Units of Competency

CHCCSL504A Apply personality and development theories

CHCCSL505A Apply learning theories in counselling
ACAP regularly revises its course materials, including assignment requirements, to ensure that the content is up-to-date and relevant. Therefore it is critical that you have the correct version of the course materials for the term that you are studying the module.

If you have purchased these module materials in a term prior to your study of this module, please ensure that you have the correct version code by checking on the ‘Order Course Materials’ page of the ‘Current Students’ part of the ACAP website (http://currentstudents.acap.edu.au). During term, the correct version of course materials is always available in your online class space.
Counselling Theories

Overview

This module aligns with two units of competency:

- CHCCSL504A Apply personality and development theories
- CHCCSL505A Apply learning theories in counselling

This module is designed to provide you with an introduction to the application of key concepts and constructs underlying theories of personality and human development. You will also develop the skills and knowledge required to apply theory underpinning behaviourism and social cognitive (modelling) in counselling practice.

Skills and knowledge developed in this module are intended to be applied in the facilitation of the client-counsellor relationship and to formulate and monitor a program for behaviour change in a counselling context.

By the end of this module you will be equipped with the essential skills to:

- use personality and development theories to help clients understand themselves and reach their goals
- understand how environmental factors impact on client behaviour
- help clients change unhelpful behaviour

Elements

The CHCCSL504A Apply personality and development theories contains two elements or learning outcomes. You will learn to:

- apply theories of personality and human development in the counselling process
- use concepts from theories of personality and human development to analyse and understand human behaviour

The unit of competency CHCCSL505A Apply learning theories in counselling contains four elements or learning outcomes. You will learn to:

- apply behaviourism in counselling practice
- analyse environmental modelling influences in counselling practice
- analyse possible behavioural outcomes of different modelling and reinforcement influences
- formulate a program for change in a counselling context

Each element has its own set of performance criteria. You are required to demonstrate an understanding of, and skills in, all of the performance criteria. Each element and its associated performance criteria are listed at the end of this unit as a Performance criteria checklist. You can use the checklist to ensure you have thoroughly covered the content of this module.
Components of the course

📚 Prescribed text

The prescribed textbook for this module is:


Whenever you see this symbol, access and read the pages indicated then complete any tasks described before proceeding.

**Note:** There is no textbook reading for this module.

➔ Activities

Various activities have been incorporated into this module to assist students in improving their understanding of the subject matter and to provide opportunities to develop and refine the associated skills. Many of these activities are not assessable, but are nevertheless intrinsic to the course and central to improving the academic and professional development of students. Assessable activities are marked accordingly.

➔ Reading

This module is supplemented by a selected reading that has been chosen to further improve the student’s understanding of the study material.

Group work or online discussion board activities

There are three group works (for on-campus students) or online discussion board activities (for flexible delivery students) for this module. These activities are intended to provide you with opportunities to practice, discuss and develop the skills required with your fellow students. It is important that you take part in these activities as you will be required to refer to them when completing Assessment 4 of this module which is a Reflective Report.

➔ Case studies

The course content of this qualification is supplemented by the inclusion of case studies. Case studies are useful in that they illustrate how the information, policies, practices and skills discussed throughout the notes are brought together and realised in practical, real-life settings.

✔ Performance criteria checklist

The Performance criteria checklist at the end of this module is designed to be used as a self-assessment tool. It provides you with an opportunity to assess your own progress and identify any areas you feel warrant further study. It is a subjective and voluntary self-evaluation. It is recommended that all students make use of it.
References and further reading

Each unit of competency includes a short list of relevant texts for further reading. Both print and electronic (e.g. Internet) sources are supplied. It is highly recommended that you take the time to seek out and read this material so as to improve your understanding of the course content and your ability to apply the knowledge and skills to the workplace.

Module review

At the conclusion of each module, there is a section titled Module review. The purpose of this section is to provide you with a brief overview of the information covered and to highlight the most salient elements of the module.

Competency assessment

At the conclusion of this module are four competency assessment tasks. You must complete each assessment task satisfactorily to achieve an overall grade of competent for the module and to be able to progress in the course.
Study and assessment plan

The module Counselling Theories is undertaken over a 12-week term. You are expected to dedicate an average of seven to eight hours of study per week to this module over the course of the term, made up of six hours of coursework and, on average, one to one-and-a-half hours of participation in either group activities (on-campus students) or online discussion boards (flexible delivery students).

The coursework component of this course is outlined in this learning manual and may comprise textbook readings, journal readings, activities and assessment tasks.

The group work or online discussion board activities are intended to provide you with opportunities to practice, discuss and develop the skills required with your fellow students. While the purpose of these activities is to ensure your progress in developing relevant skills, these activities also contribute to your overall assessment grading for this module.

The following Term schedule is designed to assist you in planning your studies throughout the term. It also identifies the weeks in which particular assessment tasks are due. You should ensure that you are familiar with the schedule and the requirements of the module before commencing study. Should you require clarification on any of these matters, immediately contact your course educator.

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<thead>
<tr>
<th>Week</th>
<th>Content</th>
<th>Activities/Case studies</th>
<th>Assessment</th>
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| 1.   | Introduction  
• Overview of counselling theories  
• Nature versus nurture  
• Genetic inheritance | Activity: Nature vs Nurture  
| 2.   | Personality and development theory  
• Freudian theory  
• The unconscious  
• Ego, id and superego  
• Anxiety  
• Defence mechanisms | Activity: Accessing the unconscious  
Activity: Id, ego and superego | |
| 3.   | Personality and development theory  
• Freud’s stages of development  
• Erikson’s psychosocial stages  
• Piaget’s stages of cognitive development | Activity: The importance of early relationships  
Activity: Personal reflection | |
## Counselling Theories

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<th>4.</th>
<th>Personality and development theory</th>
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<td>Self-esteem</td>
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<td>Self-actualisation</td>
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Activity: Group work (on-campus students) or Online discussion board 1 (flexible delivery students) to be completed this week.

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<th>5.</th>
<th>Personality and development theory applied to counselling</th>
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<tr>
<td>5.1</td>
<td>Goals of counselling</td>
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<td>5.2</td>
<td>Personality theory applied to counselling</td>
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<td>5.4</td>
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Assessment 1 due: Short-answer question

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<th>Behaviourism</th>
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<td>6.1</td>
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<td>6.2</td>
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<td>Thorndike’s law of effect</td>
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</table>

Activity: Group work (on-campus students) or Online discussion board 2 (flexible delivery students) to be completed this week.

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<th>7.</th>
<th>Behaviourism</th>
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<td>7.1</td>
<td>Positive and negative reinforcement</td>
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<td>7.2</td>
<td>Schedule reinforcement</td>
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<td>7.4</td>
<td>Extinction of behaviours</td>
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<td>7.5</td>
<td>Behaviourism applied to counselling</td>
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Activity: Personal reflection

Assessment 2 due: Case study

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</tr>
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<td>8.3</td>
<td>Modelling as a technique in behavioural counselling</td>
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Activity: Thinking and behaviour
| 9. | Formulating a program for client change  
|    | - Identifying modelling influences within a client’s environment  
|    | - Identifying changes required to achieve client outcomes  
|    | - Setting goals  
|    | - Apply and record reinforcement to ensure client behaviour change  
|    | - Monitoring client change  
|    | Activity: Setting specific goals  

| 10. | The impact of the client’s environment  
|     | - The family environment  
|     | - Other environmental influences  
|     | Activity: Personal reflection  

| 11. | The impact of the client’s environment  
|     | - The impact of sibling birth order  
|     | - Functional and dysfunctional environments  
|     | Assessment 3 due: Case study |

| 12. | Module summary and reflection  
|     | - Review of personality and development theory in working with clients  
|     | - Review of behaviour and learning theory in working with clients  
|     | - Review of environmental issues when working with clients  
|     | Activity: Self-assessment  
|     | Assessment 4 due: Reflective report on group work activities (on-campus students OR Discussion board activities (flexible delivery students)) |
Elements and performance criteria

This module contains two units of competency: Unit CHCCSL504A Apply personality and development theories and Unit CHCCSL505A Apply learning theories in counselling. Following are the elements and performance criteria relevant to these units.

In order to meet the requirements of this unit, students must be able to demonstrate (by the conclusion of this module) the following knowledge and skills:

**CHCCSL504A Apply personality and development theories**

<table>
<thead>
<tr>
<th>Elements</th>
<th>Performance criteria</th>
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</thead>
<tbody>
<tr>
<td>Elements define the essential outcomes of a unit of competency.</td>
<td>Performance criteria specify the level of performance required to demonstrate achievement of the element. Terms in italics are elaborated in the Range Statement.</td>
</tr>
<tr>
<td>1. <strong>Apply theories of personality and human development in the counselling process</strong></td>
<td>1.1 Undertake case study/analysis drawing on a range of personality and human development theories, including: - Nature–nurture theory - Freudian concepts - Maslow’s hierarchy of needs - Piaget’s stages of cognitive development - Erikson’s psychosocial stages 1.2 Assist client to understand their personal history drawing on a range of theories, including: - Nature–nurture theory - Freudian concepts - Maslow’s hierarchy of needs - Piaget’s stages of cognitive development - Erikson’s psychosocial stages</td>
</tr>
<tr>
<td>2. <strong>Use concepts from theories of personality and human development to analyse and understand human behaviour</strong></td>
<td>2.1 Use concepts from personality and lifespan development theories to describe and analyse aspects of individual development 2.2 Analyse individual behaviour using theoretical concepts from a range of approaches to personality and lifespan development 2.3 Identify potential applications of personality and lifespan development theories in the counselling process 2.4 Identify strengths and weaknesses of each theory in relation to understanding human development and individual behaviour</td>
</tr>
</tbody>
</table>
## CHCCSL505A Apply learning theories in counselling

<table>
<thead>
<tr>
<th>Element</th>
<th>Performance criteria</th>
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<tbody>
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<td>1. Elements define the essential outcomes of a unit of competency.</td>
<td>The performance criteria specify the level of performance required to demonstrate achievement of the element. Terms in italics are elaborated in the Range Statement.</td>
</tr>
<tr>
<td>2. Apply behaviourism in counselling practice</td>
<td>1.1 Identify the contributions of stimulus and response theory to counselling practice</td>
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<td></td>
<td>1.2 Analyse and apply stimulus and response techniques in counselling practice</td>
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<td></td>
<td>1.3 Analyse and demonstrate application of principles of negative and positive reinforcement</td>
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<td></td>
<td>1.4 Explain the relationship between punishment and negative reinforcement</td>
</tr>
<tr>
<td></td>
<td>1.5 Apply positive and negative reinforcement in counselling practice</td>
</tr>
<tr>
<td>3. Analyse environmental modelling influences in counselling practice</td>
<td>2.1 Explain the impact of environmental modelling influences</td>
</tr>
<tr>
<td></td>
<td>2.2 Identify and analyse the impact of modelling influences within a client’s environment to facilitate client change</td>
</tr>
<tr>
<td>4. Analyse possible behavioural outcomes of different modelling and reinforcement influences</td>
<td>3.1 Analyse different reinforcement influences of siblings in relation to sequence of birth</td>
</tr>
<tr>
<td></td>
<td>3.2 Analyse individual responses to similar modelling/reinforcement</td>
</tr>
<tr>
<td></td>
<td>3.3 Analyse the effects of environmental differences and dysfunctional environments</td>
</tr>
<tr>
<td>5. Formulate a program for change in a counselling context</td>
<td>4.1 Identify change required to achieve identified outcomes and formulate and record a program for change</td>
</tr>
<tr>
<td></td>
<td>4.2 Apply and record the method of reinforcements to ensure behaviour change</td>
</tr>
<tr>
<td></td>
<td>4.3 Formulate a process for program monitoring, recording and intervention where appropriate</td>
</tr>
</tbody>
</table>
Counselling Theories

Week 1 – Introduction

Part of studying counselling is to learn about different theories, models or approaches that you can apply when dealing with a client’s issues. There are many different theories or approaches.

The purpose of this section is to give you a basic understanding of the different approaches. None of the approaches we discuss are simple in practice. The overview is not sufficient in detail to fully explain any one approach and we therefore recommend that you seek further study on one or several theories that you feel may be useful in helping your clients. Keep in mind that some counsellors study for up to ten years to fully comprehend the concepts and techniques of a particular approach.

Overview of counselling theories

It is a fact that we all have different backgrounds, different values and different needs, and we therefore deal with issues differently. It is also a fact that different counsellors have different strengths because of different personalities. For this reason counsellors need to look at each client’s case and ‘match’ their needs with the most effective approach or theory – one theory/approach/model will not be suitable to deal with every client you will come into contact with.

The following definitions will be useful throughout your studies.

**Approach:** an approach is where skills and knowledge are applied for expected outcomes. A specific approach, for example the Client Centred Approach, is a philosophy that helps the client to see the big picture. Approach means the same as model.

**Theory:** a theory is a set of ideas based on researched evidence and careful reasoning, which offers an explanation of how something functions or happens. It does not mean that these ideas are set in stone. An example of a theory is Piaget’s Stages of Cognitive Development.

**Therapy:** a therapy is the use of a special set of skills and knowledge to address the symptoms of physical, mental or social disorders. An example of a type of therapy is psychoanalysis.

**Strategy:** a strategy is a long-term plan of action based on the specific needs, support mechanisms and coping strategies of the client with the goal of improved outcomes.

**Technique:** a technique is a method used for a specific task to achieve a specified outcome. This word has been used in the same context as skill, for example communication skills.
As we discussed at the beginning of this course, counselling theories can be broadly divided into four main groups:

1. Behavioural Group
2. Psychoanalytical Group
3. Humanistic Group
4. Post Modern Group

We provided the following table to highlight the focus, associated theories and the key figures for each group.

**Table 1.1: Key counselling approaches**

<table>
<thead>
<tr>
<th>Approach</th>
<th>Major focus</th>
<th>Associated therapies</th>
<th>Key figures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavioural Group</strong></td>
<td>Identification and modification of problem behaviours</td>
<td>Behavioural Therapy, Multimodal Therapy, Cognitive Therapy, Cognitive Behaviour Therapy (CBT), Cognitive Behaviour Modification, Rational Emotive Behaviour Therapy (REBT)</td>
<td>BF Skinner, Albert Bandura, Arnold Lazarus, Albert Ellis, Aaron Beck, Donald Meichenbaum</td>
</tr>
<tr>
<td></td>
<td>Assertion training</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Self-management programs</td>
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<td></td>
</tr>
<tr>
<td><strong>Psychoanalytic Group</strong></td>
<td>Concentration on the unconscious mind and past experiences</td>
<td>Psychosocial Perspective of Erikson, Contemporary psychoanalysis or ego psychoanalysis, Jungian Theory, Object Relation Theory, Adlerian Therapy</td>
<td>Sigmund Freud, Erik Erikson, C. J. Jung, Margaret Mahler, Melanie Klein, Alfred Adler</td>
</tr>
<tr>
<td><strong>Humanistic Group</strong></td>
<td>Looking at the person in a holistic way</td>
<td>Person Centred Therapy, Existentialism, Gestalt, Reality Therapy</td>
<td>Carl Rogers, Viktor Frankl, Rollo May, Fritz Perls, William Glasser</td>
</tr>
</tbody>
</table>
Apart from the conventional approaches and theories, new ones are being developed all the time. The reason for the development of new approaches is that society is finding different or better ways to deal with issues. Another reason for the development of new approaches is that counsellors and psychologists are learning more about human behaviour and, as their understanding increases, they find better ways of dealing with issues.

In this module we will discuss behavioural and psychoanalytical approaches in greater depth and you will come to the understanding that as a counsellor you can choose the approach that will best deal with your client’s problems and your own personality.

**Nature versus nurture**

Counsellors and psychologists study human behaviour, or the entire range of ways that people conduct themselves. Counselling theories develop from this understanding of human behaviour. As well as understanding specific theories of counselling it is therefore important to be aware of factors that impact on human behaviour.

One of the most debated issues in the study of human behaviour is the question: “Is behaviour because of the genetic makeup of a person, or because of the person’s environmental influences?” In other words, is our behaviour determined by nature or nurture? Laura Berk (2008) summarises the difference:

By *nature*, we mean inborn biological givens – the hereditary information children receive from their parents at the moment of conception that signals the body to grow and affect all their characteristics and skills. By *nurture*, we mean the complex forces of the physical and social world that influence children’s biological makeup and psychological experiences before and after birth (p. 8)

Each counselling theory takes a stand on this question of whether we are genetically pre-programmed to develop and behave in the way that we do, or if environmental factors are more influential:
Although all theories grant at least some role to both nature and nurture, they vary in the emphasis placed on each. For example, consider the following questions: is the older child’s ability to think in more complex ways largely the result of an inborn timetable of growth, or is it primarily influenced by stimulation from parents and teachers? Do young children acquire language rapidly because they are genetically predisposed to do so, or because parents tutor them from an early age? And what accounts for the vast individual differences among children – in height, weight, physical coordination, intelligence, personality, and social skills? Is nature or nurture more responsible (Berk, 2008, p. 9)?

Genetic inheritance

The issue of nature versus nurture has been the focus of many studies on human behaviour and development. The outcome of these studies, broadly, is that there is a genetic component to our development and that this genetic inheritance is supported or discouraged to develop by environmental factors. These include factors such as:

- home environment, including parental involvement, level of stimulation, responsive parents
- social class
- family size and birth order
- racial and ethnic differences

The question of how strong those genetic factors are however and how influential environmental factors can be remains under debate. For example, consider the following case study of twins who were separated at birth.

Case study

Dorothy and Bridget

Dorothy and Bridget were separated just after their birth in 1945 and reunited in 1979. Their list of coincidences is a long one, and includes the following facts from their reunion:

- both used the same perfume
- both wore the same dresses at their weddings and carried the same flowers
- both had cats called Tiger
- both had meningitis
- both took piano lessons to the same grade and stopped after the same exam
- Dorothy called her son Richard Andrew and her daughter Catherine Louise; Bridget called her son Andrew Richard and her daughter Karen Louise – she originally decided on Catherine Louise but was persuaded against it (Warwick, 2000, pp. 60–61)
**Activity**

**Nature versus nurture**

Consider your own behaviour and development and answer the following questions:

- Do you consider that your genetic inheritance has played a significant role in your life, e.g. do you think that you have a natural talent for some things, or that your talent has been developed by outside factors, such as your parents?

- How influential have environmental factors been in your life? For example, do you think you might have developed differently if you had gone to a different school or had a different family?

**Reading**


This article discusses the concept of nature versus nurture based on the study of identical twins separated at birth.
Week 2 – Personality and development theory

Before we engage in a discussion of the contemporary methods of counselling, we first introduce Sigmund Freud’s psychoanalytic theory. By understanding the concepts introduced by Freud, you will appreciate more fully the development and modifications made to his approach by other founders of counselling approaches. What we describe is how his ideas are generally understood today.

Although most counsellors today do not use the classical approach developed by Freud, his theories are still influential and many modern approaches to counselling are based on Freud’s ideas.

Freudian theory

Sigmund Freud (1856–1939) was born in a small town in Austria, now a part of the Czech Republic, to Jewish parents and was the eldest of eight children. The family later moved to Vienna where Freud eventually studied medicine and developed his ideas on personality development.

Freud was fascinated with emotions and the thoughts that block them. He theorised that emotional blocks have something to do with trauma and psychological anguish. He argued that the only way to deal with blockages and pain is to push the event out of the way and defend against the pain. The ‘cure’ is to recover the original event and to fully experience the original emotions. In 1896, Freud coined the term psychoanalysis to describe his techniques and counselling methods.

Over the years, Freud’s work has brought out in people one of two strong reactions – they either feel very pro-Freud or very anti-Freud. It is generally acknowledged that, whether we agree or disagree with Freud’s ideas, his contribution to the field of psychology has been enormous (Archer & McCarthy, 2007; Corey, 2009; Sharf, 2008). Many of his ideas are still used today, and his theories are the foundation of all psychoanalysis and psychodynamic therapies practiced today, whether they agree with him or have challenged his ideas.

The unconscious

Freud’s theory of personality attributes thoughts and actions to unconscious motives and conflicts. According to him, we all have unacceptable thoughts, wishes, feelings and memories that we store in our unconscious mind. Freud’s theory that the unconscious is a powerful force in causing psychological difficulties and in understanding the human mind remains one of his most important legacies.
Freud believed that although the content of our unconscious mind is hidden, those suppressed memories and desires impact on us every day and make themselves felt through behaviours such as dreams, slips of the tongue, forgetting and, in some cases, psychological problems. One of the main aims of psychoanalysis is to help clients become aware of unconscious causes of their behaviour:

If one can become aware of why she feels and behaves in a certain way and how this is related to unconscious material, typically from her childhood, she has a good chance of eliminating the problem (Archer & McCarthy, 2007, p. 34).

One important implication of Freud’s theory of the unconscious is that it means that all human behaviour has a purpose and a motivation. This idea is known as psychic determinism, i.e. nothing occurs randomly, including our mental processes. There is a cause for every thought, memory, feeling and action. Every mental event is brought about by conscious or unconscious intention and preceding events.

Activity

Accessing the unconscious

Look at the inkblot below and answer the following questions:

• What does the inkblot make you think of?
• What emotions does it raise?

Now ask another person to look at the inkblot (a friend or colleague) and ask them to answer the same questions.

In the activity above, it is likely that you and the other person perceived the inkblot in different ways. Even though you may see it differently, there are no ‘wrong’ ways to see it. It is our difference in perception that Freud would argue illustrates the presence of unconscious material: since there is no obvious form to the inkblot, we must each project our own thoughts and feelings, and during this process unconscious material emerges (Archer & McCarthy, 2007).
Ego, id and superego

In order to better understand the relationship between the conscious and unconscious parts of our mind, or psyche, and to explain the dynamic forces that led to suppression of some experience into the unconscious, Freud developed a theory known as the structural model of the psyche. This model understands the mind as the interaction between three forces, each with their own agenda and priorities:

1. the id
2. the ego
3. the superego

Freud named these components to help describe the psychological processes that structure and maintain the function of our personality. However, it is important to understand that our personality acts as a whole, not as three discrete segments. Freud explains that we are energy systems with the dynamics of our personality consisting of the ways in which psychic energy is distributed to these three components. The amount of energy is limited; therefore if one system gains control over the available energy, it is at the expense of the other two systems.

The id is the name used to describe our innate biological drives. It is the original system of personality, laid down at birth, when we instinctively sought to satiate hunger and thirst and to avoid discomfort of any sort. The id is ruled by the pleasure principle, which aims to reduce tension and avoid pain. It does not reason nor think logically. It is purely biological. While the id knows what it wants and needs, it is not based on reality. Hence it may seek unsafe and unethical ways to be fulfilled, such as quenching thirst with large amounts of alcohol. Reckless and amoral actions, which gratify self, stem from the id component of our psyche.

The ego is the everyday mind in which we live. The ego develops from the id when infants become aware of their own identity. It acts as an intermediary between the id and the external world. It mediates between the id and reality through reasoning, evaluating and remembering information from the external world. According to Corey (2009), the ego “is ‘the executive’ that governs, controls and regulates the personality” (p.62).

According to Richard Sharf (2008), the ego thinks logically and makes plans for appropriate ways to satisfy needs and wants. It evaluates potential consequences of pleasure-seeking actions, sometimes delaying gratification until the means are safer or more appropriate. The ego operates on a reality principle. Its task is to ensure our health, safety and sanity.

To use the earlier example, the ego monitors the body’s signals and seeks to avoid dehydration. When it needs to quench thirst, it attempts to control the thirst by consuming safe and healthy beverages, limiting the intake of toxins in order to maintain good health.
The **superego** is the censor, or judge, over our activities and thoughts. The superego is responsible for our moral codes and standards of conduct. It defines what is ‘good’ and ‘bad’; it imposes rules and standards for self and others. These rules and standards are personalised and based on the integration of culture, family and society to guide our behaviour. The superego is formed when we internalise social and moral rules and standards as we develop, incorporating the attitudes, values and ideas of those with whom we have contact, especially our parents and primary caregivers.

The goal of psychodynamic counselling is to strengthen the ego so that it can be both independent of, and in touch with, the forces of the id and superego.

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**Activity**

**Id, ego and superego**

Think of something that you really enjoy doing that would be detrimental for you to do too often or as often as you really want to, such as eating sweets or watching soap operas, and answer the following questions:

1. What stops you from giving in to this aspect of your id and doing the activity excessively?
2. What logical plan does your ego have to allow you to enjoy the activity sometimes, but not to your detriment?
3. How is your superego involved in this process (e.g. perhaps you feel guilty when you indulge in the activity)?

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**Anxiety**

The concept of anxiety is an essential component of psychodynamic counselling. In this theory, anxiety develops out of a conflict between the id, superego and ego over control of the available psychic energy. It tends to be triggered by an increase in displeasure, especially when the body and mind are threatened or ignored.

Freud defines three types of anxiety:

- **Reality anxiety** - the ego fears real dangers in the external world
- **Neurotic anxiety** - the id becomes strong and threatens to overthrow the ego, unbalancing the psyche.
- **Moral anxiety** - the superego fears failure to live up to society’s standards. An example of moral anxiety is a feeling of guilt when we do something contrary to the social or moral code.
Situations that cause anxiety are:
- loss of a desired object, e.g. a child who is deprived of a parent or friend
- loss of love, e.g. rejection or failure to win back the love or approval of someone
- loss of identity, e.g. loss of faith or public ridicule
- loss of love for self, resulting in low self-confidence, guilt and/or self-hate

There are two ways of controlling anxiety:
- deal directly with the situation by resolving the problem, overcoming any obstacles and coming to terms with the situation
- defend against anxiety by either distorting or denying it

**Defense mechanisms**

Defense mechanisms are ways in which we defend ourselves against anxiety. While they serve a useful purpose and help us to function, overuse of defence mechanisms can lead to problems. The table below describes a number of common defence mechanisms with examples of how they might manifest in a client.

<table>
<thead>
<tr>
<th>Defense mechanism</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denial</td>
<td>A smoker concludes that the evidence linking cigarette use to health problems is scientifically worthless.</td>
</tr>
<tr>
<td>Projection</td>
<td>A woman who dislikes her boss thinks she likes her boss but feels that he doesn't like her.</td>
</tr>
<tr>
<td>Dissociation</td>
<td>A woman who was severely abused as a child develops distinctly different personalities (also known as Dissociative Identity Disorder, formerly multiple personality disorder).</td>
</tr>
<tr>
<td>Repression</td>
<td>A traumatised soldier has no recollection of the details of a close brush with death.</td>
</tr>
<tr>
<td>Displacement</td>
<td>After a parental scolding, a young girl takes her anger out on her little brother.</td>
</tr>
<tr>
<td>Sublimation</td>
<td>A young man who feels aggression channels his energy into football or boxing.</td>
</tr>
</tbody>
</table>
### Counselling Theories

<table>
<thead>
<tr>
<th>Regression</th>
<th>An adult has a temper tantrum when he doesn’t get his way.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reaction formation</td>
<td>A parent who unconsciously resents a child spoils the child with outlandish gifts.</td>
</tr>
<tr>
<td>Intellectualisation or isolation</td>
<td>A prisoner on death row awaiting execution resists appeals on his behalf and coldly insists that the letter of the law be followed.</td>
</tr>
<tr>
<td>Rationalisation</td>
<td>A student watches TV instead of studying, stating that “additional study wouldn’t do any good anyway”.</td>
</tr>
<tr>
<td>Identification</td>
<td>An insecure young man joins a fraternity to boost his self-esteem.</td>
</tr>
<tr>
<td>Overcompensation</td>
<td>A dangerously overweight woman goes on eating binges when she feels neglected by her husband.</td>
</tr>
</tbody>
</table>


The first three defense mechanisms listed above (denial, projection and dissociation) are known as primary defenses as they show no recognition of the separateness of the external world. They lead us to deny reality by ignoring or wishing away the real world (Archer & McCarthy, 2007). The remaining defence mechanisms are higher order ego defences that function more realistically with the outside world.
Week 3 – Personality and development theory

Freud’s psychoanalytic theory is simply the first of many perspectives for understanding the development of human personality. Theorists of this school of thought have developed a range of effective techniques for exploring, measuring and helping clients achieve positive and purposeful psychological growth and personality development. The ultimate goal of counselling is to help clients improve their awareness and effectiveness for gaining satisfaction from life.

In this section we discuss Freud’s theory of developmental stages, which make up his theory of personality development. We compare Freud’s developmental theory with that of Erik Erikson, another well-known psychodynamic theorist on personality development. We also introduce another theory of development, Piaget’s theory of cognitive development.

Freud’s stages of development

Freud believed that personality development, which includes the formation of the id, ego and superego, is dependent on the experiences of the child in the first five years of life. He based this theory of personality development on the idea of biological drives. In other words, Freud believed that as children we move through different stages of development at different ages, and at each stage we are preoccupied with different parts of our bodies. Historically, Freud was one of the first theorists to offer an understanding of the relationship between the mind and the body.

Freud believed that this sexual energy, or libido, develops throughout childhood via a number of different stages. At each stage the child experiences pleasure, or gratification, from a different part of their body. Each stage is given a name and a focus on how gratifications are sought.

