: D

5. What common early symptoms of Alzheimer's disease?

a) Memory loss

b) Vision loss

c) Hearing loss

d) Motor weakness

Answer: A

6. What can help support individuals with Alzheimer's disease?

a) Medications

b) Cognitive training

c) Supportive care

d) All of the above

Answer: D

7. What is a common cause of vision impairment in older adults?

a) Cataracts

b) Glaucoma

c) Age related macular degeneration

d) All of the above

Answer: D

8. What can help individuals with hearing loss?

a) Hearing aids

b) Cochlear implants

c) Communication strategies

d) All of the above

Answer: D

9. What is a common consequence for substance addiction?

a) Physical health problems

b) Physical and mental health issues

c) Increased productivity

d) None of the above

Answer: B

10. What is a common benefit for mental health support?

a) Financial stability

b) Improved relationships

c) Reduced symptoms

d) Both b and c

Answer: D

Unit 5 - SHORT ANSWER TYPE QUESTIONS

1. What are the four goals of misbehaviour in geriatric counselling?
2. What are the goals of therapy with dying persons?
3. What is Dementia?
4. What are the types of hearing impairment?
5. What is the role of a counsellor in addiction and health counselling?

REFERENCES

1. On Becoming a Person - by Carl Rogers
2. The Psychodynamic Approach to Therapeutic Change - by Leopold Bellak
3. Cognitive Behavioural Therapy for Dummies - by Rhena Branch and Rob Willson
4. Cognitive-Behavioral Therapy: Basics and Beyond - by Judith S. Beck
5. CBT: A Practical Guide - by Windy Dryden and Rachel Zayat
6. Person - Centered Therapy - by Carl Rogers
7. Types of Counselling: Theory and Practice of Counselling and Psychotherapy -by Gerald Corey
8. A Short Textbook of Psychiatry -Niraj Ahuja
9. Counselling children with psychological problems - Malavika Kapur
10. Counselling and guidance - S Narayana Rao and Prem Shajpal
11. Counselling a Comprehensive Profession - Samuel T. Gladding and Promila Batra
12. Psychological Testing - Anne Anastasia and Susana Urbina
13. Counseling - Samuel T. Gladding, Promila Batra
14. Counseling & Therapy - Richard Nelson Jones
15. Introduction to Counselling: voices from the Field - by Jeffrey A. Kottler and Richard S. Balkin