1. The oral stage begins at birth when both needs and gratifications are generally focused on lips, tongue and, later, teeth.
2. The anal stage begins at ages 3 to 4 when gratification is learning how to control the anal sphincter and bladder.
3. The phallic stage begins as early as age 3 when gratification stems from a conscious focus on genitals and sexual differences, as children develop an awareness of a penis or lack thereof.
4. Latency, lasting from approximately age 6 to age 12, is a time when the libido is suppressed and the energy channelled into school, friends, sports, etc.
5. The genital stage, which onsets at puberty, is marked by biological and psychological gratifications.

The first two stages – the oral and anal – are related to the basic survival functions of life – the pleasure of nursing from the mother, and gaining control over excretory functions. The later stages – phallic, latent and genital – move away from survival instincts and the focus becomes more sexual.
The oral, anal and phallic stages are known as the **pre-genital period**. A major characteristic of this period is a narcissistic orientation, or an inward, self-centred preoccupation. During middle childhood years there is a turning outward to other relationships. Freud considered that neuroses are acquired only during this pre-genital period, even though symptoms of neurotic conflict may not appear until much later. This is due to early conflicts being repressed because the ego was not strong enough to cope.

The time span from the age of five to the onset of puberty is called the **latency period**. Normal sexuality makes no development. During this time, children’s attachment to their parents tends to turn towards other people at school, in sports and/or the neighbourhood.

This is also an appropriate and normal time for children to be curious about sexual matters. They ask their parents questions, have sexual fantasies, masturbate and play gender games with one another, such as the common doctor and nurse game.

Freud argued that these developmental stages are the cause of conflict between the child and their environment, particularly their parents and family (McLeod, 2009). He believed that an overly controlling response from a parent, or a response that is not controlling enough, significantly influences the child’s personality later in life. John McLeod (2009) explains this process:

> Little babies cry when they are hungry. If the mother feeds the baby immediately every time, or even feeds before demand has been made, the baby may learn, at a deep emotional level, that it does not need to do anything to be taken care of. It may grow up believing, deep down, that there exists a perfect world and it may become a person who finds it hard to accept the inevitable frustrations of the actual world. On the other hand, if the baby has to wait too long to be fed, it may learn that the world only meets its needs if it gets angry or verbally aggressive (p. 84).

Freud describes his developmental stages (which he called psychosexual stages) or shifts in terms of **gratifications**. If we do not progress normally from one stage to another (e.g. if we are overly gratified or frustrated), aspects of us can remain fixed at one stage. Freud named this state **fixation**, and argued that all of us have elements of fixation.

Each stage is given a name and a focus on how gratifications are sought, as outlined in the following table.
Table 3.1: Freud’s stages of development: gratifications and fixations

<table>
<thead>
<tr>
<th>Stage name</th>
<th>Age</th>
<th>Physical focus zone</th>
<th>Conflict issues</th>
<th>Potential problems in adulthood (fixations)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>Birth to 1 year</td>
<td>Mouth, lips, tongue</td>
<td>Weaning</td>
<td>Oral behaviour, such as smoking, overeating, passivity and gullibility</td>
</tr>
<tr>
<td>Anal</td>
<td>1–3 years</td>
<td>Anus</td>
<td>Toilet training</td>
<td>Orderliness, obstinacy or messiness, disorganisation</td>
</tr>
<tr>
<td>Phallic</td>
<td>3–6 years</td>
<td>Genital region</td>
<td>Resolving the Oedipus/Electra complex</td>
<td>Vanity, recklessness, sexual dysfunction or deviancy</td>
</tr>
<tr>
<td>Latency *</td>
<td>6–12 years</td>
<td>Repressed sexuality</td>
<td>Developing defence mechanisms, identifying with same-sex peers</td>
<td>None</td>
</tr>
<tr>
<td>Genital</td>
<td>Adolescence onwards</td>
<td>Sexual maturity throughout body</td>
<td>Achieving sexual intimacy</td>
<td>Adults who have successfully integrated earlier stages should emerge with sincere interest in others and mature sexuality</td>
</tr>
</tbody>
</table>

* Freud thought that the latency period is not really a psychosexual stage, because libido is not focused on the body during this period; therefore fixation is impossible.

The importance of early relationships

Freud suggests that our current relationships are related to our relationships with our parents. The following activity is a way to explore this possibility.

- Make a list of the people you have liked or loved in your life, excluding your parents. List men and women separately. List their desirable and undesirable personality traits.
- Reflect on whether the men and women share traits in common or not.
- Describe the traits of your parents as you were growing up.
- Do you notice any shared patterns between the qualities of your friends and parents?

Erikson’s psychosocial stages

Although Freud’s stages of development theory has been challenged by more recent psychoanalytic and psychodynamic theorists, the concept of developmental stages remains an important one in psychology today. Erikson (1902-1994) in particular, a post-Freudian psychodynamic therapist and theorist, expanded and developed Freud’s ideas on development. Erikson differed from Freud in that he opened up the idea of continued development in adulthood. He argued that “each stage of human development is characterised by a kind of struggle with two opposing outcomes, one leading to psychological health, and one problematic” (Archer & McCarthy, 2007, p. 39).

Erikson built on Freud’s ideas, extending his theory of personality development to stress psychosocial aspects of development. Erikson felt that many psychosocial aspects occur beyond early childhood and that psychosexual and psychosocial growth takes place together. Erikson argued that at each stage of life, we face the task of establishing equilibrium between our social world and ourselves.

Table 3.2 shows Erikson’s developmental stages. To help you understand the table, consider the following: for each stage, a person has to complete some developmental tasks. When these are achieved, they will have an optimal outcome. If they do not complete this stage, a psychological issue will present itself. For example, Stage 1 would read: “In the oral sensory stage, we look for attachment to our mother, which lays the foundation for later trust in others. When a person has fully completed this stage, they will have basic trust and optimism. If they do not complete this stage, they will mistrust others.”
### Table 3.2: Erikson’s developmental stages

<table>
<thead>
<tr>
<th>Stage</th>
<th>Name of stage</th>
<th>Developmental tasks</th>
<th>Optimal outcome</th>
<th>Psychological issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Oral-sensory (0–1 year)</td>
<td>Attachment to our mother, which lays the foundation for later trust in others</td>
<td>Basic trust and optimism</td>
<td>Trust vs mistrust</td>
</tr>
<tr>
<td>2.</td>
<td>Muscular-anal (2–3 years)</td>
<td>Gaining some basic control of ourself and our environment (e.g. toilet training and exploration)</td>
<td>Sense of control over oneself and environment</td>
<td>Autonomy vs shame, doubt</td>
</tr>
<tr>
<td>3.</td>
<td>Locomotor-genital (3–5 years)</td>
<td>Becoming purposeful and directive</td>
<td>Goal-directedness and purpose</td>
<td>Initiative vs guilt</td>
</tr>
<tr>
<td>4.</td>
<td>Latency (6–puberty)</td>
<td>Developing social, physical and school skills</td>
<td>Competence</td>
<td>Competence vs inferiority</td>
</tr>
<tr>
<td>5.</td>
<td>Adolescence</td>
<td>Making transition from childhood to adulthood and developing a sense of our own identity</td>
<td>Reintegration of past with present goals, fidelity</td>
<td>Identity vs role confusion</td>
</tr>
<tr>
<td>6.</td>
<td>Early adulthood</td>
<td>Establishing intimate bonds of love and friendship</td>
<td>Commitment, sharing, closeness and love</td>
<td>Intimacy vs isolation</td>
</tr>
<tr>
<td>7.</td>
<td>Middle adulthood</td>
<td>Fulfilling life goals that involve family, career and society; developing concerns that embrace future generations</td>
<td>Reproduction and concern with the world and future generations</td>
<td>Generativity vs self-absorption</td>
</tr>
</tbody>
</table>
Counselling Theories

8. Mature adult

<table>
<thead>
<tr>
<th></th>
<th>Looking back over one’s life and accepting its meaning</th>
<th>Perspective, satisfaction with one’s past life, wisdom</th>
<th>Integrity vs despair</th>
</tr>
</thead>
</table>


Activity

Personal reflection

Describe your own life to date in terms of each developmental stage as explained by Erikson’s model.

Piaget’s stages of cognitive development

Our understanding of the cognitive developments in childhood has been considerably enhanced through the efforts of Swiss psychologist Piaget (1896–1980). His theory of conceptual development is unique and one of the most comprehensive to date.

Piaget was interested in how knowledge develops in human beings. To answer this question, he studied children and their mental processes. To Piaget, the term *cognition* was synonymous with intelligence, and he considered cognition to be a biological process, just as biologists consider digestion to be a biological process. We might say that Piaget studied the ‘biology of thinking’.

For example, Piaget had observed that at different age levels we have different levels of comprehension and reasoning. A 3-year-old child, for example, has basic reasoning skills but can solve problems that escaped him or her at 2 years of age. Similarly, a 4-year-old may be able to deal with some concepts unsolved a year before yet be unable to keep pace with the thinking of a 7-year-old. All of this led Piaget to believe intellectual development proceeds in an orderly sequence characterised by specific growth stages. He theorised that these growth stages enable the child to develop certain concepts necessary for intellectual maturity.

Piaget proposed four stages of cognitive development, which are outlined in the following table.

<table>
<thead>
<tr>
<th>Approximate ages</th>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to 18 months</td>
<td>Sensorimotor</td>
<td>The baby understands the world through her senses and her motor actions; she begins to use simple symbols, such as single words and pretend play, near the end of this period.</td>
</tr>
<tr>
<td>18 months to 6 years</td>
<td>Preoperational</td>
<td>By age 2, the child can use symbols both to think and to communicate; he develops the abilities to take others’ points of view, classify objects and use simple logic by the end of this stage.</td>
</tr>
<tr>
<td>Age</td>
<td>Stage</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>6 to 12 years</td>
<td>Concrete operational</td>
<td>The child’s logic takes a great leap forward with the development of new internal operations, such as conversation and class inclusion, but is still tied to the known world; by the end of the period, he can reason about simple ‘what if’ questions.</td>
</tr>
<tr>
<td>12 years +</td>
<td>Formal operational</td>
<td>The child begins to manipulate ideas as well as objects; she thinks hypothetically and, by adulthood, can easily manage a variety of ‘what if’ questions; she greatly improves her ability to organise ideas and objects mentally.</td>
</tr>
</tbody>
</table>


Piaget’s explanation of this systematic process, the most important theme in all his writings, has provided fields such as psychology and education with a detailed and methodical analysis of cognitive development. In it, people, especially children, are viewed as developing organisms acquiring conceptual awareness as they pass through orderly and progressive stages.

In summation, we can see that Piaget, like Freud and Erikson, has a biological background that shows up in his explanation of cognitive development. He places heavy emphasis on genetics with his age-stage theory based on genetic inheritance. He is an interactionist however in that he highlights how the environment provides the catalyst for development. His theory places humans in an active (versus passive) role of learning.
Counselling Theories

Week 4 – Personality and development theory

To understand how clients change their behaviour it is important to understand what your client’s needs are – are they fulfilled? Is their goal to work towards fulfilment of certain needs? Or are there patterns that make your client unfulfilled and leave them dissatisfied?

Q. What is a need? Is it food and water, a career or a new car every three years?

A. The answer is that they are all needs, it’s just that some needs are more important or have a higher priority than other needs.

Don’t forget that your first group work or online discussion board activity is due to be undertaken this week.

Maslow’s hierarchy of needs

Abraham Maslow (1908–1970) proposed that human motives are organised into a hierarchy of needs, usually depicted as a triangle or pyramid (as in Diagram 1). He stated that once we have met the basic needs at the lower levels of the pyramid, we strive for further growth, with the ultimate aim of self-actualisation. The needs at the bottom of the triangle are the most basic and must be fulfilled for the person to seek the next level of needs, and so on up the triangle.

Diagram 1: Maslow’s hierarchy of needs

Physiological needs

Physiological needs are basic survival needs, such as air, food, water, sleep, shelter and warmth. We cannot continue to function without these basic human needs. This set of needs is physical and the impact of these needs not being met is manifested in the body, such as in the case of starvation or suffocation.

Safety and security needs

Once a person’s physiological needs are met, they become concerned with a new set of needs – safety and security. Examples of people aiming to satisfy these needs include opening a bank account, buying health insurance, or a desire for job security. Usually, if these needs are not met there will be an emotional rather than a physical response such as anxiety. As a counsellor, you may work with some clients who are predominantly concerned with fulfilling safety and security needs.

Love and belonging

Once basic survival and safety needs are met, we tend to become more focused on social needs, the third layer of Maslow’s hierarchy. The need for a feeling of belonging, through family, intimate relationships or friendship, is called the group need and usually remains dominant until it is satisfied. It can assume a most important place in communication at work and greatly influence your activities and the topics you like to talk about. Once this need is satisfied (you have a number of close friends, or you join a club), you will soon give priority to other goals.

Self-esteem

Being accepted as part of a group is good. Being recognised by the group as a popular or useful member is even better: withdrawal of such recognition is therefore a serious threat. Self-esteem needs are related to acceptance and recognition by others. People with low self-esteem often focus on their lack of recognition by others and are concerned with achieving respect. They might want to be famous, or be seen as special in some way. Maslow recognised that there is a danger involved in allowing others to influence your self-esteem and advocated that we learn to gain self-esteem from within, rather than through outside recognition.

Self-actualisation

At the highest level of needs, after all other needs have been satisfied, people are less concerned about material success and more about knowledge, justice and helping others rather than themselves. People at this level of motivation display a special interest in excellence, whether in art, architecture, styles of management, communication or cooking. The result is the form of individual behaviour that Maslow calls self-actualisation.
Maslow’s ladder of needs may be neither complete nor accurate, but it helps you to identify others’ priorities and to understand why it is hard to get and to create a good counselling relationship with a client unless they feel you are interested in helping them gain at least one of their current needs. As people’s needs change, they tend to change their level of interest in any particular activity. This affects every aspect of their communication.

Tuning into this on an everyday level, with friends, family or colleagues, can help you develop your awareness of the different needs different people have. The topics they were keen to talk about last week have no interest now. They may ignore instructions about extra workloads but tune in to rumours about pay rises. They may forget completely what you tell them yet remember every detail of a conversation with someone else. Tuning in to people helps you to work out what needs or goals will get top priority when you want to talk to them.

Group work or online discussion board activity

This activity is the first to be undertaken either with your assigned study group (on-campus students) or with your peers through the online discussion board (flexible delivery students).

For this activity you will need to reflect on Maslow’s hierarchy of needs and discuss the following questions:

• Which level of needs do you think you are currently most preoccupied with?
• Has this always been the case or can you identify a time when you were focused on a different level of needs?
• How might an understanding of the different needs help you work with clients?

If you are a student studying on-campus you will need to arrange to meet with your assigned study group to discuss your responses with the group. If you are studying through flexible delivery you will discuss your responses with your peers through the online discussion board which is to be completed this week.

This activity forms part of Assessment 4, the Reflective report, which is due in Week 12 of this module. The purpose of the Reflective report is to enable you to learn about differences in perspective, about your own values, biases and assumptions, and the impact of these on your interpretation of scenarios and your ability to help a diverse range of clients. It is suggested that you keep a journal or diary record of your discussions in order to remember them.
Week 5 – Personality and development theory applied to counselling

Each of the theories we have discussed in this module make particular assumptions about the way human beings develop. While different counsellors agree with different theories, the benefits of these theories when applied to counselling are that they help inform the counsellor and provide a framework for understanding some of the client’s issues and challenges.

As we discussed earlier in this module, Freud used his theories of personality and development to create a whole therapeutic approach to counselling, known as psychoanalysis, that forms the basis of modern-day psychodynamic counselling. In this section we discuss ways in which personality and development theory can be applied to counselling through the psychodynamic approach to counselling, as well as the strengths and weaknesses of personality and development theory.

Don’t forget that Assessment 1 ‘Short-answer question’ is due this week.

Goals of counselling

According to Allen Ivey, Mary Ivey, Michael D’Andrea and Lynn Simek-Morgan (2007), the task of psychodynamic counselling is to “help clients become more conscious of the ways in which past influences impact their present thinking” (p. 117). While the goals of counselling are identified in a collaborative process between the client and counsellor, the ultimate task of psychodynamic counselling is to help clients make the unconscious conscious, and in doing so a restructuring of some aspects of the client’s personality takes place (Corey & Corey, 2007). In working towards this goal, childhood experiences are recounted and connections are made with the client’s adult experiences and issues. Jeffrey Magnavita (2008) summarises:

The key goals of psychodynamic psychotherapy are to overcome developmental obstacles and personality patterns that interfere with the person’s ability to function at his or her highest level of adaptive capacity possible based on a realistic assessment of his or her inherent capacities (p. 219).

Personality theory applied to counselling

Freud’s concept of personality in terms of the unconscious processes of the id, ego and superego helps the counsellor to assess what part of the client’s personality structure is causing problems for them. They can then work with the client to strengthen their ego and manage the demands of the id and superego. Consider the example below:

Joe Id: I know I should be out there looking for a job, but it just seems too hard.

Counsellor: Well, what seems to get in your way?

Joe Id: Well, I just seem to sit in front of my television and eat most of the day. I’m really up on all the soaps.
Counsellor: Joe, have you always had a hard time getting things done?

Joe Id: Hey, get off my back. I don’t feel like looking for a job, ok, and you’re not going to make me!


In this example, Joe’s id is the part of his personality structure with most energy – he is not interested in taking on a job that might be hard work, but prefers instead to watch television and relax. This may be satisfying for Joe in the short term, as his pleasure-seeking id is dictating the focus of his energy, but will not be good for him in the long run. The counsellor asks Joe questions to help him connect his current problems to past experiences and would work with Joe to help him strengthen his ego to be more able to function in real life (Archer & McCarthy, 2007).

Consider the next example:

Margaret SuperEgo: I just get so nervous when my boyfriend starts to hint that he wants to have sex.

Counsellor: What’s going through your mind?

Margaret SuperEgo: I just keep thinking about all those years of my folks telling me how horrible it was to have sex before marriage.

Counsellor: So that makes you pretty anxious.

Margaret SuperEgo: Yes! I’m 22 and have been going with Jeff for two years now, and I feel like a prude. I’m just not sure what I want to do.


In this example, Margaret’s superego, the internalisation of external values and influences such as her parents’ values, is causing so much anxiety that she is struggling to know what her own values really are. The counsellor would not tell Margaret what to do in this situation but would focus on helping her identify her own values and the implications of whatever choice she finally does make (Archer & McCarthy, 2007).

As a comprehensive therapeutic approach, the psychodynamic approach consists of a range of techniques that the counsellor might use, such as:

- **Free association**: asking the client to say anything that comes to mind no matter how painful, silly, trivial, illogical or irrelevant it might seem. It is one of the key techniques used to open the doors to unconscious wishes, fantasies, conflicts and motivations. It usually leads to recollections of past events and the releasing of intense and blocked emotions. The release itself is not as crucial as the insight and the unlocking of unconscious, repressed materials.
• **Analysis of transference**: the counsellor assumes that the way the client behaves towards them in counselling will mirror the relationships they had in childhood with significant people in their lives, e.g. their father or mother. The counsellor will make interpretations about the counselling relations and help the client to recognise that they are repeating old patterns of behaviour.

Consider the following extract:

| Roy: | I don’t really think you can help me that much. This whole counselling thing seems like a big waste of time. |
| Counsellor: | So I guess you’re thinking about giving up on it. |
| Roy: | Well, I often leave here emotionally exhausted, and I’m just tired of all the effort that doesn’t seem to pay off. |
| Counsellor: | Remember when you told me about your Mom and how she did everything for you, even when you were old enough to do a lot of things yourself? |
| Roy: | Yeah, she was really overprotective. |
| Counsellor: | And when you did want to be independent you had a really hard time. |
| Roy: | Let’s not blame it on my Mom. |
| Counsellor: | Well, it might sound like that, but I would like you to consider how your wanting to quit therapy and being angry with me for not taking care of you may be similar to what happened between you and your Mom. |


• **Interpretation**: blocks and interruptions to the flow of free association serve as cues to the counsellor that some kind of anxiety-provoking material, known as resistance or defences, is present. After several instances or gaps occur, the counsellor may interpret what they think these gaps mean.

• **Challenging resistance**: resistance comes in many shapes and forms. Clients may fail to hear what is said, leave out a key part of a dream or arrive late. At the appropriate moment, the counsellor points out resistance and helps the client confront internal conflicts. The aim is to produce a free flow of material to help clients address their unconscious.

• **Dream analysis**: as another way of accessing unconscious material, the counsellor will ask clients to describe their dreams and the thoughts and feelings they associate with those dreams.

### Development theory applied to counselling

Psychodynamic counselling and associated counselling approaches also consider developmental issues in working with clients and will try to understand client’s problems in terms of developmental stages.
Consider the following case study:

Sherry is an attractive 15-year-old girl whose relationship with Robert has become the centre of her life. She gets by in school, but most of what goes on in the classroom bores her. Her relationship with her parents has been strained, partly because her mother does not want her to spend so much time with Robert. Robert, aged 16, is also struggling at school and juggling his part-time job, family responsibilities, and time with Sherry. And these two teenagers have a more serious problem: Sherry is pregnant. The sex ‘just happened’ one night after a party and continued thereafter. Neither Sherry nor Robert wanted a baby; neither used a contraceptive.


Depending on which counselling theory you adhere to, you will have a particular view of how to understand Sherry and Robert’s behaviour:

- **A Freudian** counsellor might see the situation in terms of unconscious processing – they would argue that the teenagers are acting out their biological drives (untamed in the id) and have not yet developed strong enough egos and/or superegos to contain those urges. They could also see the behaviour in terms of psychosexual stages. At 16 and 17 years old, they are in the genital stage of development and therefore having to manage the anxiety-provoking experience of becoming once again aware of their bodies and sexuality. The counsellor would work with them to help them strengthen their egos and identify any earlier challenging childhood experiences that have been re-awakened in the genital stage.

- A counsellor who agrees more with **Erikson’s** views on development would see the situation in terms of the unresolved issues from early childhood. They may be interested to know whether any problems with their caregiver or parents in the first year of infancy, for example, has led to a lack of trust which has manifested as fear of being abandoned. They may see sex as a way of preventing that abandonment. Alternatively, they may argue that Sherry and Robert, who are in Erikson’s adolescence stage of development, are searching for their identities and their behaviour is a signal that they are struggling to resolve that stage of their development.

- A counsellor who agrees with **Piaget**, on the other hand, will not see the situation in terms of personality conflicts, as Freud and Erikson might, but in terms of cognitive development. They would argue that the teenagers have not yet developed enough cognitively to be able to make appropriate and informed decisions on contraception and relationships. The fact that they are not doing well in school might confirm this for the counsellor, indicating that they are still cognitively immature.

- Keeping in mind **Maslow’s hierarchy of needs**, a counsellor would see the situation for Sherry and Robert in terms of needs and how those needs are being fulfilled or thwarted. They might argue that the teenagers are struggling to manage their needs of love and belonging and are trying various ways (such as sex) to meet that need. The counsellor might try to assist them to find more appropriate or safe ways to have those needs met.
Looking to the past, and to developmental problems, to assist clients with their current life difficulties, is a common theme in psychodynamic therapies (Leiper & Maltby, 2004). The role of therapy is to assist clients to free the developmental blockages or ‘stuckness’ (‘fixations’ in Freudian terms) and enable the process of normal development and maturation to occur or restart.

**Strengths and weaknesses of personality and development theory**

One of the main criticisms of Freud’s theory of personality and development is that there is limited hard evidence to support the theory and it is difficult to test. His psychosexual stages of development in particular have been called into question in recent times. Freud’s main contributions to counselling today are still influential however with the concept of the unconscious remaining important, as it was the first theory to bring attention to underlying motivations for human behaviour. The idea that we are significantly impacted by our childhood and family experiences is also an important concept that counsellors still pay attention to today.

Like Freud, Erikson and Piaget have also been criticised for their theories that all human beings go through the same development stages at the same times. Despite criticisms however these theories remain influential and help us to understand how nature (genetics) and nurture (environmental factors) interact to influence human development (Sigelman & Rider, 2006).


This reading explains how the key ideas and theories that we have discussed in the module so far are applied in counselling through psychoanalytic therapy.
Week 6 – Behaviourism

Behaviour is anything a person does – any action you can observe and record. Yelling, smiling, talking, playing sport and so on are examples of behaviours because we can observe them. We cannot observe a sensation, a feeling or a thought. Behaviour can also be described as how people respond to different situations.

Behaviourism is the theory that human behaviour can be understood by studying observable behaviour rather than by examining cognitive (thinking) and emotional processes. Behaviourists believe that nurture, not nature, is the most important factor in human development, and that environmental influences and experiences are more influential in our development than genetic inheritance.

Behaviour therapy is an approach to counselling based on the concepts of behaviourism. As the name suggests, it focuses on the client’s behaviour (rather than their emotions, for example, as might be the case in psychodynamic counselling). The counsellor will work with the client to identify unwanted behaviours and help the client to change them.

In this section we will look at how people learn and will discuss the fundamental theories of behaviourism.

Don't forget that the second group work activity or online discussion board is due this week.

Stimulus and response theory

Learning theorists suggest that experience leads to development. The repetitive nature of behaviour is founded on the individual gaining some desired outcome from that behaviour. However, in some cases an undesirable outcome is the result and the individual learns to decrease or eradicate that behaviour.

Behaviourists use the term stimulus to describe an external event that initiates behaviour. They use the term response for the behaviour itself. Thus, the stimulus-response (S-R) school is another term used for the early behaviourist school of psychology. Stimulus and response theory is the basis for conditioning theory, which suggests that we can be conditioned to respond in a particular way to external stimuli (learned association).

John B. Watson (1878–1958) was the first theorist to become interested in this aspect of learning and was the founder of behaviourism. His main belief related to the need to focus on what was observable rather than the unobservable areas of emotions and thoughts. It was Watson and his colleague, Rosalie Raynor, who developed the notion of learned association. These learned associations between external stimuli and the response of the individual form the basis of development. Adaptive associations result in ‘normal’ development while ‘abnormal’ development results from maladaptive associations.

This approach suggests that children are born without any inborn information or tendencies and only develop in response to how significant people treat them. This notion of the ‘blank slate’ or ‘tabular rasa’ comes from John Locke’s work and Watson built on this idea. Watson expanded the notion to the point that there was no mention of genetic influences on the individual.
Conditioning

**Classical conditioning** refers to the learning by association, which occurs when a neutral stimulus is capable of eliciting a certain involuntary response (Sigelman & Rider, 2006). In his classic experiment, Ivan Pavlov (1849–1936) found that a dog would salivate if meat powder was placed on its tongue. He discovered that if a bell sounded at the same time as meat powder was applied to a dog’s tongue, eventually the dog would salivate at the sound of the bell alone. This experimentation changed Pavlov’s focus from physiology to psychology.

Both Watson and Pavlov completed famous classical conditioning experiments. Pavlov worked with dogs and produced a salivation response to the sound of a bell. Watson and Raynor completed their experiment by inducing fear in a young child called Albert. Both of these are described in textbooks on psychological experiments. In the case of Albert, the baby was presented with a white rat and had no particular response. A loud noise was then made which elicited a fear response from the baby. The rat and the loud noise were then presented together and the fear response was elicited. Eventually, after several presentations of the rat and the noise, Albert responded with fear to the rat alone, without the accompanying noise.

The following example illustrates how the process of classical conditioning works.

Joe delights in talking about himself to anyone who will listen. He is likely to knock on your door any time of the day or evening and talk incessantly. After this has occurred a few times you develop a particular response to Joe. His mere knock causes feelings of aggravation and annoyance to surface in you (Avery & Barker, 1990, pp. 206-207).

The process is explained in tables 6.1 to 6.3.

**Table 6.1: Before Classical conditioning (preconditioning phase)**

| The neutral stimulus is Joe knocking on your door | ⇒ ⇒ ⇒ ⇒ ⇒ | Your initial response is your curiosity. |
| The unconditioned stimulus is Joe’s incessant talking. | ⇒ ⇒ ⇒ ⇒ ⇒ | Your unconditioned response (reflex) is a feeling of aggravation and annoyance. |

**Table 6.2: During Classical conditioning**

| The neutral stimulus (Joe knocking on your door) becomes associated with the unconditioned stimulus of Joe’s incessant talking. | ⇒ ⇒ ⇒ ⇒ ⇒ | The unconditioned response is your feeling of aggravation or annoyance. |
Table 6.3: After Classical conditioning (post-conditioning phase)

The **conditioned** stimulus is Joe’s knock.

In this example you began with no particular response to Joe knocking on your door. By the end of the conditioning process you are conditioned to become annoyed when you hear Joe knocking on your door because you now associate the knocking with his annoying chattering.

Classical conditioning can be reversed by:
- extinguishing or removing the second stimulus in order to break the association linkage
- counter-conditioning or replacing one conditioned response with a new, more beneficial conditioned response
- eliminating the response to the stimulus through **systematic desensitisation**. Classic treatments for phobias and other anxiety responses use the threshold method of stimulus response by presenting the stimulus at a minimal level initially so that the person doesn’t respond to it in the habitual manner. The stimulus is then presented at increasing intensities so that gradually the person continues not to respond.
- replacing the response with a new response that is incompatible with the existing conditioned response
- exhaustion or continual repetition of the stimulus until the individual is too tired to respond in the habitual way

**Thorndike’s law of effect**

Edward Thorndike developed a theory suggesting that the responses we make to stimuli or particular situations that are closely followed by satisfaction are more likely to be repeated. We learn that the response to the situation has led to a positive outcome for us and will therefore respond in the same way each time to maintain the positive outcome. Conversely, if the situation is followed by discomfort, we are less likely to behave in the same way each time we are faced with the same situation.

Thorndike developed his theory, known as **Thorndike’s law of effect**, by experimenting with cats and puzzle boxes. He found that cats learn to perform a task through a gradual trial-and-error process. Through the **reinforcement principle**, the cat tends to repeat those behaviours that bring about satisfaction and discard those which bring about annoyance and dissatisfaction.

Joseph Wolpe (1915–1997) developed Pavlov’s concept of conditioning to apply to counselling by theorising that counsellors could help clients learn new ways to respond in old situations. Consider the following extract from a counselling session with Arnie, a recent retiree who has come to counselling because he has been diagnosed with diabetes and wants to stop eating and drinking too much.
Counselling Theories

<table>
<thead>
<tr>
<th>Counsellor:</th>
<th>Arnie, tell me about the last time you had too much to eat or drink.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arnie:</td>
<td>Well, it happens just about every day. In the afternoon, I usually have a few beers, and then I start snacking on anything in sight until my wife comes home and fixes dinner.</td>
</tr>
<tr>
<td>Counsellor:</td>
<td>Do you think snacking is connected to having a few beers?</td>
</tr>
<tr>
<td>Arnie:</td>
<td>I suppose so. When I’m hanging around the house, I just seem to get the urge to go to the fridge and have a beer.</td>
</tr>
<tr>
<td>Counsellor:</td>
<td>So feeling bored seems to trigger your wanting a drink?</td>
</tr>
<tr>
<td>Arnie:</td>
<td>I don’t know exactly. I guess you could say that.</td>
</tr>
<tr>
<td>Counsellor:</td>
<td>And what does it feel like when you have a few beers and snacks?</td>
</tr>
<tr>
<td>Arnie:</td>
<td>Well, it feels good, but then I start to feel guilty.</td>
</tr>
</tbody>
</table>


In this example the counsellor is trying to understand the connections between the situation (stimulus) and Arnie’s behaviour. The counsellor will explore with Arnie what rewards he gets from his response to boredom (eating and drinking) and will help him to make new behaviour responses and build different associations to the best response to boredom.

Group work or online discussion board activity

This activity is the second to be undertaken either with your assigned study group (on-campus students) or with your peers through the online discussion board (flexible delivery students).

For this activity please identify some examples where classical conditioning has impacted your life. An example is the bell at school for breaks. Think about the bell as the neutral stimulus, your time eating and playing as the unconditioned stimulus leading to the unconditioned response of excitement, then after the conditioning phase, the bell can elicit feelings of comfort, fun and excitement (the conditioned response).

Discuss your experiences of conditioning with your study group.

If you are a student studying on-campus you will need to arrange to meet with your assigned study group to discuss your responses with the group. If you are studying through flexible delivery you will discuss your responses with your peers through the online discussion board which is to be completed this week.

This activity forms part of Assessment 4, the Reflective report, which is due in Week 12 of this module. The purpose of the Reflective report is to enable you to learn about differences in perspective, about your own values, biases and assumptions, and the impact of these on your interpretation of scenarios and ability to help a diverse range of clients. It is suggested that you keep a journal or diary record of your discussions in order to remember them.
Week 7 – Behaviourism

In the discussion in the previous section, we explained the impact of rewards on behaviour. However, psychologists prefer to use the term **reinforcements** instead of rewards.

Reinforcement is defined as occurring when “a consequence strengthens a response, or makes it more likely to reoccur” (Sigelman & Rider, 2006, p. 37). In other words, reinforcement is something that happens when we act, which makes it more likely that we will repeat that action. For example, returning a smile will be reinforcing if it increases the likelihood that the smile will be returned the next time.

In this section we explore the concept of reinforcement and the impact of different types of reinforcement on behaviour.

**Don’t forget that Assessment 2 ‘Case study’ is due this week.**

**Positive and negative reinforcement**

The famous psychologist B. F. Skinner (1904–1990) developed the concept of classical conditioning into a new theory called **operant conditioning**. The basic notion is that, like Thorndike's law of effect, the consequence of behaviour will increase or decrease the repetition of that behaviour. In other words, we are likely to keep repeating behaviours that have pleasant consequences and stop or cut back on behaviours that have unpleasant ones (Sigelman & Rider, 2006).

The consequences of our behaviours are known as reinforcers, and can be positive or negative.

**Positive reinforcement** happens when we have a pleasant consequence to behaviour and is likely to strengthen our behaviour, or encourage us to repeat it. An example of positive reinforcement can be seen in a child who helps tidy away his toys. If he receives hugs and praise for helping tidy up, he is likely to help again in order to again receive hugs and praise.

**Negative reinforcement** also encourages us to continue with behaviour, but for different reasons. Negative reinforcement happens when our response, or behaviour, means that we stop or avoid an unpleasant outcome. In the example of the child helping to tidy away his toys, negative reinforcement could be nagging from his parents. He will still tidy away his toys, but in this case to avoid or stop the nagging rather than to receive the hugs.
Schedule reinforcement

Schedule reinforcement is the rate or frequency of reinforcement of a particular behaviour. Psychologists and researchers have found that the most effective schedule for maintaining a behaviour is when the reinforcement comes randomly. That way, the person is likely to keep repeating the behaviour even if the reinforcement stops. A good example of this is gambling on slot machines. If the person wins sometimes (but not every time), they are likely to keep playing in the hope of eventually winning again (Archer & McCarthy, 2007).

Punishment

Reinforcement is something that follows a behaviour that causes it to be repeated. The other way behaviour change occurs is through punishment – anything that follows a behaviour that causes it to stop. Punishment may be something that adds to someone’s world, such as yelling, smacking, etc. Or it may take something away from the person’s world, such as having a favourite toy removed or being ‘grounded’ to remove social contact.

Positive punishment happens when an unpleasant stimulus is added after the behaviour. For example, a teenager who truants from school may experience positive punishment in the form of a ‘telling off’ from his parents.

Negative punishment occurs when something pleasant is taken away from the person after a particular behaviour. This leads to the person engaging less in the behaviour as it brings an undesirable consequence. Negative punishment may occur in that the truanting teenager is grounded and unable to attend a party that he was looking forward to, or is not allowed to watch TV for a period of time.

Many studies have been done on punishment and its effect on behaviour. Gayle Avery and Ellen Baker (1990) offer the following summary of these studies:

- Punishment can be effective when it is delivered close in time to the behaviour.
- Desired behaviour should be encouraged at the same time as the incorrect behaviour is suppressed by punishment.
- Watching other people being punished is an effective form of punishment.

The problems associated with punishment include:

- punishment tells a person what not to do; it does not tell the person what to do
- the effectiveness of particular punishments varies from one individual to another; it is not consistent
- punishment often has unpleasant side effects; it may produce anxiety or lead to resentment

Just as reinforcers encourage behaviours, punishments reduce the behaviour.
Case study

Sam comes into the TV room and sees his father talking and joking with his sister, Lulu, as the two watch a football game. Soon Sam begins to whine, louder and louder, that he wants them to turn off the TV so he can play Nintendo games. Sam’s father may choose to react in one of the following ways:

1. He might give into Sam’s whining and allow him to play Nintendo games.
2. He might stop talking and joking with Lulu and turn his attention to Sam.
3. He might call Sam a ‘baby’ and tell him to stop whining.
4. He might confiscate the Nintendo game.

In the case study of behaviour above, the first two reactions are reinforcement of the behaviour and are likely to make Sam continue to whine next time a similar situation occurs. In other words, Sam has gained what he wanted. The second two reactions are punishments that are likely to stop Sam whining in a similar situation next time. In other words, whining has not helped him get what he wanted. These options are described in the diagram 2 in terms of reinforcement and punishment theory.

Diagram 2: Possible consequences of whining behaviour

<table>
<thead>
<tr>
<th>Positive reinforcement: adding a pleasant stimulus</th>
<th>Positive punishment: adding an unpleasant stimulus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sam is allowed to play his game</td>
<td>Dad calls Sam ‘baby’</td>
</tr>
<tr>
<td><strong>Outcome</strong>: Sam is likely to whine again.</td>
<td><strong>Outcome</strong>: Sam doesn’t like being called a baby and is less likely to whine again.</td>
</tr>
<tr>
<td><strong>The behaviour is strengthened</strong></td>
<td><strong>The behaviour is weakened</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Negative reinforcement: withdrawing an unpleasant stimulus</th>
<th>Negative punishment: withdrawing a pleasant stimulus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dad turns his attention to Sam and stops talking to Lulu. Sam likes this outcome.</td>
<td>Sam’s game is confiscated</td>
</tr>
<tr>
<td><strong>Outcome</strong>: Sam is likely to whine again.</td>
<td><strong>Outcome</strong>: Sam is less likely to whine again.</td>
</tr>
<tr>
<td><strong>The behaviour is strengthened</strong></td>
<td><strong>The behaviour is weakened</strong></td>
</tr>
</tbody>
</table>

Extinction of behaviours

If reinforcement is removed, the conditioned response to a stimuli weakens and eventually disappears. The process, known as **extinction**, eliminates it. For example, if the child receives less and less praise and fewer hugs for helping tidy away his toys, until he no longer receives any recognition, he is likely to gradually stop helping.

Ignoring (not reinforcing) bad behaviours and reinforcing good behaviour is often seen as an alternative to punishment in working with children as a way to encourage them to become more well-behaved. The belief here is that behaviours that are ignored are less likely to recur as they are not reinforced in any way.

Stimulus control

Another way of changing behaviour is to take away the stimulus that had led to the behaviour. For example, a client who wants to lose weight may be advised not to keep any unhealthy foods in their kitchen. Taking away the fattening cakes and biscuits means that they are less available and therefore the client is less likely to be triggered by the stimulus (the cakes and biscuits) and eat them (the unwanted behaviour) (Archer & McCarthy, 2007).

Behaviourism applied to counselling

The theories of behaviour suggested by Watson, Skinner and other behaviourists have contributed significantly to counselling. Behavioural counsellors are interested primarily in their client’s behaviour and will help them to identify the causes of behaviours that they want to change and replace the behaviours with more appropriate and acceptable responses to stimuli. The counsellor and client will decide on a goal of counselling and the role of the counsellor is then to educate and guide the client about the causes and responses that elicit the undesirable behaviour.

The most direct behavioural technique is the provision of reinforcement and rewards for desired behaviour, in the same way that we learn as children. Based on the concept of operant conditioning, Ivey, Ivey and Simek-Morgan (2007) suggest that the use of reinforcement is of great benefit and power when working with clients. This is because all of us seek reinforcement and reward. The aim of reinforcement methods, positive and negative, is to modify behaviour by altering the consequences. Reinforcement increases desirable behaviours and decreases undesirable behaviours by reinforcing alternative behaviours. Thereby its use strengthens the probability of the response.

Reinforcement may be in the form of a smile, a head nod or simple attention and praise by others. Reward may be in the form of money, recognition and status. People who provide us with positive reinforcement and rewards tend to be included in our social network, whereas those who do not reward nor reinforce tend to be ignored or avoided.
In the behavioural approach to counselling, counsellors note that positive reinforcers maintain desirable behaviours. For example, in some schools, psychiatric hospitals and prison systems a system of tokens or rewards is used. Tokens are given for desired acts and they may be exchanged for other tangible items, such as food and privileges. Another example of reward and reinforcement is used in the treating of patients with eating disorders. When patients gain weight, their reward is release from hospital. If patients do not gain weight, they will remain in hospital, reinforcing the behaviour with negative consequences.

For positive reinforcement to succeed, the client must identify that the desired behaviour is associated with the reward. If there is a long delay in reinforcement, its effectiveness in changing behaviour is reduced.

Activity

Self-reflection

- Do you believe that counselling should focus on behaviour change?
- Do you think that by helping clients to change their behaviours, we can help them to be happier?
Week 8 – Behaviourism and the client’s environment

As we discussed in the previous sections, Watson and Skinner believed that we are shaped by our environment: our behaviour is a reaction to forces outside ourselves (external stimuli) and we therefore have little say in how we develop.

Albert Bandura (b. 1925), on the other hand, believes that it is a combination of the environment, internal thought processes and our behaviour that shapes us, not the environment alone. In this section we will discuss Bandura’s social cognitive theory and the significance of the environment on a client’s experience.

Bandura’s Social Cognitive Theory

Albert Bandura built on the work of operant conditioning, proposing yet another view of learning. While Bandura agrees with Skinner that operant conditioning is an important type of learning, he also suggests that humans learn differently from Skinner’s subjects – rats, pigeons and the like. Bandura suggests that there is also an active thinking process linking our behaviour and its consequences. He argues that this thinking process sets humans apart from other animals and creates a more active process for humans in their choice of behaviour. Bandura also suggests that humans are “more affected by what they believe will happen than by the consequences they actually encounter” (Sigelman & Rider, 2006, p. 39). Bandura’s theory on learning is known as Social Cognitive Theory (previously called social learning theory).

Activity

Thinking and behaviour

• Try to identify two or three situations in which you acted based on what you thought would happen rather than what actually happened (i.e. you changed your behaviour to suit the situation as you saw it).
• How did your thoughts about the situation before it happened impact on your action?
• How does that affect your thinking in similar situations now?

In sharp contrast to the notion of stable characteristics of personality, Bandura and other researchers suggest that people change as required. Their personalities are far more responsive to the environment than the psychometric or psychoanalytic models suggest. In fact, social learning theory moves from the intra-psychic (e.g. Freud’s concept of the id, ego and superego as unconscious, intra-psychic forces) to an interpersonal focus.

What social learning theorists suggest is that individuals act consistently when the environment is consistent. So individuals engage in consistent behaviour in similar environments and adapt their behaviour to the environment in other cases. Think about the person who may sing confidently in the shower yet would be unable to sing publicly. It is only the environment that has changed – not the person’s singing ability.
Social learning theorists align with the contextual theorists in agreeing that behaviour does not occur in a vacuum. Therefore to understand a person’s behaviour we need to put it in context.

The impact of environmental modelling influences

One of Bandura’s main contributions to learning theory is the notion of observational learning, i.e. “learning that results from observing the behaviour of other people (called models)” (Sigelman & Rider, 2006, p. 39). We use this process whenever we enter a new situation and we need to make sense of that environment and how we should behave within it.

An example of modelling might be seen in a person attending a new meeting at work. Initially they may sit back and watch what is occurring. Questions they may ask themselves as they observe include:

- Who is speaking?
- How do they get to speak? Do they ask for permission, do they talk in turn, do they follow a particular person?
- Who seems to be powerful within the room?
- Do people talk one at a time or are they competitive for the air space?

The person can then use the information acquired from watching the other people in the meeting (the models) to determine how they might act in the meeting themselves. This is an example of observational learning.

Bandura proved his theory, that we learn from observing others, and that we choose our responses based on those observations, in a classic experiment with a group of children. He arranged for different groups of children to watch a short film in which an adult attacked a doll (called ‘Bobo’), shouting at it, hitting it with hammers, etc. Some of the children then saw the adult being praised for his behaviour, some saw him being punished, and others did not see any consequences. In later play-time, Bandura noted that the children who saw the attack praised, or saw that it had no consequences, repeated it in play. The children who saw the behaviour being punished were less likely to act it out in play. When questioned, however, all the children remembered what had happened, proving that while they all learned the same things, some children made a choice not to copy the behaviour.

Bandura called this choice vicarious reinforcement: whether we repeat the behaviour of a model or not is based on the consequences we observed for the model when they engaged in the behaviour.
According to this view, children gradually become more selective in what they imitate. From watching others engage in self-praise and self-blame and through feedback about the worth of their own actions, children develop personal standards for behaviour and a sense of self-efficacy: beliefs about their own abilities and characteristics that guide responses in particular situations (Bandura, 2001). For example, imagine a parent who often remarks, “I’m glad I kept working on that task, even though it was hard”, who explains the value of persistence to her child, and who encourages him by saying, “I know you can do a good job on that homework!” As a result, the child starts to view himself as hard working and high achieving and, from the people available in the environment, selects models with these characteristics to copy.

Modelling as technique in behavioural counselling

Modelling is a simple way to help clients learn new behaviours. Behavioural counsellors find that clients can learn new ways of coping with difficulties when they observe and then model people engaging in successful coping behaviour.

For example, a client who has difficulty talking to women may set a goal in counselling of being able to ask a woman out on a date. In this case, the counsellor can use the concept of observational learning to help the client become more confident in starting conversations with women. The counsellor might suggest that the client think of a positive model for his goal, such as a friend or colleague who easily talks to women, and remember what he saw that person doing (Archer & McCarthy, 2007). A model similar to the observer in characteristics, such as age, gender, prestige, status and attitudes, is more likely to be effective and imitated later.

At a basic level, the counsellor can act as the model, teaching the client different behaviours, influencing attitudes and values, and teaching social skills. They do this by being open, honest and compassionate when self-disclosing and listening.

Modelling or behavioural rehearsal is a key ingredient in behavioural counselling. For example, Bandura found that live modelling of snake handling was effective in teaching people with snake phobia to cope with their anxieties. Three major ways modelling can be effective are listed below.

- It can help the client learn new skills or responses and the performance of them, e.g. learning language patterns, sports, social skills, coping skills – all new patterns of behaviour which can be integrated by watching a model or models.
- It can help with the inhibition of fear responses – seeing others react without fear to a similar situation can stop fear in the client or help them develop more positive responses.
- It can teach clients how to behave in different situations because models provide cues for others to emulate. Advertising is one form of this when we see that teenagers want to dress in the same way as their celebrity role-models (Sigelman & Rider, 2006).
Identifying modelling influences within a client’s environment

Observational learning is a critical aspect of social cognitive theory. As Robert Kail & John Cavanaugh (2000) point out, “people learn much by simply watching those around them, which is known as imitation or observational learning” (p. 19). However, this modelling of others’ behaviour does not occur all the time. We are more likely to copy or model behaviour that others have modelled for us if:

- the person we see is popular, smart or talented
- we see the behaviour being rewarded

Modelling can also be the source of problems that clients may have. A client who is having problems caused by violent behaviour, for example, may have seen a significant person in life use violence (e.g. his father or mother) and is now repeating the behaviour modelled by that person.

It is therefore useful for the counsellor to ask the client questions about the models that they have in their lives to understand how those models have impacted on the client's choice of behaviour.

Consider the case study below, first introduced in Section 5.

**Case study**

Sherry is an attractive 15-year-old girl whose relationship with Robert has become the centre of her life. She gets by in school, but most of what goes on in the classroom bores her. Her relationship with her parents has been strained, partly because her mother does not want her to spend so much time with Robert. Robert, aged 16, is also struggling at school and juggling his part-time job, family responsibilities and time with Sherry. And these two teenagers have a more serious problem: Sherry is pregnant. The sex ‘just happened’ one night after a party and continued thereafter. Neither Sherry nor Robert wanted a baby; neither used a contraceptive.


In the case of Sherry and Robert, a counsellor who takes a behavioural approach may say that the teenagers risked pregnancy because of the positive reinforcement of their behaviour: they enjoyed having sex. A counsellor working from a more cognitive perspective might see the situation in terms of modelling and ask what behaviour Sherry and Robert saw modelled in their environment that has led them to risk unprotected sex. Watching sex on TV, for example, may have contributed to their behaviour, as would having a sexually active older brother or sister or friends who engage in sexual activity. If they see their siblings or friends enjoying sex without negative consequences, they too are more likely to model the behaviour (Sigelman & Rider, 2006).

Bandura argues, therefore, that external stimuli in the environment do impact on our behaviour, but that it is the interaction between the environment and our thought processes that ultimately determines how we choose to act. This theory has influenced counselling in that most counsellors interested in behavioural theories will now use a combination of behaviour therapy and cognitive learning theory to help clients change.
Their behaviour and their thoughts will be examined to identify the origin of undesirable behaviours and replace them with more appropriate responses and thoughts.


This reading explains how the concepts of conditioning and other behavioural theories are applied in counselling.
Week 9 – Formulating a program for client change

In the behavioural approach to counselling, the counsellor is an expert on behaviour change and works with the client to modify or eliminate unwanted behaviours that the client identifies. In this approach the counsellor is very clear about how the process works and explains the concepts of behaviour change, such as negative and positive reinforcement, to the client. The counsellor does not focus on childhood experiences, as is common in psychodynamic counselling, but instead focuses on behaviour change.

In this section we will discuss the various techniques that behavioural counsellors use to assist clients to change behaviours.

Identify changes required to achieve client outcomes

An important step in any type of counselling is to set goals for counselling – outcomes that the client would like, that are realistic and achievable, and that both the client and counsellor agree on. This is particularly important in behavioural counselling where the goals set relate to specific behavioural changes that the client would like to achieve. Understanding the goal of counselling is therefore essential.

The counsellor's task is to pinpoint precise behaviours that contribute to, or are associated with, the client’s problem. In order to set goals and develop an appropriate treatment plan, the counsellor will meet with the client for an assessment interview. The counsellor will ask the client questions to understand the problems in as concrete terms as possible. The counsellor will ask the client about the following:

• What behaviour/lack of behaviour is a problem?
• How severe is the problem behaviour?
• What conditions trigger the behaviour?
• What thoughts and feelings are associated with the problem behaviour (or lack of behaviour)?
• What friends/partners/family are involved?
• What relationships does the client have with the others involved?

The actual questions asked by each counsellor varies. Essentially, they want to gather information in an empathic way. Questions on family, sexual life, education and occupation are likely. It is important they discover how, when, where and what. Note that behavioural counsellors rarely ask a client a why question.

Counsellors gather historical data only to the extent that it gives more information on the presenting problem. Information on the presenting problem may also include:

• medical information
• self-report questionnaires measuring overt behaviour
• discussion on client actions in situations which cause them anxiety
Counselling Theories

The counsellor may also ask the client to rate their experiences to help the counsellor understand more clearly the severity and frequency of the problem behaviours. This can also be done with friends, partners and family members to get an even clearer picture of the situation.

In the extract below, the counsellor is asking questions to get a clear picture of the exact behaviours that the client would like to change and the stimuli that are associated with the behaviour (in this case depression).

<table>
<thead>
<tr>
<th>Counsellor:</th>
<th>It sounds like you might be feeling depressed. Can you tell me how often you feel really down and how often it occurs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manny:</td>
<td>I feel this way quite a bit, almost all the time on weekends.</td>
</tr>
<tr>
<td>Counsellor:</td>
<td>How does feeling depressed like this affect you? Does it keep you from doing things you want to do?</td>
</tr>
<tr>
<td>Manny:</td>
<td>Yes, I'm not doing so well at work, and I tend to sleep a lot on weekends.</td>
</tr>
<tr>
<td>Counsellor:</td>
<td>How does it affect your work?</td>
</tr>
<tr>
<td>Manny:</td>
<td>I can’t seem to get very much done. My boss has been down on me lately.</td>
</tr>
<tr>
<td>Counsellor:</td>
<td>What kinds of things can’t you get done?</td>
</tr>
</tbody>
</table>


The counsellor is interested in Manny’s behaviours and will ask questions to assess more concretely what the behaviour entails. For example, when Manny comments that he feels ‘really down’ or depressed the counsellor asks more questions to clarify what exactly that means in concrete, behavioural terms. The counsellor is turning vague terms such as ‘feeling down’ into specific behaviours by asking questions like:

- Could you give a specific example?
- What do you mean when you say ‘all the time’?
- What happened specifically?

The counsellor will then try to help Manny understand how his behaviour is connected to external stimuli, e.g. by asking when he begins to feel depressed. They will then work together to set goals for counselling, e.g. in this case it may be to help Manny feel less depressed and avoid situations when he feels depressed. Some of the behavioural changes that may need to be taken for Manny could include recognition that:

- he is lonely and feels depressed when he is alone
- he has few interests and is bored with inactivity, leading to depression
- maybe he is having difficulty managing his staff at work and his poor work performance is causing his depression (Archer & McCarthy, 2007)

Conducting a full assessment of Manny’s experience and asking questions about his behaviour and associated triggers is the most effective way for the counsellor to assess the changes Manny needs to make.
Setting goals

Goals are of central importance in behavioural therapy. The general goal is to create new conditions for learning because learning can ameliorate problem behaviours.

The goals are formulated after the assessment process. The process of determining the goals is one of negotiation between the client and therapist. The result is a clear, concrete contract, understood by both parties. Goals are continually assessed throughout treatment in order to determine how well they are being achieved. If necessary, goals are altered throughout the process to better fit the client and their situation.

Goals serve three main functions:

• when clearly defined, they reflect specific areas which are a problem to the client, hence providing meaning and direction for counselling
• they provide a basis for selecting and using particular counselling strategies
• they provide a framework for evaluating the outcome

Selecting and defining goals involves:

• the counsellor explaining the purpose of goals
• the client specifying the positive changes desired
• the client and counsellor determining whether the stated goals are changes ‘owned’ by the client
• the client and counsellor exploring together whether the goals are realistic
• the client and counsellor discussing the advantages and disadvantages of the goals (Corey, 2009)

On the basis of the information obtained, the counsellor and client make one of the following decisions:

• to continue therapy
• to reconsider the client’s goals
• to seek a referral
Activity

Setting specific goals

The formulation of concrete and specific goals is important for behaviour therapy. Many people have vague and generalised goals and so the task of the counsellor is to help clients formulate clear, concrete goals. This activity is designed to give you practice in that task. Create specific and concrete goals using the four broad goals below. An example is offered.

Example:

**Broad goal:** I want to be happier, know who I really am.

**Specific goal:** I want to identify what I want and to have the courage to get it. I want to feel that I am doing what I really want to be doing.

1. **Broad goal:** I need to get in touch with my values and my philosophy of life.
   **Specific goal:**

2. **Broad goal:** I want to be an autonomous and assertive individual, no matter how hard I find it.
   **Specific goal:**

3. **Broad goal:** I have so many worries and fears that keep me uptight. I want to get rid of these.
   **Specific goal:**

4. **Broad goal:** I want to settle down and stop running from relationships.
   **Specific goal:**

Apply and record reinforcement to ensure client behaviour change

Asking clients to undertake homework is a common technique in behavioural counselling. This often includes asking the client to make a chart or keep a record of their behaviours and some information relating to them. For example, a client who has a problem with overeating behaviour might be asked to record each time they eat unhealthy food. To gain even more information, the counsellor might also ask them to write down their feelings and thoughts each time they eat unhealthy food – what they were feeling and thinking just before they ate and what they felt or thought during and after the behaviour. This can then help the counsellor to understand the stimuli and reinforcement for the behaviour.

Monitoring client change

Monitoring client change is essential in behavioural counselling to assess the effectiveness of counselling. Some behavioural counsellors ask clients to complete a diary so that specific behaviours can be monitored. This is something clients do on their own.

In table 9.1, a client is monitoring their behaviour associated with the fear of public speaking.
Table 9.1: An example of a self-monitoring sheet from a client diary

<table>
<thead>
<tr>
<th>Stimulus</th>
<th>Response</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.30pm Required to give a brief presentation to 15 colleagues concerning a sales project. The colleagues are seated around a conference table and I am standing at one end.</td>
<td>Feeling anxious. Speaking too quickly and failing to make eye contact with the audience. Managing to make all main points but stumbling and unclear at the end when answering their questions.</td>
<td>Audience is moderately interested. Questions show they listened. Boss congratulatory on performance. I feel relieved when it is over. I feel I am improving.</td>
</tr>
</tbody>
</table>

This helps to measure each of the behaviours identified with the problem. The counsellor then sets up a strategy for assessing the frequency of the problem. This becomes the baseline and evaluation point for determining later whether interventions are effective.

In some instances, counsellors simulate the event beforehand in role plays conducted in the safety of the counselling context. Clients enact pieces of behaviour, playing various roles, e.g. speaker, boss and audience.

Sometimes observations and measurements are made in natural settings with significant people who interact with the client on a daily basis. For instance, in the case of children, teachers or parents may be observed interacting with the child. In the case of a married client, their partner may become an observer.

The counsellor will also identify people, activities and things that can help to reinforce the new behavioural patterns, thus helping to maintain the changes after counselling ends.
Week 10 – The impact of the client’s environment

The behavioural approaches mentioned so far have something in common: none of the theorists agree with the concept of universal human stages of development that developmental theorists like Freud, Erikson and Piaget suggested. Development for all individuals is context-specific and this is largely influenced by culture. To test this theory you can consider the difference between a 5-year-old child in London and a 5-year-old in the Kalahari Desert. The type of information learned in these two environments is drastically different and the development of different types of learning is based on the cultural expectations found in each environment.

In this section and in Section 11 we will discuss the importance of environmental influences on client behaviour.

Don’t forget that the third group work activity or online discussion board is due this week.

The family environment

For counsellors who place importance on the environment as significant in understanding development, the family we grew up with is an important starting point.

The beginning of a family is the formation of the couple. This consists variously of a man and a woman, a man and a man, or a woman and a woman, and may be legally sanctioned or not through a marriage process. The traditional concept of a family, which consists of a married couple or equivalent and at least one child, is known as the nuclear family. The nuclear family is a less common type of family today, as more complex family structures become more common. This change in family structure may happen for a number of reasons, including:

- the number of children increases
- the household becomes extended – through additional family members or friends
- relationship breakdown occurs
- adults re-partner
- children from different original relationships are blended together on a constant or intermittent basis

Carol Sigelman and Elizabeth Rider (2006) identify the following trends that have led to changes in families:

- more single adults
- postponed marriage
- fewer children
- more women working [in paid employment]
- more divorce
- more single-parent families
Rather than seeing the family in one particular way, recent research into family structures conceptualise the family as a **system**. A family system is:

a whole consisting of interrelated parts, each of which affects and is affected by every other part, and each of which contributes to the functioning of the whole (Sigelman & Rider, 2006, p. 422).

The influence of the family on development and the ability to form functional relationships in later life is considered to be an important one by many psychologists and counsellors. Helen Bee and Denise Boyd (2002) state that:

Despite changing views concerning the various influences on early childhood development, psychologists agree that family relationships constitute one of the most, if not the most, influential factors on early childhood development (p. 184).

One model of understanding the importance of the family in the development of a child (and later the behaviour of the adult), developed by Kim Bartholomew, Antonio Henderson and Donald Dutton (2001), is to look at the quality of the relationships between the parents, and the child and parents. This is based on two factors:

1. **model of self** – positive or negative
2. **model of other** – positive or negative

<table>
<thead>
<tr>
<th>Positive model of other</th>
<th>Negative model of self</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure</td>
<td>Preoccupied</td>
</tr>
<tr>
<td>Comfortable with intimacy and autonomy in close relationships</td>
<td>Preoccupied with close relationships</td>
</tr>
<tr>
<td>Overly dependent on others for self-esteem and support</td>
<td></td>
</tr>
<tr>
<td>Dismissing</td>
<td>Fearful</td>
</tr>
<tr>
<td>Downplays importance of close relationships</td>
<td>Fearful of intimacy due to fear of rejection</td>
</tr>
<tr>
<td>Compulsive self-reliance</td>
<td>Socially avoidant</td>
</tr>
</tbody>
</table>

This theory suggests that secure and consistent care giving from an early age leads to positive image of self and others (secure attachment). Thus, secure individuals are comfortable with autonomy and intimacy and can rely on others as support when needed. They generally have high self-esteem and an ability to establish and maintain close intimate bonds without losing their sense of self. They expect significant others in their lives to be supportive and are likely to form intimate partnerships in which both partners act as safe havens and secure bases for each other.

The experience of inconsistent and insensitive care giving, on the other hand, leads to preoccupied attachment. This is where the individual has a positive model of others and a negative model of self. They have concluded, based on their experience as children, that they are to blame for lack of love from the care giver (e.g. mother or father). This results in an overly dependent style characterised by intense feelings of unworthiness and an excessive need for others’ approval.

Their attempts to get attachment needs fulfilled lead to a demanding and intrusive interpersonal style. They might typically say: “I scare away partners, I want to be so close all the time and they get nervous”. This is because they question the availability of attachment figures and do not expect responsiveness. When they feel unresponsiveness they experience high levels of anxiety which lead to high demands that are unlikely to be met. This cycle continues and reinforces itself over time.

Dismissing and fearful attachment styles are characterised by avoidance of close contact with others. Individuals who have either of these styles of relating usually have a history of rejecting or unsupportive attachment figures and this leads to avoidance of relying on others for support.

Individuals with a fearful attachment style believe they are unlovable and that others are uncaring and unavailable. They desire acceptance by others, are hypersensitive to social approval, and avoid intimacy due to the fear or expectation of rejection. They might typically say: “I am incapable of expressing my feelings because I am afraid I’ll say something that will ruin the relationship”.

Individuals with a fearful attachment style do not expect others to be responsive, giving rise to fear and anxiety. They are inhibited in expressing their anxiety and asking for support. Instead they deal with anxiety by maintaining a comfortable distance within their relationships. From this distance, they can anticipate rejection while gaining some indirect support without alienating their attachment figure.

Individuals with a dismissing attachment style maintain a positive self-image by distancing from attachment figures and relationships. They are likely to be self-reliant, have high emotional control, and downplay the importance of intimate relationships. They become relatively invulnerable to the potential rejection of others. They have learned to defend themselves from disappointment by avoiding relationships.
Personal reflection

Think back to your own childhood and jot down a brief description of the first ten memories that come to mind.

- How many of these early memories relate to your family?
- How important do you think your family was in making you who you are today?

Of course other factors also impact on children’s development, but none equal the influence of the family. The family introduces children to the physical world through the opportunities it provides for play and exploration of objects. It also creates unique bonds between people. The attachments children form with parents and siblings usually last a lifetime and they serve as models for relationships in the wider world of neighbourhood and school. Within the family, children experience their first social conflicts. Discipline by parents and arguments with siblings provide important lessons in compliance and cooperation and opportunities to learn how to influence the behaviour of others. Finally, within the family, children learn the language, skills and social and moral values of their culture.

Other environmental influences

While the family is an important source of knowledge for children about relationships and ways to behave (which can result in functional or dysfunctional behaviours), it is also important to note that children and young people spend a significant amount of time outside the family environment, in school, engaging in social activities, and interacting with teachers and peers. These environmental influences can also impact on their development and behaviour.

School

During early school years, children need stimulating activities and appropriate models from which to learn behaviour. An uninspiring or negative school environment can lead to behavioural problems. Consider the example of Michaela in the following case study.
Case study

Michaela Curtis is laughing, playing and happy. The seven year old, who is currently in Year 3, can be found running around the playground, chatting animatedly with her friends and actively being at school. But two years ago, her life was very different. She used to regularly wet the bed and bite her nails and was often anxious, angry and stressed.

Her father, Chris Curtis, says that when she joined Haberfield Public School’s gifted and talented (GAT) unit at the beginning of last year her life turned around. “The transformation was almost immediate,” says Chris. “The bedwetting stopped, she no longer bit her nails and she wasn’t ridden with guilt. In her previous environment (at a private school), she felt like she was different. Michaela was angry and hostile because she wasn’t getting the stimulation she needed and she felt stigmatised, that there was something wrong with her.”


Adolescent peer groups

As children move into adolescence, they become more influenced by their peers than by their parents as they experiment with new types of relationships, with more autonomy and a developing sense of self. Even though adolescents do not usually say that they are influenced by their peers, e.g. as a reason for taking drugs, peer group influence is strong.

They are aware that they want to fit in with their group but they do not necessarily perceive that they are under pressure to do so.
Group work or online discussion board activity

This activity is to be undertaken either with your assigned study group (on-campus students) or with your peers through the online discussion board (flexible delivery students).


Discuss with the group whether you believe that too much scheduled activity can impact on a child’s development. Use the behavioural and environmental theory you have been learning about to support your responses.

If you are a student studying on-campus you will need to arrange to meet with your assigned study group to discuss your responses with the group and skills practice session what you might say to the client when ending. If you are studying through flexible delivery you will discuss your responses with your peers through the online discussion board which is to be completed this week.

This activity forms part of Assessment 4, the Reflective report, which is due in Week 12 of this module. The purpose of the Reflective report is to enable you to learn about differences in perspective, about your own values, biases and assumptions, and the impact of these on your interpretation of scenarios and ability to help a diverse range of clients. It is suggested that you keep a journal or diary record of your discussions in order to remember them.
Week 11 – The impact of the client’s environment

As we discussed in section 10, the family environment is an important aspect of childhood development and as adults we often behave in the same way as we did as babies and children in our relationships with our parents.

In this section we will discuss the impact of other aspects of family life, including the impact of birth order and the roles that we take in family life. We will address the problem of dysfunctional family systems impacting on children and their later behaviour as adults.

Don’t forget that Assessment 3 ‘Case study’ is due this week.

The impact of sibling birth order

Some approaches to counselling give special importance to the relationships between siblings and the position each one has in the family. Some examples of the impact that birth order can have on development are described below.

- The oldest child
  The oldest child generally receives much attention. They tend to be dependable and hard working. However, when a new sibling arrives, they find themselves ousted from the favoured position and this brings up feelings of jealousy.

- The second child
  Right from the beginning, the second child has to share attention with the oldest child. The typical second child behaves as if they are in a race and are generally under full steam all the time, trying in some way to surpass the eldest brother or sister. This sense of competitiveness influences the later course of their lives. The younger child develops a knack for finding out the elder’s weaknesses and to get praise from others where the older sibling has failed. If one child is talented in one area, the other child strives for recognition by developing other abilities.

- The middle child
  The middle child often feels squeezed out. They feel life is unfair, that they are cheated. Often a ‘poor me’ attitude develops and they can become a problem child.

- The youngest child
  The youngest child is always the ‘baby’ and tends to be the pampered one. They have to develop strong characteristics of their own or it is likely that others will shape their life. They tend to go their own way and develop in ways different from the rest of the family.
• The only child

The ‘only’ child has some of the characteristics of the oldest child but does not learn to share or cooperate with other children, although they do learn to deal with adults. Often pampered by the mother, they may become dependent on her. They tend to want centre stage. The problem in later life comes when they no longer have this centre position.

One’s position in the family creates a particular pattern of interacting that carries over into adult relationships. It is not necessarily the birth order that is most important but the individual’s interpretation of their place within the family.

Functional and dysfunctional family environments

The family environment has been described as the “soil out of which individuals can become mature human beings” (Bradshaw, 1988, p. 42). Ideally, the soil – the family environment – is a healthy one, functioning well and in which all members of the family are supported and valued. When a family is functioning well, some of the key elements of their behaviour include:

• an ability to recuperate from adverse situations
• flexibility
• collaboration
• ability to adapt to external influences
• a sense of purpose
• an organised structure according to a generational hierarchy
• ability to communicate clear expectations about roles and relationships to each other (Goldenberg & Goldenberg, 2002)

It is essential to recognise that healthy families are not free of problems; however, they have developed resilience which helps them survive and regenerate, even when stress, misfortune and hardships occur. A resilient family has the strengths and resources to self-repair from serious life-transitioning events. In this type of healthy family environment, all family members have the use of human powers to cooperate, individuate and meet their collective and individual needs.

Parents who each have their own individual identities (rather than being ‘fused’ or too dependent on each other) and who have the ability to love and accept their children are likely to create a functional family environment for children to develop and grow into emotionally healthy and mature adults. They allow their children freedom to:

• experience what is here and now in their lives rather than being drawn into past problems or future ‘shoulds’
• think for themselves rather than what others tell them they should think
• recognise their own feelings and experience them rather than feeling what others tell them they should feel
• have wants and choices in what they want, rather than what others tell them they should want
feel what they feel rather than what they ‘should’ feel
want (desire) and to choose what they want, rather than what they should want
(Bradshaw, 1988)

In order to achieve this, all families need to have rules and roles for each family member.

Functional roles

Functional roles are a collection of behaviours. **Primary functional roles** for adults are parent and partner. In traditional family roles, one partner is a worker, earning the family sustenance, while the other partner is the homemaker and caretaker of the children. Children may also have functional roles, such as keeping their bedrooms clean and feeding family pets.

**Secondary functional roles** are more task-specific and related to family goals. Secondary roles may include the disciplinarian, chauffeur, cook, dishwasher, gardener, mechanic, etc. The family goals help prescribe or determine roles that are required to attain them. An example of how goals determine secondary functional roles in a family situation is illustrated in a family camping trip. In order to go on the trip, the family decides that the lawn has to be mown, groceries need to be purchased and some meals prepared for the trip. The car also needs to be mechanically checked and filled with petrol for travelling. Someone needs to organise the camping gear and someone needs to make sure that everyone performed their role. If all family members perform their roles, the family functions well and the camping trip starts off well (the family needs or goals are met).

The illustration of the family camping trip is ideally how families function on a daily basis. However, if one or more family members fail to perform their functional roles or perform them poorly, family struggles and anxieties arise. It can also mean that another member of the family compensates for a poorly performed role by another family member. In other words, they pick up that role so that the family functions. This may not always be appropriate and may create more stress, e.g. when a child picks up a parental function such as preparing the family meals.

If the equilibrium is not restored and anxieties continue to escalate, the family system can become dysfunctional.

Systemic roles

Systemic roles are similar to functional roles but family members unconsciously assign them from birth. Commonly used names for these roles include:

- caretaker
- family hero
- scapegoat
- mascot
- lost child
The roles children play in dysfunctional families are their roles for coping and may be repeated in their adult lives when a similar situation occurs. Some people tend to continue their childhood roles into adulthood and will continue to play their family role, even if it no longer suits them or fails to provide them with meaning and happiness.
Week 12 – Module summary and reflection

Theory helps counsellors develop attitudes or behaviours that assist them to remain clear and focused about the process, develop an effective working relationship with their clients, and remain optimistic about the effectiveness of counselling. Working within a counselling method also has the effect of reducing anxiety about ‘what to do’ for beginning therapists (Hansen 2002).

McLeod (2009) identifies reasons that we should continue to study theories and specific methods of counselling:

- it offers the counsellor a framework for practice – structure in the face of often confusing and complex client problems
- it offers clients a new way of understanding their own problems
- it contributes to research into counselling and new ways of working with people

Studying counselling methods is therefore essential for a counsellor. When considering the different perspectives discussed in this module, it is important to reflect on the following:

- Which of the theories appeals to you most and why?
- Which theory fits most with your own ideas about the client/counsellor relationship?
- Which theory appeals to you most in its philosophy about human nature and how we change?

Don’t forget that Assessment 4 ‘Reflective report on group work activities (on-campus students OR Discussion board activities (flexible delivery students)’ is due this week.

Review of personality and development theory in working with clients

Personality and development theory has developed from various approaches to understanding how human beings develop. Key theorists in this tradition include Freud, Erikson and Piaget. These theories of personality and development are the basis for the psychodynamic approach to counselling, which places major focus on unconscious processes (e.g. the interaction between the id, ego and superego) and developmental stages, assuming that we all go through the same stages at the same approximate ages.

Freud argued that unconscious impulses and unresolved conflicts at various stages of human development, especially in childhood, are responsible for psychological disorders and difficulties in adulthood. Through a process of self-discovery – by investigating our own psyche (mind) and discovering our deepest emotions and thoughts – Freud believed we could live a fuller life.
The aim of psychodynamic counselling is to resolve internal conflicts that affect adult behaviour. The counsellor asks questions and listens carefully to the client’s dialogue. The client is encouraged to engage in free association. While listening, the counsellor considers the behaviours, attitudes and deeper thoughts that may be contributing to any inner conflicts, often known as intra-psychic conflicts.

General patterns in the client’s experience are often revealed as counselling progresses. The counsellor uses interpretation as a method for understanding the meaning underlying the client’s emotions and behaviours. The counsellor shares this insight with the client.

Before the client’s intra-psychic conflicts can be resolved, they need to acknowledge the deeper problems behind their current complaint. One way of doing this is by dealing with transference material and by loosening any defences that bury emotions and fears. Gradually, defences are lowered as realisation emerges. This insight explains how the past influences present behaviour.

Psychodynamic counselling is based on the following broad set of constructs:

- The client’s development history is important and therefore needs to be considered for full understanding of the client.
- The key people who have been involved in the client’s development are important. It is important in psychodynamic work to help the client become more aware of their relationship history and patterns and how that may be impacting on them today.
- People are unconscious or unaware of the impact that their biological needs, past object relations, and cultural determinants have on their present behaviour.
- In daily life people act out their unconscious biological drives and their past developmental history (Ivey, Ivey & Simek-Morgan, 2007)

Not all clients are considered suitable for psychodynamic counselling. Michael Jacobs (2004) provides table 8 as a guideline for identifying clients who can benefit from the psychodynamic approach. He also highlights the issues and types of clients that are suitable only for very experienced counsellors.

<table>
<thead>
<tr>
<th>Suitable clients for psychodynamic counselling and therapy</th>
<th>Only suitable for experienced psychodynamic counsellors and therapists</th>
<th>Unlikely to be suitable for psychodynamic counselling or psychotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent onset of problems (or a new problem)</td>
<td>Long-standing problems</td>
<td>Seen many helpers for only short time maybe over many years (and/or currently seeing another helper)</td>
</tr>
<tr>
<td>Possible reasons for problem clear</td>
<td>Clear difficulties but not clear reasons for them</td>
<td>Very narrowly defined problems</td>
</tr>
</tbody>
</table>
### Counselling Theories

<table>
<thead>
<tr>
<th>Verbalises thoughts and feelings</th>
<th>Verbalises, but tends to intellectualise feelings; may be rather passive, but is responsive</th>
<th>Cannot express in words, or take initiative in talking; passive and unresponsive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relates, well or badly, to at least one other person</td>
<td>Unable to form close relationships</td>
<td>No wish to form relationship with counsellor or therapist</td>
</tr>
<tr>
<td>trusts counsellor; can allow some dependence</td>
<td>Over-dependent or shows deep inability to trust</td>
<td>Unable to allow any dependency on others</td>
</tr>
<tr>
<td>Tolerates once-weekly session</td>
<td>May occasionally or for a long time need to be seen more than once weekly</td>
<td>Only wants occasional session</td>
</tr>
<tr>
<td>Able to see contributions to difficulties</td>
<td>Excessive or over-concern about self</td>
<td>Only blames others</td>
</tr>
<tr>
<td>Wish to understand self</td>
<td>Wish for deeper insight than possible in short-term contract</td>
<td>Wishes to be rid of symptoms by ‘magic’</td>
</tr>
<tr>
<td>Desire for change</td>
<td>Desire for change</td>
<td>No desire for change</td>
</tr>
<tr>
<td>Normally well-functioning central ego</td>
<td>Weak central ego but able to use therapists to support ego strength</td>
<td>Dependent on high dosage of drugs, even if medically prescribed</td>
</tr>
<tr>
<td>Able to tolerate disturbing feelings and thoughts; central self feels in sufficient control</td>
<td>Bizarre or disturbing thoughts and behaviour, but able to recognise this and can manage life day by day</td>
<td>Bizarre and disturbing thoughts and behaviour, which take over person’s normal functioning</td>
</tr>
</tbody>
</table>


### Review of behaviour and learning theory in working with clients

Behavioural theory may be seen both as an overall theory and as an experimentally based attempt to describe the laws or principles by which human behaviour is learned and maintained. Behavioural counselling offers various action-oriented methods to help clients take steps to change what they are doing and thinking. The focus is on the present, not the past.
Behaviour counselling is based largely on the work of three men:

- **Joseph Wolpe (1915–1997)**, who applied the classic concept of conditioning (originally developed by Pavlov) to therapy and developed the idea of counter-conditioning whereby clients could learn new responses to the same problems.

- **B.F. Skinner (1904-1990)**, who developed the concept of operant conditioning in which actions reinforce behaviour and produce consequences, e.g. reading, writing or driving a car.

- **Albert Bandura (b.1925)**, who further developed the relationship between learning and our environment in his Social Cognitive Theory.

Behaviour counselling focuses on how to eliminate maladaptive behaviour. After an initial assessment, specific behavioural goals are selected and strategies for meeting these goals are decided and processed.

Modern behaviourists believe that we are both the producer and the product of our environment. Hence, part of the approach is to give control to clients and to increase their range of options. It is associated with improving our skills to overcome our problems.

Behavioural counselling is based on some core assumptions about human beings and how they learn.

- Human behaviour is governed by basic learning principles. Behaviour can be understood through the application of scientific principles and, even though it is complex, it is nevertheless based on observable principles that also govern animal behaviour. Behaviour can therefore be modified and changed through conditioning and similar principles.

- Humans are neither good nor evil – they react to their environment. Human beings have the capacity to change, depending on their environment. Nurture is considered to be more influential than nature.

- All people are capable of modifying behaviours under the right circumstances. Given the appropriate stimulus and reinforcements, all of us are able to make changes to our behaviour and adapt to new circumstances (Archer & McCarthy, 2007).

**Review of environmental issues when working with clients**

The influence of the environment has been brought into particular focus through Bandura’s social learning theory (recently renamed to Social Cognitive Theory) which states that we learn to behave in certain ways because of the influence of other people in our lives. As such, nurture is considered to be more important than nature in understanding how a person develops.
Whether you choose to work from a psychodynamic or a behavioural perspective, awareness of the environmental influences on the client’s experience will be an important part of counselling. In psychodynamic counselling, environmental issues are considered important in the sense that early relationships with primary care givers is understood to influence the way a baby develops and their ability to relate to others in later life. In behavioural counselling, modelling is considered an important part of behaviour development and modification and therefore the others in a client’s life should be recognised and their own behaviour discussed in terms of their influence on the client.

Activity

Self-assessment

Complete the Performance criteria checklist at the end of this module to assess your competency against the performance criteria for this unit. Comment on ways in which you might revise your practice in the future to continuously improve in the area of facilitating the counselling process.
**Performance criteria checklist**

This checklist outlines the key skills and knowledge required to achieve competence in the elements of this unit and is based on the performance criteria for those elements. Please take the time to complete the self-assessment checklist below by ticking the appropriate column and including a current example of how you believe you have achieved competency in this area. Should you find that there are either gaps in your knowledge or that you lack a thorough understanding of the performance criteria, be sure to approach your educator for clarification. Identifying your development needs will help you plan your learning as you progress throughout the course.

<table>
<thead>
<tr>
<th>CHCCSL504A Apply personality and development theories</th>
<th>Examples of what I currently know and can do</th>
<th>Examples of skills and knowledge I need to develop further</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.1</strong> I can undertake a case study/analysis drawing on a range of personality and human development theories, including:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nature-nurture theory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freudian concepts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maslow's hierarchy of needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Piaget's stages of cognitive development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Erikson's psychosocial stages</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.2</strong> I can assist clients to understand their personal history, drawing on a range of theories, including:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nature-nurture theory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freudian concepts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maslow's hierarchy of needs</td>
<td></td>
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</tr>
<tr>
<td>Piaget's stages of cognitive development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Erikson's psychosocial stages</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2.1</strong> I can use concepts from personality and <em>lifespan development</em> theories to describe and analyse aspects of individual development</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Counselling Theories

<table>
<thead>
<tr>
<th>2.2</th>
<th>I am able to analyse individual behaviour using theoretical concepts from a range of approaches to personality and lifespan development</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3</td>
<td>I can identify potential applications of personality and lifespan development theories in the counselling process</td>
</tr>
<tr>
<td>2.4</td>
<td>I can identify strengths and weaknesses of each theory in relation to understanding human development and individual behaviour</td>
</tr>
</tbody>
</table>

### CHCCSL505A Apply learning theories in counselling

<table>
<thead>
<tr>
<th>1.1</th>
<th>I can identify the contributions of stimulus and response theory to counselling practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2</td>
<td>I am able to analyse and apply stimulus and response techniques in counselling practice</td>
</tr>
<tr>
<td>1.3</td>
<td>I am able to analyse and demonstrate application of principles of negative and positive reinforcement</td>
</tr>
<tr>
<td>1.4</td>
<td>I can explain the relationship between punishment and negative reinforcement</td>
</tr>
<tr>
<td>1.5</td>
<td>I can apply positive and negative reinforcement in counselling practice</td>
</tr>
<tr>
<td>2.1</td>
<td>I can explain the impact of environmental modelling influences</td>
</tr>
<tr>
<td>2.2</td>
<td>I am able to identify and analyse the impact of modelling influences within a client’s environment to facilitate client change</td>
</tr>
<tr>
<td>3.1</td>
<td>I can analyse different reinforcement influences of siblings in relation to sequence of birth</td>
</tr>
</tbody>
</table>
### Counselling Theories

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2</td>
<td>I am able to analyse individual responses to similar modelling/reinforcement</td>
</tr>
<tr>
<td>3.3</td>
<td>I can analyse the effects of environmental differences and dysfunctional environments</td>
</tr>
<tr>
<td>4.1</td>
<td>I can identify change required to achieve identified outcomes and formulate and record a program for change</td>
</tr>
<tr>
<td>4.2</td>
<td>I can apply and record the method of reinforcements to ensure behaviour change</td>
</tr>
<tr>
<td>4.3</td>
<td>I am able to formulate a process for program monitoring, recording and intervention where appropriate</td>
</tr>
</tbody>
</table>
References and further reading


Counselling Theories


Module review

- Part of studying counselling is to learn about different theories, models or approaches that you can apply when dealing with a client’s issues. There are many different theories or approaches.
- One theory/approach/model will not be suitable to deal with every client you will come into contact with.
- Counselling theories can be broadly divided into four main groups: the Behavioural Group, the Psychoanalytical Group, the Humanistic Group and the Post Modern Group.
- Each counselling theory takes a stand on the question of whether we are genetically pre-programmed to develop and behave in the way that we do, or if environmental factors are more influential, i.e. the question of nature versus nurture.
- There is generally considered to be a genetic component to our development, known as genetic inheritance.
- Although most counsellors today do not use the classical approach developed by Freud, his theories are still influential and many modern approaches to counselling are based on Freud’s ideas.
- Freud was fascinated with emotions and the thoughts that block them. He theorised that emotional blocks have something to do with trauma and psychological anguish.
- According to Freud we all have unacceptable thoughts, wishes, feelings and memories that we store in our unconscious mind.
- Freud developed a theory known as the structural model of the psyche, which includes the id, ego and superego.
- In Freudian theory, anxiety develops out of a conflict between the id, superego and ego over control of the available psychic energy.
- Defense mechanisms are ways in which we defend ourselves against anxiety.
- Freud believed that as children we move through different stages of development at different ages, and at each stage we are preoccupied with different parts of our bodies: the oral stage, the anal stage, the phallic stage, the latency stage and the genital stage.
- Erikson built on Freud’s ideas, extending his theory of personality development to stress psychosocial aspects of development.
- Piaget proposed four stages of cognitive development: sensorimotor, preoperational, concrete operational and formal operational.
- Maslow proposed that human motives are organised into a hierarchy of needs, usually depicted as a triangle or pyramid. He stated that once we have met the basic needs at the lower levels of the pyramid, we strive for further growth, with the ultimate aim of self-actualisation.
- The task of psychodynamic counselling is to help clients make the unconscious conscious.
Counselling Theories

- Freud’s concept of personality in terms of the unconscious processes of the id, ego and superego helps the counsellor to assess what part of the client’s personality structure is causing problems for them.

- Techniques used in psychodynamic counselling include free association, analysis of transference, interpretation, challenging resistance and dream analysis.

- Psychodynamic counselling and associated counselling approaches also consider developmental issues in working with clients and will try to understand the client’s problems in terms of developmental stages.

- One of the main criticisms of Freud’s theory of personality and development is that there is limited hard evidence to support the theory and it is difficult to test.

- Behaviour is anything a person does – any action you can observe and record.

- Behaviour therapy is an approach to counselling based on the concepts of behaviourism.

- Behaviourists use the term stimulus to describe an external event that initiates behaviour. They use the term response for the behaviour itself.

- Classical conditioning refers to the learning by association, which occurs when a neutral stimulus is capable of eliciting a certain involuntary response.

- Thorndike developed a theory suggesting that the responses we make to stimuli, or particular situations that are closely followed by satisfaction, are more likely to be repeated.

- Skinner developed the theory of operant conditioning that states that the consequence of behaviour will increase or decrease the repetition of that behaviour. It involves positive and negative reinforcement of behaviour.

- Schedule reinforcement is the rate or frequency of reinforcement of a particular behaviour.

- The other way behaviour change occurs is through punishment – anything that follows a behaviour that causes it to stop.

- If reinforcement is removed, the conditioned response to stimuli weakens and eventually disappears. The process, known as extinction, eliminates it.

- Another way of changing behaviour is to take away the stimulus that led to the behaviour, known as stimulus control.

- Bandura developed another theory of learning called Social Cognitive Theory (previously known as social learning theory). He suggests that there is also an active thinking process linking our behaviour and its consequences.

- One of Bandura’s main contributions to learning theory is the notion of observational learning, i.e. that we learn through watching others, who are known as models.

- Modelling is a simple way to help clients learn new behaviours. Behavioural counsellors find that clients can learn new ways of coping with difficulties when they observe and then model people engaging in successful coping behaviour.

- Modelling can also be the source of problems that clients may have.
• An important step in any type of counselling is to set goals for counselling – outcomes that the client would like, that are realistic and achievable, and that both the client and counsellor agree on.

• The counsellor’s task is to pinpoint precise behaviours that contribute to, or are associated with, the client’s problem. In order to set goals and develop an appropriate treatment plan, the counsellor will meet with the client for an assessment interview.

• Asking clients to undertake homework is a common technique in behavioural counselling. This often includes asking the client to make a chart or keep a record of their behaviours and some information relating to them.

• Monitoring client change is essential in behavioural counselling to assess the effectiveness of the counselling.

• For counsellors who place importance on the environment as significant in understanding development, the family we grew up with is an important starting point.

• Other environmental influences can also impact on childhood development and behaviour, such as school and friends.

• Some approaches to counselling give special importance to the relationships between siblings and the position each one has in the family.

• Family systems can be functional and dysfunctional. Children who grow up in dysfunctional families often replay this behaviour in adult life.

• Theory helps counsellors develop attitudes or behaviours that assist them to remain clear and focused about the process, develop an effective working relationship with their clients, and remain optimistic about the effectiveness of counselling.
CHCCSL504A and CHCCSL505A – Competency assessments

NOTE: Some assessment tasks specify a word count, e.g. a report must be no longer than 300 words. Most word processing programs feature a word count tool. In Microsoft Word, you access this tool by selecting Tools then Word Count from the menu bar.

Assessment task 1: Due - Week 5

Short-answer questions

Assessment task 1 should be completed in 400 - 600 words in total

Answer the following questions in your own words. Answer each question briefly but fully – using bullet points or lists in place of continuous sentences if you prefer. You may refer to your textbook or learning materials if necessary, but must not copy from them. Do not work with or share answers with other students in this course when completing this assessment task.

1. Identify four key personality/human development theories.
2. Explain the concept of nature versus nurture.
3. Explain the concept of genetic inheritance and how it applies to counselling.
4. Explain Freud’s concept of the unconscious and why it is important in counselling.
5. List the three different aspects of personality identified by Freud. Briefly explain how they relate to each other.
6. List Freud’s psychosexual stages. Briefly explain each one.
7. List the needs in Maslow’s hierarchy of needs. Briefly explain how they relate to each other.
8. List Erikson’s eight psychosocial stages of development and the tensions present within each stage.
Assessment task 2: Due – Week 7

Case study

Assessment task 2 should be completed in 1200 - 1500 words in total

Read the Case study below then answer the questions listed in your own words using the Case study as the basis for your answers. Do not work with or share answers with other students in this course when completing this assessment task.

Steven is a 37-year-old man who is separated with two young children. He married ten years ago when given an ultimatum by his parents: ‘Get married or get out of the family business’. Steven describes his parents as very organised and controlling. Growing up, he did not feel heard or attended to. Instead he felt pressured into fulfilling his parents’ expectations.

As Steven entered adolescence, he explains, he decided to live two lives – the ‘saint’ and the ‘sinner’. At home he remained dutiful and adhered to the strict rules of the house. Once his parents were in bed however he climbed out of his bedroom window and went out to drink, smoke and engage in sexual activities.

Steven is now in the process of getting a divorce. He identifies the contributors to the relationship breakdown as binge drinking, extra-marital sexual relations with a number of people over the years, and his incapacity to be sensitive to his partner’s needs for closeness.

1. Briefly explain how you could understand Steven’s case using nature versus nurture theory.

2. Describe how you could apply Freudian concepts in working with Steven.

3. Briefly analyse Steven’s situation from the perspective of Maslow’s hierarchy of needs.

4. Briefly describe how Piaget’s stages of cognitive development could help you work with Steven.

5. Briefly explain how Erikson’s stages of development could help you understand and work with Steven.

6. Briefly describe the strengths and weaknesses of using personality and development theories to work with Steven.
Assessment task 3: Due – Week 11

Case study

Assessment task 3 should be completed in 1200 - 1500 words in total

Re-read the Case study below (this case study is also the basis for Assessment task 2). Answer the questions listed below in your own words using the Case study as the basis for your answers. Do not work with or share answers with other students in this course when completing this assessment task.

---

Steven is a 37-year-old man who is separated with two young children. He married ten years ago when given an ultimatum by his parents: ‘Get married or get out of the family business’. Steven describes his parents as very organised and controlling. Growing up, he did not feel heard or attended to. Instead he felt pressured into fulfilling his parents’ expectations.

As Steven entered adolescence, he explains, he decided to live two lives – the ‘saint’ and the ‘sinner’. At home he remained dutiful and adhered to the strict rules of the house. Once his parents were in bed however he climbed out of his bedroom window and went out to drink, smoke and engage in sexual activities.

Steven is now in the process of getting a divorce. He identifies the contributors to the relationship breakdown as binge drinking, extra-marital sexual relations with a number of people over the years, and his incapacity to be sensitive to his partner’s needs for closeness.

1. Briefly explain how the concept of stimulus and response applies to Steven.
2. Briefly explain how the concept of conditioning could apply to Steven.
3. Briefly explain how positive and negative reinforcement can be applied to Steven’s experience.
4. Briefly describe the environmental factors you would take into account in working with Steven.
5. Describe how you would apply behavioural concepts in working with Steven to change his behaviour.
Assessment task 4: Due – Week 12

Reflective report on group work activities (on-campus students OR Discussion board activities (flexible delivery students)

Assessment task 4 should be completed in 400 - 600 words in total

During the term you will have been involved in group work activities (on-campus students) or online discussion board activities (flexible delivery students) which have included skills practice session the skills you have been learning, watching video-taped counselling sessions or discussing case studies with your peers.

These activities were designed to enable you to learn about the range of perspectives among your fellow students in relation to the scenarios discussed. It was suggested that you keep a journal or diary record of the discussions in order to remember them.

The reflective report due in week 12 will summarise what you have learned about differences in perspective, about your own values, biases and assumptions, and the impact of these on your interpretation of scenarios and ability to help a diverse range of clients.
Marking criteria for Competency Assessment

CHCCSL504A Apply personality and development theories
CHCCSL505A Apply learning theories in counselling

Assessment task 1: Short-answer questions

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Criteria</th>
<th>Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 1</td>
<td>Correct identification of four key personality/human development theories</td>
<td></td>
</tr>
<tr>
<td>Question 2</td>
<td>Correct explanation of the concept of nature versus nurture.</td>
<td></td>
</tr>
<tr>
<td>Question 3</td>
<td>Correct explanation of the concept of genetic inheritance.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Correct explanation of how it applies to counselling.</td>
<td></td>
</tr>
<tr>
<td>Question 4</td>
<td>Accurate explanation of Freud’s concept of the unconscious.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Correct explanation of why it is important in counselling.</td>
<td></td>
</tr>
<tr>
<td>Question 5</td>
<td>Correct identification of Freud’s three different aspects of personality.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Correct description of how they relate to each other.</td>
<td></td>
</tr>
<tr>
<td>Question 6</td>
<td>Correct identification of Freud’s four stages of psychosexual development.</td>
<td></td>
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<tr>
<td></td>
<td>Accurate description of each one.</td>
<td></td>
</tr>
<tr>
<td>Question 7</td>
<td>Correct identification of Maslow’s five levels of needs.</td>
<td></td>
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<tr>
<td></td>
<td>Accurate description of how they relate to each other.</td>
<td></td>
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<tr>
<td>Question 8</td>
<td>Correct identification of Erikson’s eight psychosocial stages of development and the tensions present within each stage.</td>
<td></td>
</tr>
</tbody>
</table>
Assessment Decision To be assessed as satisfactory in this assessment task, the candidate must address each assessment criterion satisfactorily.

☐ Satisfactory  ☐ Not yet satisfactory  ☐ More evidence/resubmission required

Each assessment task must be completed satisfactorily for a student to achieve an overall grade of competent for the module.
## Assessment task 2: Case study

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Student clearly explains how to understand Steven’s case using nature versus nurture theory.</td>
<td>Y □ N □</td>
</tr>
<tr>
<td>2. Student clearly describes how Freudian theory could be applied in working with Steven.</td>
<td>Y □ N □</td>
</tr>
<tr>
<td>3. Student clearly describes how to understand Steven’s situation from the perspective of Maslow’s hierarchy of needs.</td>
<td>Y □ N □</td>
</tr>
<tr>
<td>4. Student accurately describes how Piaget’s stages of cognitive development could apply to working with Steven.</td>
<td>Y □ N □</td>
</tr>
<tr>
<td>5. Student explains factors to take into account when considering Steven’s situation from the perspective of Erikson’s stages of development.</td>
<td>Y □ N □</td>
</tr>
<tr>
<td>6. Student describes the strengths and weaknesses of using personality and development theories to work with Steven.</td>
<td>Y □ N □</td>
</tr>
</tbody>
</table>

### Comments

**Assessment Decision** To be assessed as satisfactory in this assessment task, the candidate must address each assessment criterion satisfactorily.

☐ Satisfactory  ☐ Not yet satisfactory  ☐ More evidence/resubmission required

Each assessment task must be completed satisfactorily for a student to achieve an overall grade of competent for the module.
### Assessment task 3: Case study

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Student clearly explains how the concept of conditioning could apply to Steven.</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>2. Student clearly describes how the concept of stimulus and response applies to Steven.</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>3. Student clearly describes how positive and negative reinforcement can be applied to Steven’s experience.</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>4. Student accurately describes the environmental factors to take into account in working with Steven.</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>5. Student explains how to apply behavioural concepts in working with Steven to change his behaviour.</td>
<td>☐ ☐</td>
</tr>
</tbody>
</table>

**Comments**

**Assessment Decision** To be assessed as satisfactory in this assessment task, the candidate must address each assessment criterion satisfactorily.

- ☐ Satisfactory  ☐ Not yet satisfactory  ☐ More evidence/resubmission required

Each assessment task must be completed satisfactorily for a student to achieve an overall grade of competent for the module.
### Assessment task 4: Reflective report on group work activities (on-campus students OR Discussion board activities (flexible delivery students))

#### Assessment task 4

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>1. Student describes own values and their possible impact on counselling others.</td>
<td>☐</td>
</tr>
<tr>
<td>2. Student describes learning achieved through activities in relation to differences in perception of the same scenario by different individuals.</td>
<td>☐</td>
</tr>
<tr>
<td>3. Student identifies at least one of their own biases or assumptions that the student has questioned as a result of the activities undertaken.</td>
<td>☐</td>
</tr>
</tbody>
</table>

#### Comments

**Assessment Decision** To be assessed as satisfactory, the candidate must address each assessment criterion satisfactorily.

☐ Satisfactory  ☐ Not yet satisfactory  ☐ More evidence/resubmission required

Each assessment task must be completed satisfactorily for a student to achieve an overall grade of competent for the module.

**General comments**

**Module Assessment Decision** To be assessed as competent in this module, the candidate must be assessed as satisfactory in all individual assessment tasks

☐ Competent  ☐ Not yet competent  ☐ More evidence/resubmission required

_______________________________   _________
Assessor signature      Date
READING

A pair of identical twin girls were surrendered to an adoption agency in New York City in the late 1960s. The twins, who are known in psychological literature as Amy and Beth, might have gone through life in obscurity had they not come to the attention of Dr Peter Neubauer, a prominent psychiatrist at New York University's Psychoanalytic Institute and a director of the Freud Archives. Neubauer believed at the time that twins posed such a burden to parents, and to themselves in the form of certain developmental hazards, that adopted twins were better off being raised separately, with no knowledge of their twinship.

Neubauer also recognised the exceptional research possibilities such a separation offered. Studies of twins reared apart are one of the most powerful tools that scholars have to analyse the relative contributions of heredity and environment to the make-up of individual human natures. Identical twins are rare, however, and twins who have been separated and brought up in different families are particularly unusual. Neubauer was aware of a mere handful of studies examining twins reared apart, and in most cases the twins being studied had been separated for only part of their childhoods and were reunited at some point long before the study began. Here was an opportunity to look at twins from the moment they were separated, and to trace them through childhood,
observing at each stage of development the parallel or diverging courses of their lives. Because the sisters shared the same genetic make-up, one could evaluate the environmental effects on the twins' personalities, their behaviour, their health, their intelligence. Such a study might not set to rest the ancient quarrel over the relative importance of nature versus nurture, but there were few other experiments one could imagine that would be more pertinent to an understanding of the human condition.

Neubauer sought out other instances in which newborn twins were being placed for adoption, eventually adding three other pairs of identical twins and a set of identical triplets to his project. The complete study has never been published, and Neubauer is reluctant to discuss the details of how he enlisted twins into the project. Indeed, much of the history of the study has been kept secret. In any case, by the time that Amy and Beth were sent to their adoptive homes, there was already an extensive team of psychologists, psychiatrists, paediatricians, observers and testers waiting to follow them as they moved from infancy to adolescence. Every step of childhood would be documented through psychological and ability tests, school records, parental and sibling interviews, films, and the minutes of nearly 1,000 weekly conferences. Not surprisingly, the study was slanted towards psychoanalytical concerns. 'In particular, we were looking for the psychological variables which influence developmental processes,' says Neubauer. One would expect identical children placed in separate environments to be formed by different family dynamics. Broadly speaking, the personality differences between the girls as they grew older would measure the validity of the most fundamental assumption of clinical psychology, which is that experience - and, in particular, our family background - shapes us into the people we become.

The agency that placed the children shortly after their birth informed the potential adoptive parents that the girls were already involved in a study of child development, and the parents were strongly urged to continue it; however, neither the parents nor the girls themselves would ever be told that they were twins.

The sisters were fair-skinned blondes with small oval faces, blue-grey eyes and slightly snub noses. Amy was three ounces heavier and half an inch taller than Beth at birth, an advantage in weight and height that persisted throughout their childhood. The girls were adopted into families that were, in certain respects, quite similar. They were placed in Jewish homes in New York State. The mothers stayed at home, and in each family there was a son almost exactly seven years older than the twin. [In Beth's family, there was an older sister as well.] In other respects, the environments were profoundly different: notably, Amy's family was lower class and Beth's was well off. Amy's mother was overweight and socially awkward. Her personality was flat and her self-esteem was low. Although she had a compassionate side to her nature, she was an insecure mother who felt threatened by her daughter's attractiveness. Beth's mother, on the other hand, doted on her daughter and for the entire ten years of the study spoke positively of Beth's personality and her place in the family. The team described Beth's mother as pleasant, youthful, slim, chic, poised, self-confident, dynamic and cheerful. Where Amy's mother seemed to regard Amy as a problem, a stubborn outsider, Beth's mother treated her daughter as 'the fun child'. Instead of separating Beth from other members of the family, Beth's mother went out of her way to minimise the differences, to the extent of dyeing her own hair to emphasise their similarities. The girls' fathers were very much like each other - confident, relaxed, at ease with themselves - but different in their treatment of the girls. Amy's father came to agree with his wife that Amy was a disappointment, whereas Beth's father was more available and supportive. Amy's brother was a handsome academic star, the golden boy of the family. Beth's brother,
however, was a disturbed child, who suffered from learning disabilities and uncontrolled behaviour that got him expelled from several schools and in trouble with the law. All in all, the research team characterised Amy's family as a well-knit threesome — mother, father, and son — plus an alienated Amy. It was a family that placed a high value on academic success, simplicity, tradition, and emotional restraint. Beth's family, on the other hand, was sophisticated, full of energy — 'frenetic' at times — and it tended to put more emphasis on materialism than on education. Clearly Beth was more at the centre of her home than Amy was in hers.

And how did these identical twins in such contrasting environments turn out? As might be expected, Amy's problems began early and progressed in a disturbing direction. As an infant, she was tense and demanding. She sucked her thumb, bit her nails, clung to her blanket, cried when left alone. She wet her bed until she was four, and continued to have 'accidents' for several years more. She was prone to nightmares and full of fears. By the age of ten, when the study concluded, she had developed a kind of artificial quality that manifested itself in role-playing, gender confusion, and invented illnesses. Shy, indifferent, suffering from a serious learning disorder, pathologically immature, she was a stereotypical picture of a rejected child. The team proposed that if only Amy had had a mother who had been more empathetic, more tolerant of her limitations, more open and forthcoming [like Beth's mother], then Amy's life might have turned out far better. If only her father had been more consistently available and affectionate [like Beth's father], then she might have been better able to negotiate the oedipal dramas of childhood and achieved a clearer picture of her own sexual role. If only her brother had been less strongly favoured [like Beth's brother], Amy would have been spared the mortifying comparisons that were openly drawn in her family. In theory, if Amy had been raised in Beth's family, the sources of her crippling immaturity would have been erased, and she would have been another kind of person — happier, one presumes, and more nearly whole.

In nearly every respect, however, Beth's personality followed in lockstep with Amy's dismal development. Thumb-sucking, nail-biting, blanket-clenching, and bed-wetting characterised her infancy and early childhood. She became a hypochondriac and, like Amy, was afraid of the dark and of being left alone. She, too, became lost in role-playing, and the artificial nature of her personality was, if anything, more pronounced than Amy's. She had similar problems in school and with her peers. On the surface, she had a far closer relationship with her mother than Amy did with hers, but on psychological tests she gave vent to a longing for maternal affection that was eerily the same as her identical sister's. Beth did seem to be more successful with her friends and less confused than Amy, but she was also less connected to her feelings.

The differences between the girls seemed merely stylistic; despite the differences in their environments, their pathology was fundamentally the same. Did their family lives mean so little? Were they destined to become the people they turned out to be because of some inherent genetic predisposition towards sadness and unreality? And what would psychologists have made of either girl if they did not know that she was a twin? Wouldn't they have blamed the symptoms of her neurosis on the parenting styles of the family she grew up in? What does that say about the presumptions of psychology?

Twins pose questions we might not think to ask if we lived in a world without them. They are both an unsettling presence, because they undermine our sense of individual uniqueness, and a score-settling presence, because their mere existence allows us to test certain ideas about how we are the way we are. Every culture has had to confront the twin phenomenon and come to its own response. Often that response has been to kill the children and to ostracise or kill
the mother as well – an implicit acknowledgment of the threat twins can pose to the presumptions of an established order. From ancient times men have been known to cut off one of their testicles in the mistaken belief that it would eliminate the possibility of twin conceptions. Other cultures worship twins as a divine gift; for instance, the voodoo practitioners of West Africa and Haiti exalt twins as supernatural beings with a single soul, who are to be revered and feared. Once a year anyone connected to twins, living or dead, is obligated to make offerings at a ceremonial feast in their honour to avoid ‘chastisement’. In our own culture, we tend to dote on twins and mythologise their specialness through daytime talk shows, which turn them into freaks, but which also, to be fair, provide a forum to marvel at the wonder and the mystery of the twin event. Perhaps all these responses are ways of holding twins at bay, since too close a study of twinship might lead to discoveries about ourselves that we are unwilling to make.

In the mid-sixties, when Neubauer began his enquiry into the lives of separated twins, there were no major US twin registries; now the University of Minnesota keeps track of more than 8,000 twin pairs, Virginia Commonwealth University operates the ‘Virginia 30,000’, which follows 15,000 twin pairs plus their siblings, spouses, and parents; there are major registries in Kansas, California, and Kentucky, and smaller ones all over the country. The Veterans Administration maintains records of all twins who served in the Second World War and Vietnam. Pennsylvania State University, with several other institutions, oversees the Black Elderly Twin Study, which uses Medicare records to track down black twins throughout the United States. It is the only large-scale ethnic study in the country, but it may also become the largest study of genetics and ageing among women in the world. In Holland, Denmark, Sweden, Norway, Finland and Australia nearly every twin in the country has been identified. Moreover, in recent years, the technical analysis of twin studies has become increasingly sophisticated and subtle, often taking into account multiple environmental factors, non-twin relatives, and long-term observations. As a result of the variety and complexity of twin studies, along with powerful tools for analysis, the field of behavioural genetics has caused a revolution in the universities that has spilled into political life, reshaping the way our society views human nature and changing the terms of the debate about what government can and should do to improve the lives of its citizens.

Much of the argument over individual differences in intelligence, for instance, arises from the variation between IQ test scores of identical and fraternal twins, the difference being a measure how much of what we call intelligence is inherited. The field of psychology has been shaken by separated-twin studies, such as the one of Amy and Beth, suggesting that the development of an individual’s personality is guided by his genes, with little regard for the family in which he is raised. Matters that instinctively seem to be a reflection of one’s personal experience, such as political orientation or the degree of religious commitment, have been shown by various twin studies to be partly under genetic control. Because of the growth of twin studies, and also adoption studies, which examine unrelated individuals reared together (and which complement the study of twins reared apart), the field of behavioural genetics has been able to study traits such as criminality, alcoholism, smoking, homosexuality, marriage and divorce, job satisfaction, hobbies, fears; the results suggest that there are significant genetic contributions in all cases. Even disciplines such as linguistics and economics have seized upon twins as a way of understanding language formation (by looking at twins who create a private idiom), or of calculating the additional earning potential of higher education (by comparing twins who go to college versus twins who don’t). There is an air of irrefutability about such studies that make them so appeal-
ing. When Linus Pauling proposed that Vitamin C could cure the common cold, for instance, twin pairs were separated into two groups, one of which received Vitamin C and the other a placebo. Both caught colds, which effectively destroyed Pauling’s theory. There are now so many scientists seeking to study twins that the annual festival of twins in Twinsburg, Ohio, allows researchers to set up carnival tents, where browsing twins can stop to take stress tests or fill out questionnaires about their sex lives. Festival organizers even sponsor a prize for the best research project. Last year 90,000 people – most of them twins – attended the event.

All this comes after several decades of heightened political struggle between those, on the one hand, who believe that people are largely the same and that differences are imposed upon them by their environment, and those, on the other hand, who conclude that people differ mainly because of their genes, and that the environments they find themselves in are largely of their own making or choosing. Obviously, the roots of liberal versus conservative views are buried in such presumptions about human nature.

This argument has been raging for centuries, with science entering evidence on either side and public opinion shifting in response. Using twins, and also data derived from adoption studies, scientists can now estimate what proportion of the variation in our intelligence, our personality, our behaviour, and even seemingly random life events such as bankruptcy or the death of a spouse, might be caused by inherited tendencies. The broad movement from environmentalism to genetic determinism that has occurred in psychology over the last thirty years has foreshadowed the increasingly popular belief that people are genetically programmed to become the way they are, and therefore little can be done, in the way of changing the environment, that will make an appreciable difference in improving test scores or lowering crime rates or reducing poverty, to name several conspicuous examples.

The hallmark of liberalism is that changes in the social environment produce corresponding changes in human development. But if people’s destinies are written in their genes, why waste money on social programmes? Such thinking has led to a profound conservative shift in the last thirty years. This can be demonstrated by comparing the shifting climate of opinion in the US, which in 1965 produced the Great Society – a vast number of social programmes designed to improve the health and welfare of the poor, the elderly, and the minority populations – and in 1995 brought about the Contract with America, which generated cutbacks in many of those same programmes and marked a change in attitude about what government can be expected to do for its citizens. These changes have taken place not only in the West but in many other countries as well. Indeed, the widespread retreat of communism as a force in world politics is doubtlessly linked to the collapse of faith in social engineering, caused by the failure of communism to create the positive changes expected of it.

The genetic idea has had a tumultuous passage through the twentieth century, but the prevailing view of human nature at the end of the century resembles in many ways the view we had at the beginning. That is that people are largely responsible for their station in life, and that circumstances do not so much dictate the outcome of a person’s life as they reflect the inner nature of the person living it. Twins have been used to prove a point, and the point is that we don’t become. We are.
Sigmund Freud

Sigmund Freud (1856–1939) was the firstborn in a Viennese family of three boys and five girls. His father, like many others of his time and place, was very authoritarian. Freud’s family background is a factor to consider in understanding the development of his theory. Even though Freud’s family had limited finances and was forced to live in a crowded apartment, his parents made every effort to foster his obvious intellectual capacities. Freud had many interests, but his career choices were restricted because of his Jewish heritage. He finally settled on medicine. Only 4 years after earning his medical degree from the University of Vienna at the age of 26, he attained a prestigious position there as a lecturer.

Freud devoted most of his life to formulating and extending his theory of psychoanalysis. Interestingly, the most creative phase of his life corresponded to a period when he was experiencing severe emotional problems of his own. During his early 40s, Freud had numerous psychosomatic disorders, as well as exaggerated fears of dying and other phobias, and was involved in the difficult task of self-analysis. By exploring the meaning of his own dreams, he gained insights into the dynamics of personality development. He first examined his childhood memories and came to realize the intense hostility he had felt for his father. He also recalled his childhood sexual feelings for his mother, who was attractive, loving, and protective. He then clinically formulated his theory as he observed his patients work through their own problems in analysis.

Freud had very little tolerance for colleagues who diverged from his psychoanalytic doctrines. He attempted to keep control over the movement by expelling those who dared to disagree. Carl Jung and Alfred Adler, for example, worked closely with Freud, but each founded his own therapeutic school after repeated disagreements with Freud on theoretical and clinical issues.

Freud was highly creative and productive, frequently putting in 18-hour days. His collected works fill 24 volumes. Freud’s productivity remained at this prolific level until late in his life when he contracted cancer of the jaw. During his last two decades, he underwent 33 operations and was in almost constant pain. He died in London in 1939.

As the originator of psychoanalysis, Freud distinguished himself as an intellectual giant. He pioneered new techniques for understanding human behavior, and his efforts resulted in the most comprehensive theory of personality and psychotherapy ever developed.

Introduction

Freud’s views continue to influence contemporary practice. Many of his basic concepts are still part of the foundation on which other theorists build and develop. Indeed, most of the theories of counseling and psychotherapy discussed in this book have been influenced by psychoanalytic principles and techniques. Some of these therapeutic approaches extended the psychoanalytic model, others modified its concepts and procedures, and others emerged as a reaction against it.

Freud’s psychoanalytic system is a model of personality development and an approach to psychotherapy. He gave psychotherapy a new look and new horizons, calling attention to psychodynamic factors that motivate behavior, focusing on the role of the unconscious, and developing the first therapeutic procedures for understanding and modifying the structure of one’s basic character. Freud’s theory is a benchmark against which many other theories are measured.

It is impossible to capture in one chapter the diversity of psychodynamic approaches that have arisen since Freud. The main focus of this chapter is limited
to basic psychoanalytic concepts and practices, many of which originated with Freud. The chapter sketches therapies that apply classical psychoanalytic concepts to practice less rigorously than he did. The chapter also summarizes Erik Erikson’s theory of psychosocial development, which extends Freudian theory in several ways. Brief attention is given to Carl Jung’s approach and to contemporary psychoanalytic theory and practice.

**Key Concepts**

**View of Human Nature**

The Freudian view of human nature is basically deterministic. According to Freud, our behavior is determined by irrational forces, unconscious motivations, and biological and instinctual drives as these evolve through key psychosexual stages in the first 6 years of life.

Instincts are central to the Freudian approach. Although he originally used the term libido to refer to sexual energy, he later broadened it to include the energy of all the life instincts. These instincts serve the purpose of the survival of the individual and the human race; they are oriented toward growth, development, and creativity. Libido, then, should be understood as a source of motivation that encompasses sexual energy but goes beyond it. Freud includes all pleasurable acts in his concept of the life instincts; he sees the goal of much of life as gaining pleasure and avoiding pain.

Freud also postulates death instincts, which account for the aggressive drive. At times, people manifest through their behavior an unconscious wish to die or to hurt themselves or others. Managing this aggressive drive is a major challenge to the human race. In Freud’s view, both sexual and aggressive drives are powerful determinants of why people act as they do.

**Structure of Personality**

According to the psychoanalytic view, the personality consists of three systems: the id, the ego, and the superego. These are names for psychological structures and should not be thought of as manikins that separately operate the personality; one’s personality functions as a whole rather than as three discrete segments. The id is the biological component, the ego is the psychological component, and the superego is the social component.

From the orthodox Freudian perspective, humans are viewed as energy systems. The dynamics of personality consist of the ways in which psychic energy is distributed to the id, ego, and superego. Because the amount of energy is limited, one system gains control over the available energy at the expense of the other two systems. Behavior is determined by this psychic energy.

**The ID**

The id is the original system of personality; at birth a person is all id. The id is the primary source of psychic energy and the seat of the instincts. It lacks organization and is blind, demanding, and insistent. A cauldron of seething excitement, the id cannot tolerate tension, and it functions to discharge tension immediately. Ruled by the pleasure principle, which is aimed at reducing tension, avoiding pain, and gaining pleasure, the id is illogical, amoral,
and driven to satisfy instinctual needs. The id never matures, remaining the spoiled brat of personality. It does not think but only wishes or acts. The id is largely unconscious, or out of awareness.

THE EGO  The ego has contact with the external world of reality. It is the “executive” that governs, controls, and regulates the personality. As a “traffic cop,” it mediates between the instincts and the surrounding environment. The ego controls consciousness and exercises censorship. Ruled by the reality principle, the ego does realistic and logical thinking and formulates plans of action for satisfying needs. What is the relation of the ego to the id? The ego, as the seat of intelligence and rationality, checks and controls the blind impulses of the id. Whereas the id knows only subjective reality, the ego distinguishes between mental images and things in the external world.

THE SUPEREGO  The superego is the judicial branch of personality. It includes a person’s moral code, the main concern being whether an action is good or bad, right or wrong. It represents the ideal rather than the real and strives not for pleasure but for perfection. The superego represents the traditional values and ideals of society as they are handed down from parents to children. It functions to inhibit the id impulses, to persuade the ego to substitute moralistic goals for realistic ones, and to strive for perfection. The superego, then, as the internalization of the standards of parents and society, is related to psychological rewards and punishments. The rewards are feelings of pride and self-love; the punishments are feelings of guilt and inferiority.

Consciousness and the Unconscious

Perhaps Freud’s greatest contributions are his concepts of the unconscious and of the levels of consciousness, which are the keys to understanding behavior and the problems of personality. The unconscious cannot be studied directly but is inferred from behavior. Clinical evidence for postulating the unconscious includes the following: (1) dreams, which are symbolic representations of unconscious needs, wishes, and conflicts; (2) slips of the tongue and forgetting, for example, a familiar name; (3) posthypnotic suggestions; (4) material derived from free-association techniques; (5) material derived from projective techniques; and (6) the symbolic content of psychotic symptoms.

For Freud, consciousness is a thin slice of the total mind. Like the greater part of the iceberg that lies below the surface of the water, the larger part of the mind exists below the surface of awareness. The unconscious stores all experiences, memories, and repressed material. Needs and motivations that are inaccessible—that is, out of awareness—are also outside the sphere of conscious control. Most psychological functioning exists in the out-of-awareness realm. The aim of psychoanalytic therapy, therefore, is to make the unconscious motives conscious, for only then can an individual exercise choice. Understanding the role of the unconscious is central to grasping the essence of the psychoanalytic model of behavior.

Unconscious processes are at the root of all forms of neurotic symptoms and behaviors. From this perspective, a “cure” is based on uncovering the meaning
of symptoms, the causes of behavior, and the repressed materials that interfere with healthy functioning. It is to be noted, however, that intellectual insight alone does not resolve the symptom. The client’s need to cling to old patterns (repetition) must be confronted by working through transference distortions, a process discussed later in this chapter.

Anxiety

Also essential to the psychoanalytic approach is its concept of anxiety. Anxiety is a feeling of dread that results from repressed feelings, memories, desires, and experience that emerge to the surface of awareness. It can be considered as a state of tension that motivates us to do something. It develops out of a conflict among the id, ego, and superego over control of the available psychic energy. The function of anxiety is to warn of impending danger.

There are three kinds of anxiety: reality, neurotic, and moral. Reality anxiety is the fear of danger from the external world, and the level of such anxiety is proportionate to the degree of real threat. Neurotic and moral anxieties are evoked by threats to the “balance of power” within the person. They signal to the ego that unless appropriate measures are taken the danger may increase until the ego is overthrown. Neurotic anxiety is the fear that the instincts will get out of hand and cause one to do something for which one will be punished. Moral anxiety is the fear of one’s own conscience. People with a well-developed conscience tend to feel guilty when they do something contrary to their moral code. When the ego cannot control anxiety by rational and direct methods, it relies on indirect ones—namely, ego-defense behavior.

Ego-Defense Mechanisms

Ego-defense mechanisms help the individual cope with anxiety and prevent the ego from being overwhelmed. Rather than being pathological, ego defenses are normal behaviors that can have adaptive value provided they do not become a style of life that enables the individual to avoid facing reality. The defenses employed depend on the individual’s level of development and degree of anxiety. Defense mechanisms have two characteristics in common: (1) they either deny or distort reality, and (2) they operate on an unconscious level. Table 4.1 provides brief descriptions of some common ego defenses.

Development of Personality

IMPORTANCE OF EARLY DEVELOPMENT A significant contribution of the psychoanalytic model is delineation of the stages of psychosexual and psychosocial stages of development from birth through adulthood. The psychosexual stages refer to the Freudian chronological phases of development, beginning in infancy. The psychosocial stages refer to Erikson’s basic psychological and social tasks to be mastered from infancy through old age. This stage perspective provides the counselor with the conceptual tools for understanding key developmental tasks characteristic of the various stages of life.
<table>
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<tr>
<th>Defense</th>
<th>Uses for Behavior</th>
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<tr>
<td>Repression</td>
<td>Threatening or painful thoughts and feelings are excluded from awareness. One of the most important Freudian processes, it is the basis of many other ego defenses and of neurotic disorders. Freud explained repression as an involuntary removal of something from consciousness. It is assumed that most of the painful events of the first 5 or 6 years of life are buried, yet these events do influence later behavior.</td>
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<tr>
<td>Denial</td>
<td>“Closing one’s eyes” to the existence of a threatening aspect of reality. Denial of reality is perhaps the simplest of all self-defense mechanisms. It is a way of distorting what the individual thinks, feels, or perceives in a traumatic situation. This mechanism is similar to repression, yet it generally operates at preconscious and conscious levels.</td>
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<td>Reaction formation</td>
<td>Actively expressing the opposite impulse when confronted with a threatening impulse. By developing conscious attitudes and behaviors that are diametrically opposed to disturbing desires, people do not have to face the anxiety that would result if they were to recognize these dimensions of themselves. Individuals may conceal hate with a facade of love, be extremely nice when they harbor negative reactions, or mask cruelty with excessive kindness.</td>
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<tr>
<td>Projection</td>
<td>Attributing to others one’s own unacceptable desires and impulses. This is a mechanism of self-deception. Lustful, aggressive, or other impulses are seen as being possessed by “those people out there, but not by me.”</td>
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<tr>
<td>Displacement</td>
<td>Directing energy toward another object or person when the original object or person is inaccessible. Displacement is a way of coping with anxiety that involves discharging impulses by shifting from a threatening object to a “safer target.” For example, the meek man who feels intimidated by his boss comes home and unloads inappropriate hostility onto his children.</td>
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<td>Rationalization</td>
<td>Manufacturing “good” reasons to explain away a bruised ego. Rationalization helps justify specific behaviors, and it aids in softening the blow connected with disappointments. When people do not get positions they have applied for in their work, they think of logical reasons they did not succeed, and they sometimes attempt to convince themselves that they really did not want the position anyway.</td>
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<td>Process</td>
<td>Description</td>
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<tr>
<td><strong>Sublimation</strong></td>
<td>Diverting sexual or aggressive energy into other channels.</td>
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<tr>
<td><strong>Regression</strong></td>
<td>Going back to an earlier phase of development when there were fewer demands.</td>
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<tr>
<td><strong>Introjection</strong></td>
<td>Taking in and “swallowing” the values and standards of others.</td>
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<tr>
<td><strong>Identification</strong></td>
<td>Identifying with successful causes, organizations, or people in the hope that you will be perceived as worthwhile.</td>
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<tr>
<td><strong>Compensation</strong></td>
<td>Masking perceived weaknesses or developing certain positive traits to make up for limitations.</td>
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Freud postulated three early stages of development that often bring people to counseling when not appropriately resolved. First is the **oral stage**, which deals with the inability to trust oneself and others, resulting in the fear of loving and forming close relationships and low self-esteem. Next, is the **anal stage**, which deals with the inability to recognize and express anger, leading to the denial of one’s own power as a person and the lack of a sense of autonomy. Third, is the **phallic stage**, which deals with the inability to fully
accept one's sexuality and sexual feelings, and also to difficulty in accepting oneself as a man or woman. According to the Freudian psychoanalytic view, these three areas of personal and social development—love and trust, dealing with negative feelings, and developing a positive acceptance of sexuality—are all grounded in the first 6 years of life. This period is the foundation on which later personality development is built. When a child's needs are not adequately met during these stages of development, an individual may become fixated at that stage and behave in psychologically immature ways later on in life.

ERIKSON'S PSYCHOSOCIAL PERSPECTIVE  Erik Erikson (1963) built on Freud's ideas and extended his theory by stressing the psychosocial aspects of development beyond early childhood. His theory of development holds that psychosexual growth and psychosocial growth take place together, and that at each stage of life we face the task of establishing equilibrium between ourselves and our social world. He describes development in terms of the entire life span, divided by specific crises to be resolved. According to Erikson, a crisis is equivalent to a turning point in life when we have the potential to move forward or to regress. At these turning points, we can either resolve our conflicts or fail to master the developmental task. To a large extent, our life is the result of the choices we make at each of these stages.

Erikson is often credited with bringing an emphasis on social factors to contemporary psychoanalysis. Classical psychoanalysis is grounded on id psychology, and it holds that instincts and intrapsychic conflicts are the basic factors shaping personality development (both normal and abnormal). Contemporary psychoanalysis tends to be based on ego psychology, which does not deny the role of intrapsychic conflicts but emphasizes the striving of the ego for mastery and competence throughout the human life span. Ego psychology deals with both the early and the later developmental stages, for the assumption is that current problems cannot simply be reduced to repetitions of unconscious conflicts from early childhood. The stages of adolescence, mid-adulthood, and later adulthood all involve particular crises that must be addressed. As one's past has meaning in terms of the future, there is continuity in development, reflected by stages of growth: each stage is related to the other stages.

Viewing an individual's development from a combined perspective that includes both psychosexual and psychosocial factors is useful. Erikson believed Freud did not go far enough in explaining the ego's place in development and did not give enough attention to social influences throughout the life span. A comparison of Freud's psychosexual view and Erikson's psychosocial view of the stages of development is presented in Table 4.2.

COUNSELING IMPLICATIONS  By taking a combined psychosexual and psychosocial perspective, counselors have a helpful conceptual framework for understanding developmental issues as they appear in therapy. The key needs and developmental tasks, along with the challenges inherent at each stage of life, provide a model for understanding some of the core conflicts clients explore in
<table>
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<th>Period of Life</th>
<th>Freud</th>
<th>Erikson</th>
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<td><strong>First year of life</strong></td>
<td><strong>Oral stage</strong>&lt;br&gt;Sucking at mother’s breasts satisfies need for food and pleasure. Infant needs to get basic nurturing, or later feelings of greediness and acquisitiveness may develop. Oral fixations result from deprivation of oral gratification in infancy. Later personality problems can include mistrust of others, rejecting others; love, and fear of or inability to form intimate relationships.</td>
<td><strong>Infancy: Trust versus mistrust</strong>&lt;br&gt;If significant others provide for basic physical and emotional needs, infant develops a sense of trust. If basic needs are not met, an attitude of mistrust toward the world, especially toward interpersonal relationships, is the result.</td>
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<td><strong>Ages 1–3</strong></td>
<td><strong>Anal stage</strong>&lt;br&gt;Anal zone becomes of major significance in formation of personality. Main developmental tasks include learning independence, accepting personal power, and learning to express negative feelings such as rage and aggression. Parental discipline patterns and attitudes have significant consequences for child’s later personality development.</td>
<td><strong>Early childhood: Autonomy versus shame and doubt</strong>&lt;br&gt;A time for developing autonomy. Basic struggle is between a sense of self-reliance and a sense of self-doubt. Child needs to explore and experiment, to make mistakes, and to test limits. If parents promote dependency, child’s autonomy is inhibited and capacity to deal with world successfully is hampered.</td>
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<td><strong>Ages 3–6</strong></td>
<td><strong>Phallic stage</strong>&lt;br&gt;Basic conflict centers on unconscious incestuous desires that child develops for parent of opposite sex and that, because of their threatening nature, are repressed. Male phallic stage, known as Oedipus complex, involves mother as love object for boy. Female phallic stage, known as Electra complex, involves girl’s striving for father’s love and approval. How parents respond, verbally and nonverbally, to child’s emerging sexuality has an impact on sexual attitudes and feelings that child develops.</td>
<td><strong>Preschool age: Initiative versus guilt</strong>&lt;br&gt;Basic task is to achieve a sense of competence and initiative. If children are given freedom to select personally meaningful activities, they tend to develop a positive view of self and follow through with their projects. If they are not allowed to make their own decisions, they tend to develop guilt over taking initiative. They then refrain from taking an active stance and allow others to choose for them.</td>
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<td><strong>Ages 6–12</strong></td>
<td><strong>Latency stage</strong>&lt;br&gt;After the torment of sexual impulses of preceding years, this period is relatively quiescent. Sexual interests are replaced by interests in school, playmates, sports, and a range of new activities. This is a time of socialization as child turns outward and forms relationships with others.</td>
<td><strong>School age: Industry versus inferiority</strong>&lt;br&gt;Child needs to expand understanding of world, continue to develop appropriate gender-role identity, and learn the basic skills required for school success. Basic task is to achieve a sense of industry, which refers to setting and attaining personal goals. Failure to do so results in a sense of inadequacy.</td>
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<tr>
<td>Period of Life</td>
<td>Freud</td>
<td>Erikson</td>
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<tr>
<td>Ages 12–18</td>
<td>Genital stage&lt;br&gt;Old themes of phallic stage are re-vived. This stage begins with puberty and lasts until senility sets in. Even though there are societal restrictions and taboos, adolescents can deal with sexual energy by investing it in various socially acceptable activities such as forming friendships, engaging in art or in sports, and preparing for a career.</td>
<td>Adolescence: Identity versus role confusion&lt;br&gt;A time of transition between childhood and adulthood. A time for testing limits, for breaking dependent ties, and for establishing a new identity. Major conflicts center on clarification of self-identity, life goals, and life's meaning. Failure to achieve a sense of identity results in role confusion.</td>
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<td>Ages 18–35</td>
<td>Genital stage continues&lt;br&gt;Core characteristic of mature adult is the freedom “to love and to work.” This move toward adulthood involves freedom from parental influence and capacity to care for others.</td>
<td>Young adulthood: Intimacy versus isolation.&lt;br&gt;Developmental task at this time is to form intimate relationships. Failure to achieve intimacy can lead to alienation and isolation.</td>
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<tr>
<td>Ages 35–60</td>
<td>Genital stage continues</td>
<td>Middle age: Generativity versus stagnation. &lt;br&gt;There is a need to go beyond self and family and be involved in helping the next generation. This is a time of adjusting to the discrepancy between one's dream and one's actual accomplishments. Failure to achieve a sense of productivity often leads to psychological stagnation.</td>
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<tr>
<td>Ages 60+</td>
<td>Genital stage continues</td>
<td>Later life: Integrity versus despair&lt;br&gt;If one looks back on life with few regrets and feels personally worthwhile, ego integrity results. Failure to achieve ego integrity can lead to feelings of despair, hopelessness, guilt, resentment, and self-rejection.</td>
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their therapy sessions. Questions such as these can give direction to the therapeutic process:

- What are some major developmental tasks at each stage in life, and how are these tasks related to counseling?
- What themes give continuity to this individual's life?
- What are some universal concerns of people at various points in life? How can people be challenged to make life-affirming choices at these points?
- What is the relationship between an individual's current problems and significant events from earlier years?
• What choices were made at critical periods, and how did the person deal with these various crises?
• What are the sociocultural factors influencing development that need to be understood if therapy is to be comprehensive?

Psychosocial theory gives special weight to childhood and adolescent factors that are significant in later stages of development while recognizing that the later stages also have their significant crises. Themes and threads can be found running throughout clients’ lives.

The Therapeutic Process

Therapeutic Goals
Two goals of Freudian psychoanalytic therapy are to make the unconscious conscious and to strengthen the ego so that behavior is based more on reality and less on instinctual cravings or irrational guilt. Successful analysis is believed to result in significant modification of the individual’s personality and character structure. Therapeutic methods are used to bring out unconscious material. Then childhood experiences are reconstructed, discussed, interpreted, and analyzed. It is clear that the process is not limited to solving problems and learning new behaviors. Rather, there is a deeper probing into the past to develop the level of self-understanding that is assumed to be necessary for a change in character. Psychoanalytic therapy is oriented toward achieving insight, but not just an intellectual understanding; it is essential that the feelings and memories associated with this self-understanding be experienced.

Therapist’s Function and Role
In classical psychoanalysis, analysts typically assume an anonymous stance, which is sometimes called the “blank-screen” approach. They engage in very little self-disclosure and maintain a sense of neutrality to foster a transference relationship, in which their clients will make projections onto them. This transference relationship, which is a cornerstone of psychoanalysis, “refers to the transfer of feelings originally experienced in an early relationship to other important people in a person’s present environment” (Luborsky, O’Reilly-Landry, & Arlow, 2008, pp. 17–18). If therapists say little about themselves and rarely share their personal reactions, the assumption is that whatever the client feels toward them will largely be the product of feelings associated with other significant figures from the past. These projections, which have their origins in unfinished and repressed situations, are considered “grist for the mill,” and their analysis is the very essence of therapeutic work.

One of the central functions of analysis is to help clients acquire the freedom to love, work, and play. Other functions include assisting clients in achieving self-awareness, honesty, and more effective personal relationships; in dealing with anxiety in a realistic way; and in gaining control over impulsive and irrational behavior. The analyst must first establish a working relationship with the client and then do a lot of listening and interpreting. Particular attention is given to the client’s resistances. The analyst listens, learns, and decides when
to make appropriate interpretations. A major function of interpretation is to accelerate the process of uncovering unconscious material. The analyst listens for gaps and inconsistencies in the client’s story, infers the meaning of reported dreams and free associations, and remains sensitive to clues concerning the client’s feelings toward the analyst.

Organizing these therapeutic processes within the context of understanding personality structure and psychodynamics enables the analyst to formulate the nature of the client’s problems. One of the central functions of the analyst is to teach clients the meaning of these processes (through interpretation) so that they are able to achieve insight into their problems, increase their awareness of ways to change, and thus gain more control over their lives.

The process of psychoanalytic therapy is somewhat like putting the pieces of a puzzle together. Whether clients change depends considerably more on their readiness to change than on the accuracy of the therapist’s interpretations. If the therapist pushes the client too rapidly or offers ill-timed interpretations, therapy will not be effective. Change occurs through the process of reworking old patterns so that clients might become freer to act in new ways (Luborsky et al., 2008).

Client’s Experience in Therapy

Clients interested in traditional (or classical) psychoanalysis must be willing to commit themselves to an intensive and long-term therapy process. After some face-to-face sessions with the analyst, clients lie on a couch and engage in free association; that is, they say whatever comes to mind without self-censorship. This process of free association is known as the “fundamental rule.” Clients report their feelings, experiences, associations, memories, and fantasies to the analyst. Lying on the couch encourages deep, uncensored reflections and reduces the stimuli that might interfere with getting in touch with internal conflicts and productions. It also reduces clients’ ability to “read” their analyst’s face for reactions and, hence, fosters the projections characteristic of a transference. At the same time, the analyst is freed from having to carefully monitor facial clues.

What has just been described is classical psychoanalysis. Psychodynamic therapy emerged as a way of shortening and simplifying the lengthy process of classical psychoanalysis (Luborsky et al., 2008). Many psychoanalytically oriented practitioners, or psychodynamic therapists (as distinct from analysts), do not use all the techniques associated with classical analysis. However, psychodynamic therapists do remain alert to transference manifestations, explore the meaning of clients’ dreams, explore both the past and the present, and are concerned with unconscious material.

Clients in psychoanalytic therapy make a commitment with the therapist to stick with the procedures of an intensive therapeutic process. They agree to talk because their verbal productions are the heart of psychoanalytic therapy. They are typically asked not to make any radical changes in their lifestyle during the period of analysis, such as getting a divorce or quitting their job. The reason for avoiding making such changes pertains to the therapeutic process that oftentimes is unsettling and also associated with loosening of defenses.
Psychoanalytic clients are ready to terminate their sessions when they and their analyst mutually agree that they have resolved those symptoms and conflicts that were amenable to resolution, have clarified and accepted their remaining emotional problems, have understood the historical roots of their difficulties, have mastery of core themes, and can integrate their awareness of past problems with their present relationships. Successful analysis answers a client’s “why” questions regarding his or her life. Clients who emerge successfully from analytic therapy report that they have achieved such things as an understanding of their symptoms and the functions they serve, an insight into how their environment affects them and how they affect the environment, and reduced defensiveness (Saretsky, 1978).

Relationship Between Therapist and Client

There are some differences between how the therapeutic relationship is conceptualized by classical analysis and current relational analysis. The classical analyst stands outside the relationship, comments on it, and offers insight-producing interpretations. In contemporary relational psychoanalysis, the therapist does not strive for a detached and objective stance. Instead, the participation of the therapist is a given, and he or she has an impact on the client and on the here-and-now interaction that occurs in the therapy context (Altman, 2008). Contemporary psychoanalytic theory and practice highlights the importance of the therapeutic relationship as a therapeutic factor in bringing about change (Ainslie, 2007). Through the therapeutic relationship “clients are able to find new modes of functioning that are no longer encumbered by the neurotic conflicts that once interfered with their lives” (p. 14). According to Luborsky, O’Reilly-Landry, and Arlow (2008), current psychodynamic therapists view the emotional communication between themselves and their clients as a useful way to gain information and create connection.

Transference is the client’s unconscious shifting to the analyst of feelings and fantasies that are reactions to significant others in the client’s past. Transference involves the unconscious repetition of the past in the present. “It reflects the deep patterning of old experiences in relationships as they emerge in current life” (Luborsky et al., 2008, p. 46). The relational model of psychoanalysis regards transference as being an interactive process between the client and the therapist. A client often has a variety of feelings and reactions to a therapist, including a mixture of positive and negative feelings. When these feelings become conscious, clients can understand and resolve “unfinished business” from these past relationships. As therapy progresses, childhood feelings and conflicts begin to surface from the depths of the unconscious. Clients regress emotionally. Some of their feelings arise from conflicts such as trust versus mistrust, love versus hate, dependence versus independence, and autonomy versus shame and guilt. Transference takes place when clients resurrect from their early years intense conflicts relating to love, sexuality, hostility, anxiety, and resentment; bring them into the present; reexperience them; and attach them to the analyst. For example, clients may transfer unresolved feelings toward a stern and unloving father to the analyst, who, in their eyes, becomes stern and unloving. Angry feelings are the product of negative transference,
but clients may also develop a positive transference and, for example, fall in love with the analyst, wish to be adopted, or in many other ways seek the love, acceptance, and approval of an all-powerful therapist. In short, the analyst becomes a current substitute for significant others.

If therapy is to produce change, the transference relationship must be worked through. The **working-through** process consists of an exploration of unconscious material and defenses, most of which originated in early childhood. Working through is achieved by repeating interpretations and by exploring forms of resistance. It results in a resolution of old patterns and allows clients to make new choices. Effective therapy requires that the client develop a relationship with the analyst in the present that is a corrective and integrative experience. By experiencing a therapist who is engaged, caring, and reliable, clients can be changed in profound ways, which can lead to new experiences of human relationships (Ainslie, 2007).

Clients have many opportunities to see the variety of ways in which their core conflicts and core defenses are manifested in their daily life. It is assumed that for clients to become psychologically independent they must not only become aware of this unconscious material but also achieve some level of freedom from behavior motivated by infantile strivings, such as the need for total love and acceptance from parental figures. If this demanding phase of the therapeutic relationship is not properly worked through, clients simply transfer their infantile wishes for universal love and acceptance to other figures. It is precisely in the client-therapist relationship that the manifestation of these childhood motivations becomes apparent.

Regardless of the length of psychoanalytic therapy, traces of our childhood needs and traumas will never be completely erased. Infantile conflicts may not be fully resolved, even though many aspects of transference are worked through with a therapist. We may need to struggle at times throughout our life with feelings that we project onto others as well as with unrealistic demands that we expect others to fulfill. In this sense we experience transference with many people, and our past is always a vital part of the person we are presently becoming.

It is a mistake to assume that all feelings clients have toward their therapists are manifestations of transference. Many of these reactions may have a reality base, and clients' feelings may well be directed to the here-and-now style the therapist exhibits. Not every positive response (such as liking the therapist) should be labeled “positive transference.” Conversely, a client's anger toward the therapist may be a function of the therapist's behavior; it is a mistake to label all negative reactions as signs of “negative transference.”

The notion of never becoming completely free of past experiences has significant implications for therapists who become intimately involved in the unresolved conflicts of their clients. Even if the conflicts of therapists have surfaced to awareness, and even if therapists have dealt with these personal issues in their own intensive therapy, they may still project distortions onto clients. The intense therapeutic relationship is bound to ignite some of the unconscious conflicts within therapists. Known as **countertransference**, this phenomenon occurs when there is inappropriate affect, when therapists respond
in irrational ways, or when they lose their objectivity in a relationship because their own conflicts are triggered. In a broader sense, countertransference involves the therapist’s total emotional response to a client. Hayes (2004) refers to countertransference as the therapist’s reactions to clients that are based on his or her unresolved conflicts. Gelso and Hayes (2002) indicate that research has shed light on specific causes of countertransference within the therapist such as conflicts revolving around the therapist’s family experiences, gender roles, parenting roles, and unmet needs.

It is critical that therapists become aware of the countertransference so that their reactions toward clients do not interfere with their objectivity. For example, a male client may become excessively dependent on his female therapist. The client may look to her to direct him and tell him how to live, and he may look to her for the love and acceptance that he felt he was unable to secure from his mother. The therapist herself may have unresolved needs to nurture, to foster a dependent relationship, and to be told that she is significant, and she may be meeting her own needs by in some way keeping her client dependent. Unless she is aware of her own needs as well as her own dynamics, it is very likely that her dynamics will interfere with the progress of therapy.

Not all countertransference reactions are detrimental to therapeutic progress. Indeed, countertransference reactions can provide an important means for understanding the world of the client. Hayes (2004) reports that most research on countertransference has dealt with its deleterious effects and how to manage these reactions. Hayes adds that it would be useful to undertake systematic study of the potential therapeutic benefits of countertransference. Gelso and Hayes (2002) contend that it is important to study and understand all of the therapist’s emotional reactions to the client, which fit under the broad umbrella of countertransference. According to Gelso and Hayes, counterttransference can greatly benefit the therapeutic work, if therapists study their internal reactions and use them to understand their clients. Ainslie (2007) also agrees that the therapist’s countertransference reactions can provide rich information about both the client and the therapist. Ainslie states that the contemporary understanding of countertransference “has broadened significantly to include a range of feelings, reactions, and responses to the client’s material that are not seen as problematic but, on the contrary, are viewed as vital tools to understanding the client’s experience” (p. 17). What is critical is that therapists monitor their feelings during therapy sessions, and that they use their responses as a source for understanding clients and helping them to understand themselves.

A therapist with a relational perspective pays attention to his or her countertransference reactions and observations to a particular client and uses this as a part of therapy. The therapist who notes a countertransference mood of irritability, for instance, may learn something about a client’s pattern of being demanding. In this light, countertransference can be seen as potentially useful if it is explored in therapy. Viewed in this more positive way, countertransference can become a key avenue for helping the client gain self-understanding.

What is of paramount importance is that therapists develop some level of objectivity and not react defensively and subjectively in the face of anger, love,
adulation, criticism, and other intense feelings expressed by their clients. Most psychoanalytic training programs require that trainees undergo their own extensive analysis as a client. If psychotherapists become aware of symptoms (such as strong aversion to certain types of clients, strong attraction to other types of clients, psychosomatic reactions that occur at definite times in therapeutic relationships, and the like), it is imperative for them to seek professional consultation or enter their own therapy for a time to work out these personal issues that stand in the way of their being effective therapists.

The client-therapist relationship is of vital importance in psychoanalytic therapy. As a result of this relationship, particularly in working through the transference situation, clients acquire insights into the workings of their unconscious process. Awareness of and insights into repressed material are the bases of the analytic growth process. Clients come to understand the association between their past experiences and their current behavior. The psychoanalytic approach assumes that without this dynamic self-understanding there can be no substantial personality change or resolution of present conflicts.

**Application: Therapeutic Techniques and Procedures**

This section deals with the techniques most commonly used by psychoanalytically oriented therapists. It also includes a section on the applications of the psychoanalytic approach to group counseling. Psychoanalytic therapy, or psychodynamic therapy (as opposed to traditional psychoanalysis), includes these features:

- The therapy is geared more to limited objectives than to restructuring one’s personality.
- The therapist is less likely to use the couch.
- There are fewer sessions each week.
- There is more frequent use of supportive interventions—such as reassurance, expressions of empathy and support, and suggestions—and more self-disclosure by the therapist.
- The focus is more on pressing practical concerns than on working with fantasy material.

The techniques of psychoanalytic therapy are aimed at increasing awareness, fostering insights into the client’s behavior, and understanding the meanings of symptoms. The therapy proceeds from the client’s talk to catharsis (or expression of emotion) to insight to working through unconscious material. This work is done to attain the goals of intellectual and emotional understanding and reeducation, which, it is hoped, leads to personality change. The six basic techniques of psychoanalytic therapy are (1) maintaining the analytic framework, (2) free association, (3) interpretation, (4) dream analysis, (5) analysis of resistance, and (6) analysis of transference. See *Case Approach to Counseling and Psychotherapy* (Corey, 2009, chap. 2), where Dr. William Blau, a psychoanalytically oriented therapist, illustrates some treatment techniques in the case of Ruth.
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Maintaining the Analytic Framework
The psychoanalytic process stresses maintaining a particular framework aimed at accomplishing the goals of this type of therapy. Maintaining the analytic framework refers to a whole range of procedural and stylistic factors, such as the analyst’s relative anonymity, the regularity and consistency of meetings, and starting and ending the sessions on time. One of the most powerful features of psychoanalytically oriented therapy is that the consistent framework is itself a therapeutic factor, comparable on an emotional level to the regular feeding of an infant. Analysts attempt to minimize departures from this consistent pattern (such as vacations, changes in fees, or changes in the meeting environment).

Free Association
Free association is a central technique in psychoanalytic therapy, and it plays a key role in the process of maintaining the analytic framework. In free association, clients are encouraged to say whatever comes to mind, regardless of how painful, silly, trivial, illogical, or irrelevant it may be. In essence, clients flow with any feelings or thoughts by reporting them immediately without censorship. As the analytic work progresses, most clients will occasionally depart from this basic rule, and these resistances will be interpreted by the therapist when it is timely to do so.

Free association is one of the basic tools used to open the doors to unconscious wishes, fantasies, conflicts, and motivations. This technique often leads to some recollection of past experiences and, at times, a release of intense feelings (catharsis) that have been blocked. This release is not seen as crucial in itself, however. During the free-association process, the therapist’s task is to identify the repressed material that is locked in the unconscious. The sequence of associations guides the therapist in understanding the connections clients make among events. Blockings or disruptions in associations serve as cues to anxiety-arousing material. The therapist interprets the material to clients, guiding them toward increased insight into the underlying dynamics.

As analytic therapists listen to their clients’ free associations, they hear not only the surface content but also the hidden meaning. This awareness of the language of the unconscious has been termed “listening with the third ear” (Reik, 1948). Nothing the client says is taken at face value. For example, a slip of the tongue can suggest that an expressed emotion is accompanied by a conflicting affect. Areas that clients do not talk about are as significant as the areas they do discuss.

Interpretation
Interpretation consists of the analyst’s pointing out, explaining, and even teaching the client the meanings of behavior that is manifested in dreams, free association, resistances, and the therapeutic relationship itself. The functions of interpretations are to enable the ego to assimilate new material and to speed up the process of uncovering further unconscious material.

Interpretation is grounded in the therapist’s assessment of the client’s personality and of the factors in the client’s past that contributed to his or her
difficulties. Under contemporary definitions, interpretation includes identifying, clarifying, and translating the client's material.

In making an appropriate interpretation, the therapist must be guided by a sense of the client's readiness to consider it (Saretsky, 1978). The therapist uses the client's reactions as a gauge. It is important that interpretations be well timed; the client will reject ones that are inappropriately timed. A general rule is that interpretation should be presented when the phenomenon to be interpreted is close to conscious awareness. In other words, the analyst should interpret material that the client has not yet seen for him- or herself but is capable of tolerating and incorporating. Another general rule is that interpretation should always start from the surface and go only as deep as the client is able to go. A third general rule is that it is best to point out a resistance or defense before interpreting the emotion or conflict that lies beneath it.

Dream Analysis

Dream analysis is an important procedure for uncovering unconscious material and giving the client insight into some areas of unresolved problems. During sleep, defenses are lowered and repressed feelings surface. Freud sees dreams as the "royal road to the unconscious," for in them one's unconscious wishes, needs, and fears are expressed. Some motivations are so unacceptable to the person that they are expressed in disguised or symbolic form rather than being revealed directly.

Dreams have two levels of content: latent content and manifest content. Latent content consists of hidden, symbolic, and unconscious motives, wishes, and fears. Because they are so painful and threatening, the unconscious sexual and aggressive impulses that make up latent content are transformed into the more acceptable manifest content, which is the dream as it appears to the dreamer. The process by which the latent content of a dream is transformed into the less threatening manifest content is called dream work. The therapist's task is to uncover disguised meanings by studying the symbols in the manifest content of the dream.

During the session, therapists may ask clients to free associate to some aspect of the manifest content of a dream for the purpose of uncovering the latent meanings. Therapists participate in the process by exploring clients' associations with them. Interpreting the meanings of the dream elements helps clients unlock the repression that has kept the material from consciousness and relate the new insight to their present struggles. Dreams may serve as a pathway to repressed material, but they also provide an understanding of clients' current functioning.

Analysis and Interpretation of Resistance

Resistance, a concept fundamental to the practice of psychoanalysis, is anything that works against the progress of therapy and prevents the client from producing previously unconscious material. Specifically, resistance is the client's reluctance to bring to the surface of awareness unconscious material that has been repressed. Resistance refers to any idea, attitude, feeling, or action (conscious or unconscious) that fosters the status quo and
gets in the way of change. During free association or association to dreams, the client may evidence an unwillingness to relate certain thoughts, feelings, and experiences. Freud viewed resistance as an unconscious dynamic that people use to defend against the intolerable anxiety and pain that would arise if they were to become aware of their repressed impulses and feelings.

As a defense against anxiety, resistance operates specifically in psychoanalytic therapy to prevent clients and therapists from succeeding in their joint effort to gain insights into the dynamics of the unconscious. Because resistance blocks threatening material from entering awareness, analytic therapists point it out, and clients must confront it if they hope to deal with conflicts realistically. The therapists' interpretation is aimed at helping clients become aware of the reasons for the resistance so that they can deal with them. As a general rule, therapists point out and interpret the most obvious resistances to lessen the possibility of clients' rejecting the interpretation and to increase the chance that they will begin to look at their resistive behavior.

Resistances are not just something to be overcome. Because they are representative of usual defensive approaches in daily life, they need to be recognized as devices that defend against anxiety but that interfere with the ability to accept change that could lead to experiencing a more gratifying life. It is extremely important that therapists respect the resistances of clients and assist them in working therapeutically with their defenses. When handled properly, resistance can be one of the most valuable tools in understanding the client.

Analysis and Interpretation of Transference

As was mentioned earlier, transference manifests itself in the therapeutic process when clients' earlier relationships contribute to their distorting the present with the therapist. The transference situation is considered valuable because its manifestations provide clients with the opportunity to reexperience a variety of feelings that would otherwise be inaccessible. Through the relationship with the therapist, clients express feelings, beliefs, and desires that they have buried in their unconscious. Through appropriate interpretations and working through of these current expressions of early feelings, clients are able to become aware of and to gradually change some of their long-standing patterns of behavior. Analytically oriented therapists consider the process of exploring and interpreting transference feelings as the core of the therapeutic process because it is aimed at achieving increased awareness and personality change.

The analysis of transference is a central technique in psychoanalysis and psychoanalytically oriented therapy, for it allows clients to achieve here-and-now insight into the influence of the past on their present functioning. Interpretation of the transference relationship enables clients to work through old conflicts that are keeping them fixated and retarding their emotional growth. In essence, the effects of early relationships are counteracted by working through a similar emotional conflict in the therapeutic relationship. An example of utilizing transference is given in a later section on the case of Stan.
Psychoanalytic Therapy Applied to the Case of Stan

In each of the chapters in Part 2, the case of Stan is used to demonstrate the practical applications of the theory in question. To give you a focus on Stan’s central concerns, refer to the end of Chapter 1, where his biography is given. I also recommend that you at least skim Chapter 16, which deals with an integrative approach as applied to Stan.

In Chapters 4 through 14 you will notice that Stan is working with a female therapist. Given his feelings toward women, it may seem odd that he selected a woman for his therapist. However, knowing that he had difficulty with women, he consciously made this choice as a way to challenge himself. As you will see, one of Stan’s goals is to learn how to become less intimidated in the presence of women and to be more himself around them.

The psychoanalytic approach focuses on the unconscious psychodynamics of Stan’s behavior. Considerable attention is given to material that he has repressed. At the extreme, Stan demonstrated a self-destructive tendency, which is a way of inflicting punishment on himself. Instead of directing his hostility toward his parents and siblings, he turned it inward toward himself. Stan’s preoccupation with drinking could be hypothesized as evidence of an oral fixation. Because he never received love and acceptance during his early childhood, he is still suffering from this deprivation and still desperately searching for approval and acceptance from others. Stan’s gender-role identification was fraught with difficulties. He learned the basis of female-male relationships through his early experiences with his parents. What he saw was fighting, bickering, and discounting. His father was the weak one who always lost, and his mother was the strong, domineering force who could and did hurt men. Stan generalized his fear of his mother to all women. It could be further hypothesized that the woman he married was similar to his mother, both of whom reinforced his feelings of impotence.

The opportunity to develop a transference relationship and work through it is the core of the therapy process. An assumption is that Stan will eventually relate to his therapist as he did to his mother and that the process will be a valuable means of gaining insight into the origin of his difficulties with women. The analytic process stresses an intensive exploration of Stan’s past. The goal is to make the unconscious conscious, so that he will no longer be controlled by unconscious forces. Stan devotes much therapy time to reliving and exploring his early past. As he talks, he gains increased understanding of the dynamics of his behavior. He begins to see connections between his present problems and early experiences in his childhood. Stan explores memories of relationships with his siblings and with his mother and father and also explores how he has generalized his view of women and men from his view of these family members. It is expected that he will reexperience old feelings and uncover buried feelings related to traumatic events. From another perspective, apart from whatever conscious insight Stan may acquire, the goal is for him to have a more integrated self, where feelings split off as foreign (the id) become more a part of what he is comfortable with (the ego). The relationship with his therapist, where old feelings have different outcomes from his past experiences with significant others, can result in deep personality growth.

The therapist is likely to explore some of these questions with Stan: “What did you do when you felt unloved?” “As a child, what did you do with your negative feelings?” “Could you express your rage, hostility, hurt, and fears?” “What effects did your relationship with your mother have on you?” “What did this teach you about all women?” Brought into the here and now of the transference relationship, questions might include “When have you felt anything like this with me?” and “What are you learning from our relationship about how relationships with women might go?”

The analytic process focuses on key influences in Stan’s developmental years, sometimes explicitly, sometimes in terms of how those earlier events are being relived in the present analytic relationship. As he comes to understand how he has been shaped by these past experiences, he is increasingly able to exert control over his present functioning. Many of Stan’s fears become conscious, and then his energy does not have to remain fixed on defending himself from unconscious feelings. Instead, he can make new
decisions about his current life. He can do this only if the therapist works through the transference relationship, however, for the depth of his endeavors in therapy largely determine the depth and extent of his personality changes.

If the therapist is operating from a contemporary psychoanalytic orientation, her focus may well be on Stan’s developmental sequences. Particular attention is paid to understanding his current behavior in the world as largely a repetition of one of his earlier developmental phases. Because of his dependency, it is useful in understanding his behavior to see that he is now repeating patterns that he formed with his mother during his infancy. Viewed from this perspective, Stan has not accomplished the task of separation and individuation. He is still “stuck” in the symbiotic phase on some levels. He is unable to obtain his confirmation of worth from himself, and he has not resolved the dependence–independence struggle. Looking at his behavior from the viewpoint of self psychology can help the therapist deal with his difficulties in forming intimate relationships.

Follow-Up: You Continue as Stan’s Psychoanalytic Therapist

With each of the 11 theoretical orientations, you will be encouraged to try your hand at applying the principles and techniques you have just studied in the chapter to working with Stan from that particular perspective. The information presented about Stan from each of these theory chapters will provide you with some ideas of how you might continue working with him if he were referred to you. Do your best to stay within the general spirit of each theory by identifying specific concepts you would draw from and techniques that you might use in helping him explore the struggles he identifies. Here are a series of questions to provide some structure in your thinking about his case:

- How much interest would you have in Stan’s early childhood? What are some ways you’d help him see patterns between his childhood issues and his current problems?
- Consider the transference relationship that is likely to be established between you and Stan. How might you react to his making you into a significant person in his life?
- In working with Stan, what countertransference issues might arise for you?
- What resistances might you predict in your work with Stan? From a psychoanalytic perspective, how would you interpret and work with this resistance?

See the online and DVD program, *Theory in Practice: The Case of Stan* (Session 1, an initial session with Stan, and Session 2, on psychoanalytic therapy), for a demonstration of my approach to counseling Stan from this perspective. The first session consists of the intake and assessment process. The second session focuses on Stan’s resistance and dealing with transference.
READING

CHAPTER NINE

Behavior Therapy

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Four Areas of Development

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View of Human Nature
Basic Characteristics and Assumptions

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Therapeutic Goals
Therapist's Function and Role
Client's Experience in Therapy
Relationship Between Therapist and Client

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Applied Behavioral Analysis: Operant Conditioning Techniques
Relaxation Training and Related Methods
Systematic Desensitization
In Vivo Exposure and Flooding
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Self-Modification Programs and Self-Directed Behavior
Multimodal Therapy. Clinical Behavior Therapy
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Application to Group Counseling

Behavior Therapy From a Multicultural Perspective
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Summary and Evaluation
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Recommended Supplementary Readings
References and Suggested Readings
B. F. SKINNER (1904–1990) reported that he was brought up in a warm, stable family environment. As he was growing up, Skinner was greatly interested in building all sorts of things, an interest that followed him throughout his professional life. He received his PhD in psychology from Harvard University in 1931 and eventually returned to Harvard after teaching in several universities. He had two daughters, one of whom is an educational psychologist and the other an artist.

Skinner was a prominent spokesperson for behaviorism and can be considered the father of the behavioral approach to psychology. Skinner championed radical behaviorism, which places primary emphasis on the effects of environment on behavior. Skinner was also a determinist; he did not believe that humans had free choice. He acknowledged that feelings and thoughts exist, but he denied that they caused our actions. Instead, he stressed the cause-and-effect links between objective, observable environmental conditions and behavior. Skinner maintained that too much attention had been given to internal states of mind and motives, which cannot be observed and changed directly, and that too little focus had been given to environmental factors that can be directly observed and changed. He was extremely interested in the concept of reinforcement, which he applied to his own life. For example, after working for many hours, he would go into his constructed cocoon (like a tent), put on headphones, and listen to classical music (Frank Dattilio, personal communication, December 9, 2006).

Most of Skinner’s work was of an experimental nature in the laboratory, but others have applied his ideas to teaching, managing human problems, and social planning. *Science and Human Behavior* (Skinner, 1953) best illustrates how Skinner thought behavioral concepts could be applied to every domain of human behavior. In *Walden II* (1948) Skinner describes a utopian community in which his ideas, derived from the laboratory, are applied to social issues. His 1971 book, *Beyond Freedom and Dignity*, addressed the need for drastic changes if our society was to survive. Skinner believed that science and technology held the promise for a better future.

*This biography is based largely on Nye’s (2000) discussion of B. F. Skinner’s radical behaviorism.*

ALBERT BANDURA (b. 1925) was born near Alberta, Canada; he was the youngest of six children in a family of Eastern European descent. Bandura spent his elementary and high school years in the one school in town, which was short of teachers and resources. These meager educational resources proved to be an asset rather than a liability as Bandura early on learned the skills of self-directedness, which would later become one of his research themes. He earned his PhD in clinical psychology from the University of Iowa in 1952, and a year later he joined the faculty at Stanford University. Bandura and his colleagues did pioneering work in the area of social modeling and demonstrated that modeling is a powerful process that explains diverse forms of learning (see Bandura 1971a, 1971b; Bandura & Walters, 1963). In his research programs at Stanford University, Bandura and his colleagues explored social learning theory and the prominent role of observational learning and social modeling in human motivation, thought, and action. By the mid-1980s Bandura had renamed his theoretical approach social cognitive theory, which sheds light on how we function as self-organizing, proactive, self-reflective, and self-regulating beings (see Bandura, 1986). This notion that we are not simply reactive organisms shaped by environmental forces or driven by inner impulses represented a dramatic shift in the development of behavior therapy. Bandura broadened the scope of behavior therapy by exploring the inner cognitive-affective forces that motivate human behavior.

There are some existential qualities inherent in Bandura’s social cognitive theory. Bandura has produced a wealth of empirical evidence that demonstrates the life choices we have in all aspects of our lives. In *Self-Efficacy: The Exercise of Control* (Bandura, 1997), Bandura shows the comprehensive applications of his theory of self-efficacy to areas such as human development, psychology, psychiatry, education, medicine and health, athletics, business, social and political change, and international affairs.
Introduction

Behavior therapy practitioners focus on observable behavior, current determinants of behavior, learning experiences that promote change, tailoring treatment strategies to individual clients, and rigorous assessment and evaluation (Kazdin, 2001; Wilson, 2008). Behavior therapy has been used to treat a wide range of psychological disorders with different client populations (Wilson, 2008). Anxiety disorders, depression, substance abuse, eating disorders, domestic violence, sexual problems, pain management, and hypertension have all been successfully treated using this approach. Behavioral procedures are used in the fields of developmental disabilities, mental illness, education and special education, community psychology, clinical psychology, rehabilitation, business, self-management, sports psychology, health-related behaviors, and gerontology (Miltenberger, 2008).

Historical Background

The behavioral approach had its origin in the 1950s and early 1960s, and it was a radical departure from the dominant psychoanalytic perspective. The behavior therapy movement differed from other therapeutic approaches in its application of principles of classical and operant conditioning (which will be explained shortly) to the treatment of a variety of problem behaviors. Today, it is difficult to find a consensus on the definition of behavior therapy because the field has grown, become more complex, and is marked by a diversity of views. Indeed, as behavior therapy has evolved and developed, it has increasingly overlapped in some ways with other psychotherapeutic approaches (Wilson, 2008). The discussion presented here is based on Spiegler and Guevremont’s (2003) historical sketch of behavior therapy.

Traditional behavior therapy arose simultaneously in the United States, South Africa, and Great Britain in the 1950s. In spite of harsh criticism and resistance from psychoanalytic psychotherapists, the approach survived. Its focus was on demonstrating that behavioral conditioning techniques were effective and were a viable alternative to psychoanalytic therapy.
In the 1960s Albert Bandura developed social learning theory, which combined classical and operant conditioning with observational learning. Bandura made cognition a legitimate focus for behavior therapy. During the 1960s a number of cognitive behavioral approaches sprang up, and they still have a significant impact on therapeutic practice (see Chapter 10).

Contemporary behavior therapy emerged as a major force in psychology during the 1970s, and it had a significant impact on education, psychology, psychotherapy, psychiatry, and social work. Behavioral techniques were expanded to provide solutions for business, industry, and child-rearing problems as well. Known as the “first wave” in the behavioral field, behavior therapy techniques were viewed as the treatment of choice for many psychological problems.

The 1980s were characterized by a search for new horizons in concepts and methods that went beyond traditional learning theory. Behavior therapists continued to subject their methods to empirical scrutiny and to consider the impact of the practice of therapy on both their clients and the larger society. Increased attention was given to the role of emotions in therapeutic change, as well as to the role of biological factors in psychological disorders. Two of the most significant developments in the field were (1) the continued emergence of cognitive behavior therapy as a major force and (2) the application of behavioral techniques to the prevention and treatment of health-related disorders.

By the late 1990s the Association for Behavioral and Cognitive Therapies (ABCT) (formerly known as the Association for Advancement of Behavior Therapy) claimed a membership of about 4,300. The current description of ABCT is “a membership organization of more than 4,500 mental health professionals and students who are interested in empirically based behavior therapy or cognitive behavior therapy.” This name change and description reveals the current thinking of integrating behavioral and cognitive therapies. Cognitive therapy is considered to be the “second wave” of the behavioral tradition.

By the early 2000s, the “third wave” of the behavioral tradition emerged, enlarging the scope of research and practice. This newest development includes dialectical behavior therapy, mindfulness-based stress reduction, mindfulness-based cognitive therapy, and acceptance and commitment therapy.

Four Areas of Development

Contemporary behavior therapy can be understood by considering four major areas of development: (1) classical conditioning, (2) operant conditioning, (3) social learning theory, and (4) cognitive behavior therapy.

Classical conditioning (respondent conditioning) refers to what happens prior to learning that creates a response through pairing. A key figure in this area is Ivan Pavlov who illustrated classical conditioning through experiments with dogs. Placing food in a dog’s mouth leads to salivation, which is respondent behavior. When food is repeatedly presented with some originally neutral stimulus (something that does not elicit a particular response), such as the sound of a bell, the dog will eventually salivate to the sound of the bell alone. However, if a bell is sounded repeatedly but not paired again with food, the salivation response will eventually diminish and become extinct. An example
of a procedure that is based on the classical conditioning model is Joseph Wolpe's systematic desensitization, which is described later in this chapter. This technique illustrates how principles of learning derived from the experimental laboratory can be applied clinically. Desensitization can be applied to people who, through classical conditioning, developed an intense fear of flying after having a frightening experience while flying.

Most of the significant responses we make in everyday life are examples of operant behaviors, such as reading, writing, driving a car, and eating with utensils. Operant conditioning involves a type of learning in which behaviors are influenced mainly by the consequences that follow them. If the environmental changes brought about by the behavior are reinforcing—that is, if they provide some reward to the organism or eliminate aversive stimuli—the chances are increased that the behavior will occur again. If the environmental changes produce no reinforcement or produce aversive stimuli, the chances are lessened that the behavior will recur. Positive and negative reinforcement, punishment, and extinction techniques, described later in this chapter, illustrate how operant conditioning in applied settings can be instrumental in developing prosocial and adaptive behaviors. Operant techniques are used by behavioral practitioners in parent education programs and with weight management programs.

The behaviorists of both the classical and operant conditioning models excluded any reference to mediational concepts, such as the role of thinking processes, attitudes, and values. This focus is perhaps due to a reaction against the insight-oriented psychodynamic approaches. The social learning approach (or the social-cognitive approach), developed by Albert Bandura and Richard Walters (1963), is interactional, interdisciplinary, and multimodal (Bandura, 1977, 1982). Social learning and cognitive theory involves a triadic reciprocal interaction among the environment, personal factors (beliefs, preferences, expectations, self-perceptions, and interpretations), and individual behavior. In the social-cognitive approach the environmental events on behavior are mainly determined by cognitive processes governing how environmental influences are perceived by an individual and how these events are interpreted (Wilson, 2008). A basic assumption is that people are capable of self-directed behavior change. For Bandura (1982, 1997), self-efficacy is the individual's belief or expectation that he or she can master a situation and bring about desired change. An example of social learning is how people can develop effective social skills after they are in contact with other people who effectively model interpersonal skills.

Cognitive behavior therapy and social learning theory now represent the mainstream of contemporary behavior therapy. Since the early 1970s, the behavioral movement has conceded a legitimate place to thinking, even to the extent of giving cognitive factors a central role in understanding and treating emotional and behavioral problems. By the mid-1970s cognitive behavior therapy had replaced behavior therapy as the accepted designation and the field began emphasizing the interaction among affective, behavioral, and cognitive dimensions (Lazarus, 2003; Wilson, 2008). A good example of this more integrative approach is multimodal therapy, which is discussed later in this chapter. Many techniques, particularly those developed within the last three decades,
emphasize cognitive processes that involve private events such as the client's self-talk as mediators of behavior change (see Bandura, 1969, 1986; Beck, 1976; Beck & Weishaar, 2008).

The former distinction between behavior therapy and cognitive behavior therapy is far less of one now than it used to be, and in reality, is much more blended in theory, practice, and research (Sherry Cormier, personal communication, November 20, 2006). This chapter goes beyond the pure or traditional behavioral perspective and deals mainly with the applied aspects of this model. Chapter 10 is devoted to the cognitive behavioral approaches, which focus on changing clients' cognitions (thoughts and beliefs) that maintain psychological problems.

Key Concepts

View of Human Nature

Modern behavior therapy is grounded on a scientific view of human behavior that implies a systematic and structured approach to counseling. This view does not rest on a deterministic assumption that humans are a mere product of their sociocultural conditioning. Rather, the current view is that the person is the producer and the product of his or her environment.

The current trend in behavior therapy is toward developing procedures that actually give control to clients and thus increase their range of freedom. Behavior therapy aims to increase people's skills so that they have more options for responding. By overcoming debilitating behaviors that restrict choices, people are freer to select from possibilities that were not available earlier, increasing individual freedom (Kazdin, 1978, 2001). It is possible to make a case for using behavioral methods to attain humanistic ends (Kazdin, 2001; Watson & Tharp, 2007).

Basic Characteristics and Assumptions

Six key characteristics of behavior therapy are described below.

1. Behavior therapy is based on the principles and procedures of the scientific method. Experimentally derived principles of learning are systematically applied to help people change their maladaptive behaviors. The distinguishing characteristic of behavioral practitioners is their systematic adherence to precision and to empirical evaluation. Behavior therapists state treatment goals in concrete objective terms to make replication of their interventions possible. Treatment goals are agreed upon by the client and the therapist. Throughout the course of therapy, the therapist assesses problem behaviors and the conditions that are maintaining them. Research methods are used to evaluate the effectiveness of both assessment and treatment procedures. Therapeutic techniques employed must have demonstrated effectiveness. In short, behavioral concepts and procedures are stated explicitly, tested empirically, and revised continually.

2. Behavior therapy deals with the client's current problems and the factors influencing them, as opposed to an analysis of possible historical determinants.
Emphasis is on specific factors that influence present functioning and what factors can be used to modify performance. At times understanding of the past may offer useful information about environmental events related to present behavior. Behavior therapists look to the current environmental events that maintain problem behaviors and help clients produce behavior change by changing environmental events, through a process called functional assessment, or what Wolpe (1990) referred to as a “behavioral analysis.”

3. Clients involved in behavior therapy are expected to assume an active role by engaging in specific actions to deal with their problems. Rather than simply talking about their condition, they are required to do something to bring about change. Clients monitor their behaviors both during and outside the therapy sessions, learn and practice coping skills, and role-play new behavior. Therapeutic tasks that clients carry out in daily life, or homework assignments, are a basic part of this approach. Behavior therapy is an action-oriented and an educational approach, and learning is viewed as being at the core of therapy. Clients learn new and adaptive behaviors to replace old and maladaptive behaviors.

4. This approach assumes that change can take place without insight into underlying dynamics. Behavior therapists operate on the premise that changes in behavior can occur prior to or simultaneously with understanding of oneself, and that behavioral changes may well lead to an increased level of self-understanding. While it is true that insight and understanding about the contingencies that exacerbate one’s problems can supply motivation to change, knowing that one has a problem and knowing how to change it are two different things (Martell, 2007).

5. The focus is on assessing overt and covert behavior directly, identifying the problem, and evaluating change. There is direct assessment of the target problem through observation or self-monitoring. Therapists also assess their clients’ cultures as part of their social environments, including social support networks relating to target behaviors (Tanaka-Matsumi, Higginbotham, & Chang, 2002). Critical to behavioral approaches is the careful assessment and evaluation of the interventions used to determine whether the behavior change resulted from the procedure.

6. Behavioral treatment interventions are individually tailored to specific problems experienced by clients. Several therapy techniques may be used to treat an individual client’s problems. An important question that serves as a guide for this choice is: “What treatment, by whom, is the most effective for this individual with that specific problem and under which set of circumstances?” (Paul, 1967, p. 111).

The Therapeutic Process

Therapeutic Goals

Goals occupy a place of central importance in behavior therapy. The general goals of behavior therapy are to increase personal choice and to create new conditions for learning. The client, with the help of the therapist, defines specific
treatment goals at the outset of the therapeutic process. Although assessment and treatment occur together, a formal assessment takes place prior to treatment to determine behaviors that are targets of change. Continual assessment throughout therapy determines the degree to which identified goals are being met. It is important to devise a way to measure progress toward goals based on empirical validation.

Contemporary behavior therapy stresses clients’ active role in deciding about their treatment. The therapist assists clients in formulating specific measurable goals. Goals must be clear, concrete, understood, and agreed on by the client and the counselor. The counselor and client discuss the behaviors associated with the goals, the circumstances required for change, the nature of subgoals, and a plan of action to work toward these goals. This process of determining therapeutic goals entails a negotiation between client and counselor that results in a contract that guides the course of therapy. Behavior therapists and clients alter goals throughout the therapeutic process as needed.

Therapist’s Function and Role

Behavior therapists conduct a thorough functional assessment (or behavioral analysis) to identify the maintaining conditions by systematically gathering information about situational antecedents, the dimensions of the problem behavior, and the consequences of the problem. This is known as the ABC model, which addresses antecedents, behaviors, and consequences. This model of behavior suggests that behavior (B) is influenced by some particular events that precede it, called antecedents (A), and by certain events that follow it called consequences (C).

Antecedent events are ones that cue or elicit a certain behavior. For example, with a client who has trouble going to sleep, listening to a relaxation tape may serve as a cue for sleep induction. Turning off the lights and removing the television from the bedroom may elicit sleep behaviors as well. Consequences are events that maintain a behavior in some way either by increasing or decreasing it. For example, a client may be more likely to return to counseling after the counselor offers verbal praise or encouragement for having come in or having completed some homework. A client may be less likely to return after the counselor is consistently late to sessions. In doing an assessment interview, the therapist’s task is to identify the particular antecedent and consequent events that influence or are functionally related to an individual’s behavior (Cormier, Nurtus, & Osborn, 2009).

Behaviorally oriented practitioners tend to be active and directive and to function as consultants and problem solvers. They pay close attention to the clues given by clients, and they are willing to follow their clinical hunches. Behavioral practitioners must possess skills, sensitivity, and clinical acumen (Wilson, 2008). They use some techniques common to other approaches, such as summarizing, reflection, clarification, and open-ended questioning. However, behavioral clinicians perform other functions as well (Miltenerberger, 2008; Spiegler & Guevremont, 2003):

- Based on a comprehensive functional assessment, the therapist formulates initial treatment goals and designs and implements a treatment plan to accomplish these goals.
• The behavioral clinician uses strategies that have research support for use with a particular kind of problem. These strategies are used to promote generalization and maintenance of behavior change. A number of these strategies are described later in this chapter.

• The clinician evaluates the success of the change plan by measuring progress toward the goals throughout the duration of treatment. Outcome measures are given to the client at the beginning of treatment (called a baseline) and collected again periodically during and after treatment to determine if the strategy and treatment plan are working. If not, adjustments are made in the strategies being used.

• A key task of the therapist is to conduct follow-up assessments to see whether the changes are durable over time. Clients learn how to identify and cope with potential setbacks. The emphasis is on helping clients maintain changes over time and acquire behavioral and cognitive coping skills to prevent relapses.

Let's examine how a behavior therapist might perform these functions. A client comes to therapy to reduce her anxiety, which is preventing her from leaving the house. The therapist is likely to begin with a specific analysis of the nature of her anxiety. The therapist will ask how she experiences the anxiety of leaving her house, including what she actually does in these situations. Systematically, the therapist gathers information about this anxiety. When did the problem begin? In what situations does it arise? What does she do at these times? What are her feelings and thoughts in these situations? Who is present when she experiences anxiety? What does she do to reduce the anxiety? How do her present fears interfere with living effectively? After this assessment, specific behavioral goals will be developed, and strategies such as relaxation training, systematic desensitization, and exposure therapy will be designed to help the client reduce her anxiety to a manageable level. The therapist will get a commitment from her to work toward the specified goals, and the two of them will evaluate her progress toward meeting these goals throughout the duration of therapy.

Client's Experience in Therapy

One of the unique contributions of behavior therapy is that it provides the therapist with a well-defined system of procedures to employ. Both therapist and client have clearly defined roles, and the importance of client awareness and participation in the therapeutic process is stressed. Behavior therapy is characterized by an active role for both therapist and client. A large part of the therapist's role is to teach concrete skills through the provision of instructions, modeling, and performance feedback. The client engages in behavioral rehearsal with feedback until skills are well learned and generally receives active homework assignments (such as self-monitoring of problem behaviors) to complete between therapy sessions. Martell (2007) emphasized that changes clients make in therapy must be translated into their daily lives; clients must continue working on the changes begun in the therapy office throughout the week. Clients must be motivated to change and are expected to cooperate in
carrying out therapeutic activities, both during therapy sessions and in everyday life. If clients are not involved in this way, the chances are slim that therapy will be successful. However, if clients are not motivated, another behavioral strategy that has considerable empirical support is motivational interviewing. This strategy involves honoring the client's resistance in such a way that his or her motivation to change is increased over time (Cormier et al., 2009).

Clients are encouraged to experiment for the purpose of enlarging their repertoire of adaptive behaviors. Counseling is not complete unless actions follow verbalizations. Indeed, it is only when the transfer of changes is made from the sessions to everyday life and when the effects of therapy are extended beyond termination that treatment can be considered successful (Granvold & Wodarski, 1994). Clients are as aware as the therapist is regarding when the goals have been accomplished and it is appropriate to terminate treatment. It is clear that clients are expected to do more than merely gather insights; they need to be willing to make changes and to continue implementing new behavior once formal treatment has ended.

**Relationship Between Therapist and Client**

Clinical and research evidence suggests that a therapeutic relationship, even in the context of a behavioral orientation, can contribute significantly to the process of behavior change (Granvold & Wodarski, 1994). Most behavioral practitioners stress the value of establishing a collaborative working relationship (J. Beck, 2005). For example, Lazarus (2008) believes a flexible repertoire of relationship styles, plus a wide range of techniques, enhances treatment outcomes. He emphasizes the need for therapeutic flexibility and versatility above all else. Lazarus contends that the cadence of client-therapist interaction differs from individual to individual and even from session to session. The skilled behavior therapist conceptualizes problems behaviorally and makes use of the client-therapist relationship in facilitating change.

As you will recall, the experiential therapies (existential therapy, person-centered therapy, and Gestalt therapy) place primary emphasis on the nature of the engagement between counselor and client. In contrast, most behavioral practitioners contend that factors such as warmth, empathy, authenticity, permissiveness, and acceptance are necessary, but not sufficient, for behavior change to occur. The client-therapist relationship is a foundation on which therapeutic strategies are built to help clients change in the direction they wish. However, behavior therapists assume that clients make progress primarily because of the specific behavioral techniques used rather than because of the relationship with the therapist.

**Application: Therapeutic Techniques and Procedures**

A strength of the behavioral approaches is the development of specific therapeutic procedures that must be shown to be effective through objective means. The results of behavioral interventions become clear because therapists receive continual direct feedback from their clients. A hallmark of the behavioral approaches is that the therapeutic techniques are empirically supported and
evidence-based practice is highly valued. To its credit, the effectiveness of behavior therapy (and cognitive behavior therapy) has been researched with different populations and a wide array of disorders.

According to Arnold Lazarus (1989, 1992b, 1996b, 1997a, 2005, 2008), a pioneer in contemporary clinical behavior therapy, behavioral practitioners can incorporate into their treatment plans any technique that can be demonstrated to effectively change behavior. Lazarus advocates the use of diverse techniques, regardless of their theoretical origin. It is clear that behavior therapists do not have to restrict themselves only to methods derived from learning theory. Likewise, behavioral techniques can be incorporated into other approaches. This is illustrated later in this chapter in the sections on the integration of behavioral and psychoanalytic techniques and, as well, by the incorporation of mindfulness and acceptance-based approaches into the practice of behavior therapy.

The therapeutic procedures used by behavior therapists are specifically designed for a particular client rather than being randomly selected from a "bag of techniques." Therapists are often quite creative in their interventions. In the following sections I describe a range of behavioral techniques available to the practitioner: applied behavioral analysis, relaxation training, systematic desensitization, exposure therapies, eye movement desensitization and reprocessing, social skills training, self-modification programs and self-directed behavior, multimodal therapy, and mindfulness and acceptance-based approaches. These techniques do not encompass the full spectrum of behavioral procedures, but they do represent a sample of the approaches used in contemporary behavior therapy.

**Applied Behavioral Analysis: Operant Conditioning Techniques**

This section describes a few key principles of operant conditioning: positive reinforcement, negative reinforcement, extinction, positive punishment, and negative punishment. For a detailed treatment of the wide range of operant conditioning methods that are part of contemporary behavior modification, I highly recommend Kazdin (2001) and Miltenberger (2008).

In applied behavior analysis, operant conditioning techniques and methods of assessment and evaluation are applied to a wide range of problems in many different settings (Kazdin, 2001). The most important contribution of applied behavior analysis is that it offers a functional approach to understanding clients' problems and addresses these problems by changing antecedents and consequences (the ABC model).

Behaviorists believe we respond in predictable ways because of the gains we experience (positive reinforcement) or because of the need to escape or avoid unpleasant consequences (negative reinforcement). Once clients' goals have been assessed, specific behaviors are targeted. The goal of reinforcement, whether positive or negative, is to increase the target behavior. Positive reinforcement involves the addition of something of value to the individual (such as praise, attention, money, or food) as a consequence of certain behavior. The stimulus that follows the behavior is the positive reinforcer. For example, a child earns excellent grades and is praised for studying by her parents. If she values this praise, it is likely that she will have an investment in studying in the
future. When the goal of a program is to decrease or eliminate undesirable behaviors, positive reinforcement is often used to increase the frequency of more desirable behaviors, which replace undesirable behaviors.

Negative reinforcement involves the escape from or the avoidance of aversive (unpleasant) stimuli. The individual is motivated to exhibit a desired behavior to avoid the unpleasant condition. For example, a friend of mine does not appreciate waking up to the shrill sound of an alarm clock. She has trained herself to wake up a few minutes before the alarm sounds to avoid the aversive stimulus of the alarm buzzer.

Another operant method of changing behavior is extinction, which refers to withholding reinforcement from a previously reinforced response. In applied settings, extinction can be used for behaviors that have been maintained by positive reinforcement or negative reinforcement. For example, in the case of children who display temper tantrums, parents often reinforce this behavior by the attention they give to it. An approach to dealing with problematic behavior is to eliminate the connection between a certain behavior (tantrums) and positive reinforcement (attention). Doing so can decrease or eliminate such behaviors through the extinction process. It should be noted that extinction might well have negative side effects, such as anger and aggression. Extinction can reduce or eliminate certain behaviors, but extinction does not replace those responses that have been extinguished. For this reason, extinction is most often used in behavior modification programs in conjunction with various reinforcement strategies (Kazdin, 2001).

Another way behavior is controlled is through punishment, sometimes referred to as aversive control, in which the consequences of a certain behavior result in a decrease of that behavior. The goal of reinforcement is to increase target behavior, but the goal of punishment is to decrease target behavior. Miltenberger (2008) describes two kinds of punishment that may occur as a consequence of behavior: positive punishment and negative punishment. In positive punishment an aversive stimulus is added after the behavior to decrease the frequency of a behavior (such as withholding a treat from a child for misbehavior or reprimanding a student for acting out in class). In negative punishment a reinforcing stimulus is removed following the behavior to decrease the frequency of a target behavior (such as deducting money from a worker's salary for missing time at work, or taking television time away from a child for misbehavior). In both kinds of punishment, the behavior is less likely to occur in the future. These four operant procedures form the basis of behavior therapy programs for parent skills training and are also used in the self-management procedures that are discussed later in this chapter.

Skinner (1948) believed punishment had limited value in changing behavior and was often an undesirable way to modify behavior. He opposed using aversive control or punishment, and recommended substituting positive reinforcement. The key principle in the applied behavior analysis approach is to use the least aversive means possible to change behavior, and positive reinforcement is known to be the most powerful change agent. Skinner believed in the value of analyzing environmental factors for both the causes and remedies for behavior problems and contended that the greatest benefits to the individual
and to society occur by using systematic positive reinforcement as a route to behavior control (Nye, 2000).

In everyday life, punishment is often used as a means of getting revenge or expressing frustration. However, as Kazdin (2001) has noted, “punishment in everyday life is not likely to teach lessons or suppress intolerable behavior because of the specific punishments that are used and how they are applied” (p. 231). Even in those cases when punishment suppresses undesirable responses, punishment does not result in teaching desirable behaviors. Punishment should be used only after nonaversive approaches have been implemented and found to be ineffective in changing problematic behavior (Kazdin, 2001; Miltenberger, 2008). It is essential that reinforcement be used as a way to develop appropriate behaviors that replace the behaviors that are suppressed.

Relaxation Training and Related Methods
Relaxation training has become increasingly popular as a method of teaching people to cope with the stresses produced by daily living. It is aimed at achieving muscle and mental relaxation and is easily learned. After clients learn the basics of relaxation procedures, it is essential that they practice these exercises daily to obtain maximum results.

Jacobson (1938) is credited with initially developing the progressive muscle relaxation procedure. It has since been refined and modified, and relaxation procedures are frequently used in combination with a number of other behavioral techniques. These include systematic desensitization, assertion training, self-management programs, audiotape recordings of guided relaxation procedures, computer simulation programs, biofeedback-induced relaxation, hypnosis, meditation, and autogenic training (teaching control of bodily and imaginal functions through autosuggestion).

Relaxation training involves several components that typically require from 4 to 8 hours of instruction. Clients are given a set of instructions that teaches them to relax. They assume a passive and relaxed position in a quiet environment while alternately contracting and relaxing muscles. This progressive muscle relaxation is explicitly taught to the client by the therapist. Deep and regular breathing is also associated with producing relaxation. At the same time clients learn to mentally “let go,” perhaps by focusing on pleasant thoughts or images. Clients are instructed to actually feel and experience the tension building up, to notice their muscles getting tighter and study this tension, and to hold and fully experience the tension. Also, it is useful for clients to experience the difference between a tense and a relaxed state. The client is then taught how to relax all the muscles while visualizing the various parts of the body, with emphasis on the facial muscles. The arm muscles are relaxed first, followed by the head, the neck and shoulders, the back, abdomen, and thorax, and then the lower limbs. Relaxation becomes a well-learned response, which can become a habitual pattern if practiced daily for about 25 minutes each day.

For an exercise of the phases of the progressive muscle relaxation procedure that you can apply to yourself, see Student Manual for Theory and Practice of Counseling and Psychotherapy (Corey, 2009b). For an excellent audiotape demonstration of progressive muscle relaxation, see Dattilio (2006).
Relaxation procedures have been applied to a variety of clinical problems, either as a separate technique or in conjunction with related methods. The most common use has been with problems related to stress and anxiety, which are often manifested in psychosomatic symptoms. Some ailments for which relaxation training is helpful include asthma, headache, hypertension, insomnia, irritable bowel syndrome, and panic disorder (Cormier et al., 2009).

**Systematic Desensitization**

Systematic desensitization, which is based on the principle of classical conditioning, is a basic behavioral procedure developed by Joseph Wolpe, one of the pioneers of behavior therapy. Clients imagine successively more anxiety-arousing situations at the same time that they engage in a behavior that competes with anxiety. Gradually, or systematically, clients become less sensitive (desensitized) to the anxiety-arousing situation. This procedure can be considered a form of exposure therapy because clients are required to expose themselves to anxiety-arousing images as a way to reduce anxiety.

Systematic desensitization is an empirically researched behavior therapy procedure that is time consuming, yet it is clearly an effective and efficient treatment of anxiety-related disorders, particularly in the area of specific phobias (Cormier et al., 2009; McNeil & Kyle, 2009; Spiegler & Guevremont, 2003). Before implementing the desensitization procedure, the therapist conducts an initial interview to identify specific information about the anxiety and to gather relevant background information about the client. This interview, which may last several sessions, gives the therapist a good understanding of who the client is. The therapist questions the client about the particular circumstances that elicit the conditioned fears. For instance, under what circumstances does the client feel anxious? If the client is anxious in social situations, does the anxiety vary with the number of people present? Is the client more anxious with women or men? The client is asked to begin a self-monitoring process consisting of observing and recording situations during the week that elicit anxiety responses. Some therapists also administer a questionnaire to gather additional data about situations leading to anxiety.

If the decision is made to use the desensitization procedure, the therapist gives the client a rationale for the procedure and briefly describes what is involved. McNeil and Kyle (2009) describe several steps in the use of systematic desensitization: (1) relaxation training, (2) development of the anxiety hierarchy, and (3) systematic desensitization proper.

The steps in relaxation training, which were described earlier, are presented to the client. The therapist uses a very quiet, soft, and pleasant voice to teach progressive muscular relaxation. The client is asked to create imagery of previously relaxing situations, such as sitting by a lake or wandering through a beautiful field. It is important that the client reach a state of calm and peacefulness. The client is instructed to practice relaxation both as a part of the desensitization procedure and also outside the session on a daily basis.

The therapist then works with the client to develop an anxiety hierarchy for each of the identified areas. Stimuli that elicit anxiety in a particular area, such as rejection, jealousy, criticism, disapproval, or any phobia, are analyzed. The
therapist constructs a ranked list of situations that elicit increasing degrees of anxiety or avoidance. The hierarchy is arranged in order from the worst situation the client can imagine down to the situation that evokes the least anxiety. If it has been determined that the client has anxiety related to fear of rejection, for example, the highest anxiety-producing situation might be rejection by the spouse, next, rejection by a close friend, and then rejection by a coworker. The least disturbing situation might be a stranger’s indifference toward the client at a party.

Desensitization does not begin until several sessions after the initial interview has been completed. Enough time is allowed for clients to learn relaxation in therapy sessions, to practice it at home, and to construct their anxiety hierarchy. The desensitization process begins with the client reaching complete relaxation with eyes closed. A neutral scene is presented, and the client is asked to imagine it. If the client remains relaxed, he or she is asked to imagine the least anxiety-arousing scene on the hierarchy of situations that has been developed. The therapist moves progressively up the hierarchy until the client signals that he or she is experiencing anxiety, at which time the scene is terminated. Relaxation is then induced again, and the scene is reintroduced again until little anxiety is experienced to it. Treatment ends when the client is able to remain in a relaxed state while imagining the scene that was formerly the most disturbing and anxiety-producing. The core of systematic desensitization is repeated exposure in the imagination to anxiety-evoking situations without experiencing any negative consequences.

Homework and follow-up are essential components of successful desensitization. Clients can practice selected relaxation procedures daily, at which time they visualize scenes completed in the previous session. Gradually, they also expose themselves to daily-life situations as a further way to manage their anxieties. Clients tend to benefit the most when they have a variety of ways to cope with anxiety-arousing situations that they can continue to use once therapy has ended McNeil and Kyle (2009).

Systematic desensitization is an appropriate technique for treating phobias, but it is a misconception that it can be applied only to the treatment of anxiety. It has also been used to treat a variety of conditions beside anxiety, including anger, asthmatic attacks, insomnia, motion sickness, nightmares, and sleep-walking (Spiegler, 2008). Historically, desensitization probably has the longest track record of any behavioral technique in dealing with fears, and its positive results have been documented repeatedly McNeil and Kyle (2009). Systematic desensitization is often acceptable to clients because they are gradually and symbolically exposed to anxiety-evoking situations. A safeguard is that clients are in control of the process by going at their own pace and terminating exposure when they begin to experience more anxiety than they want to tolerate (Spiegler & Guenremont, 2003).

**In Vivo Exposure and Flooding**

Exposure therapies are designed to treat fears and other negative emotional responses by introducing clients, under carefully controlled conditions, to the situations that contributed to such problems. Exposure is a key process in treating
a wide range of problems associated with fear and anxiety. Exposure therapy involves systematic confrontation with a feared stimulus, either through imagination or in vivo (live). Whatever the route used, exposure involves contact by clients and what they find fearful (McNeil & Kyle, 2009). Desensitization is one type of exposure therapy, but there are others. Two variations of traditional systematic desensitization are in vivo exposure and flooding.

**IN VIVO EXPOSURE** In vivo exposure involves client exposure to the actual anxiety-evoking events rather than simply imagining these situations. Live exposure has been a cornerstone of behavior therapy for decades (Hazlett-Stevens & Craske, 2003). Together, the therapist and the client generate a hierarchy of situations for the client to encounter in ascending order of difficulty. Clients engage in brief and graduated series of exposures to feared events. Clients can terminate exposure if they experience a high level of anxiety. As is the case with systematic desensitization, clients learn competing responses involving muscular relaxation. In some cases the therapist may accompany clients as they encounter feared situations. For example, a therapist could go with clients in an elevator if they had phobias of using elevators. Of course, when this kind of out-of-office procedure is used, matters of safety and appropriate ethical boundaries are always considered. People who have extreme fears of certain animals could be exposed to these animals in real life in a safe setting with a therapist. Self-managed in vivo exposure—a procedure in which clients expose themselves to anxiety-evoking events on their own—is an alternative when it is not practical for a therapist to be with clients in real-life situations.

**FLOODING** Another form of exposure therapy is flooding, which refers to either in vivo or imaginal exposure to anxiety-evoking stimuli for a prolonged period of time. As is characteristic of all exposure therapies, even though the client experiences anxiety during the exposure, the feared consequences do not occur.

In vivo flooding consists of intense and prolonged exposure to the actual anxiety-producing stimuli. Remaining exposed to feared stimuli for a prolonged period without engaging in any anxiety-reducing behaviors allows the anxiety to decrease on its own. Generally, highly fearful clients tend to curb their anxiety through the use of maladaptive behaviors. In flooding, clients are prevented from engaging in their usual maladaptive responses to anxiety-arousing situations. In vivo flooding tends to reduce anxiety rapidly.

Imaginal flooding is based on similar principles and follows the same procedures except the exposure occurs in the client's imagination instead of in daily life. An advantage of using imaginal flooding over in vivo flooding is that there are no restrictions on the nature of the anxiety-arousing situations that can be treated. In vivo exposure to actual traumatic events (airplane crash, rape, fire, flood) is often not possible nor is it appropriate for both ethical and practical reasons. Imaginal flooding can re-create the circumstances of the trauma in a way that does not bring about adverse consequences to the client. Survivors of an airplane crash, for example, may suffer from a range of debilitating symptoms. They are likely to have nightmares and flashbacks to the disaster, they may
avoid travel by air or have anxiety about travel by any means, and they probably
have a variety of distressing symptoms such as guilt, anxiety, and depression.
Flooding is frequently used in the behavioral treatment for anxiety-related
disorders, phobias, obsessive-compulsive disorder, posttraumatic stress disor-
der, and agoraphobia.

Prolonged and intense exposure can be both an effective and efficient way
to reduce clients' anxiety. However, because of the discomfort associated with
prolonged and intense exposure, some clients may not elect these exposure
treatments. It is important for the behavior therapist to work with the client to
create motivation and readiness for exposure. From an ethical perspective, cli-
ents should have adequate information about prolonged and intense exposure
therapy before agreeing to participate. It is important that they understand that
anxiety will be induced as a way to reduce it. Clients need to make informed
decisions after considering the pros and cons of subjecting themselves to tem-
porarily stressful aspects of treatment.

Research consistently indicates that exposure therapy can reduce the cli-
ent's degree of fear and anxiety (Tryon, 2005). The repeated success of exposure
therapy in treating various disorders has resulted in exposure being used as a
part of most behavioral and cognitive behavioral treatments for anxiety disor-
exposure therapies are the single most potent behavioral procedures available
for anxiety-related disorders, and they can have long-lasting effects. However,
they add, using exposure as a sole treatment procedure is not always sufficient.
In cases involving severe and multifaceted disorders, more than one behavioral
intervention is often required. Increasingly, imaginal and in vivo exposure are
being used in combination, which fits with the trend in behavior therapy to use
treatment packages as a way to enhance the effectiveness of therapy.

Eye Movement Desensitization and Reprocessing

Eye movement desensitization and reprocessing (EMDR) is a form of exposure
therapy that involves imaginal flooding, cognitive restructuring, and the use of
rapid, rhythmic eye movements and other bilateral stimulation to treat clients
who have experienced traumatic stress. Developed by Francine Shapiro (2001),
this therapeutic procedure draws from a wide range of behavioral interven-
tions. Designed to assist clients in dealing with posttraumatic stress disorders,
(EMDR has been applied to a variety of populations including children, cou-
ples, sexual abuse victims, combat veterans, victims of crime, rape survivors,
accident victims, and individuals dealing with anxiety, panic, depression, grief,
addictions, and phobias.

Shapiro (2001) emphasized the importance of the safety and welfare of the
client when using this approach. EMDR may appear simple to some, but the
ethical use of the procedure demands training and clinical supervision. Because
of the powerful reactions from clients, it is essential that practitioners know
how to safely and effectively manage these occurrences. Therapists should not
use this procedure unless they receive proper training and supervision from
an authorized EMDR instructor. A more complete discussion of this behavioral
procedure can be found in Shapiro (2001, 2002a).
There is some controversy whether the eye movements themselves create change, or the application of cognitive techniques paired with eye movements act as change agents. The empirical support for EMDR has been mixed, which makes it difficult to draw firm conclusions about the success or failure of this intervention (McNeil & Kyle, 2009). In writing about the future of EMDR, Prochaska and Norcross (2007) make several predictions: increasing numbers of practitioners will receive training in EMDR; outcome research will shed light on EMDR’s effectiveness compared to other current therapies for trauma; and further research and practice will provide a sense of its effectiveness with disorders besides posttraumatic stress disorder.

Social Skills Training

Social skills training is a broad category that deals with an individual’s ability to interact effectively with others in various social situations; it is used to correct deficits clients have in interpersonal competencies (Spiegler, 2008). Social skills involve being able to communicate with others in a way that is both appropriate and effective. Individuals who experience psychosocial problems that are partly caused by interpersonal difficulties are good candidates for social skills training. Some of the desirable aspects of this training are that it has a very broad base of applicability and it can easily be tailored to suit the particular needs of individual clients (Segrin, 2003). Social skills training includes psychoeducation, modeling, reinforcement, behavioral rehearsal, role playing, and feedback (Antony & Roemer, 2003). Another popular variation of social skills training is anger management training, which is designed for individuals who have trouble with aggressive behavior. Assertion training, which is described next, is for people who lack assertive skills.

Assertion Training

One specialized form of social skills training that has gained increasing popularity is teaching people how to be assertive in a variety of social situations. Many people have difficulty feeling that it is appropriate or right to assert themselves. People who lack social skills frequently experience interpersonal difficulties at home, at work, at school, and during leisure time. Assertion training can be useful for those (1) who have difficulty expressing anger or irritation, (2) who have difficulty saying no, (3) who are overly polite and allow others to take advantage of them, (4) who find it difficult to express affection and other positive responses, (5) who feel they do not have a right to express their thoughts, beliefs, and feelings, or (6) who have social phobias.

The basic assumption underlying assertion training is that people have the right (but not the obligation) to express themselves. One goal of assertion training is to increase people’s behavioral repertoire so that they can make the choice of whether to behave assertively in certain situations. It is important that clients replace maladaptive social skills with new skills. Another goal is teaching people to express themselves in ways that reflect sensitivity to the feelings and rights of others. Assertion does not mean aggression; truly assertive people do not stand up for their rights at all costs, ignoring the feelings of others.

Assertion training is based on the principles of social learning theory and incorporates many social skills training methods. Generally, the therapist both
teaches and models desired behaviors the client wants to acquire. These behaviors are practiced in the therapy office and then enacted in everyday life. Most assertion training programs focus on clients’ negative self-statements, self-defeating beliefs, and faulty thinking. People often behave in unassertive ways because they don’t think they have a right to state a viewpoint or ask for what they want or deserve. Thus their thinking leads to passive behavior. Effective assertion training programs do more than give people skills and techniques for dealing with difficult situations. These programs challenge people’s beliefs that accompany their lack of assertiveness and teach them to make constructive self-statements and to adopt a new set of beliefs that will result in assertive behavior.

Assertion training is often conducted in groups. When a group format is used, the modeling and instructions are presented to the entire group, and members rehearse behavioral skills in role-playing situations. After the rehearsal, the member is given feedback that consists of reinforcing the correct aspects of the behavior and instructions on how to improve the behavior. Each member engages in further rehearsals of assertive behaviors until the skills are performed adequately in a variety of simulated situations (Miltonberger, 2008).

Because assertion training is based on Western notions of the value of assertiveness, it may not be suited for clients with a cultural background that places more emphasis on harmony than on being assertive. This approach is not a panacea, but it can be an effective treatment for clients who have skill deficits in assertive behavior or for individuals who experience difficulties in their interpersonal relationships. Although counselors can adapt this form of social skills training procedures to suit their own style, it is important to include behavioral rehearsal and continual assessment as basic aspects of the program. If you are interested in learning more assertion training, consult Your Perfect Right: A Guide to Assertive Behavior (Alberti & Emmons, 2008).

**Self-Modification Programs and Self-Directed Behavior**

For some time there has been a trend toward “giving psychology away.” This involves psychologists being willing to share their knowledge so that “consumers” can increasingly lead self-directed lives and not be dependent on experts to deal with their problems. Psychologists who share this perspective are primarily concerned with teaching people the skills they will need to manage their own lives effectively. An advantage of self-modification (or self-management) techniques is that treatment can be extended to the public in ways that cannot be done with traditional approaches to therapy. Another advantage is that costs are minimal. Because clients have a direct role in their own treatment, techniques aimed at self-change tend to increase involvement and commitment to their treatment.

Self-modification strategies include self-monitoring, self-reward, self-contracting, stimulus control, and self-as-model. The basic idea of self-modification assessments and interventions is that change can be brought about by teaching people to use coping skills in problematic situations. Generalization and maintenance of the outcomes are enhanced by encouraging clients to accept the responsibility for carrying out these strategies in daily life.
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In self-modification programs people make decisions concerning specific behaviors they want to control or change. People frequently discover that a major reason that they do not attain their goals is the lack of certain skills or unrealistic expectations of change. Hope can be a therapeutic factor that leads to change, but unrealistic hope can pave the way for a pattern of failures in a self-change program. A self-directed approach can provide the guidelines for change and a plan that will lead to change.

For people to succeed in such a program, a careful analysis of the context of the behavior pattern is essential, and people must be willing to follow some basic steps such as those provided by Watson and Tharp (2007):

1. **Selecting goals.** Goals should be established one at a time, and they should be measurable, attainable, positive, and significant for the person. It is essential that expectations be realistic.

2. **Translating goals into target behaviors.** Identify behaviors targeted for change. Once targets for change are selected, anticipate obstacles and think of ways to negotiate them.

3. **Self-monitoring.** Deliberately and systematically observe your own behavior, and keep a behavioral diary, recording the behavior along with comments about the relevant antecedent cues and consequences.

4. **Working out a plan for change.** Devise an action program to bring about actual change. Various plans for the same goal can be designed, each of which can be effective. Some type of self-reinforcement system is necessary in this plan because reinforcement is the cornerstone of modern behavior therapy. Self-reinforcement is a temporary strategy used until the new behaviors have been implemented in everyday life. Take steps to ensure that the gains made will be maintained.

5. **Evaluating an action plan.** Evaluate the plan for change to determine whether goals are being achieved, and adjust and revise the plan as other ways to meet goals are learned. Evaluation is an ongoing process rather than a one-time occurrence, and self-change is a lifelong practice.

Many people who develop some kind of self-modification program encounter repeated failure, a situation Polivy and Herman (2002) refer to as the “false hope syndrome,” which is characterized by unrealistic expectations regarding the likely speed, amount, ease, and consequences of self-change attempts. Self-change efforts are frequently doomed to failure from the outset by these unrealistic expectations, but individuals often continue to try and try in the hope that they will eventually succeed in changing a behavioral pattern. Many people interpret their failures to change as the result of inadequate effort or getting involved in the wrong program.

Self-modification strategies have been successfully applied to many populations and problems, a few of which include coping with panic attacks, helping children to cope with fear of the dark, increasing creative productivity, managing anxiety in social situations, encouraging speaking in front of a class, increasing exercise, control of smoking, and dealing with depression (Watson & Tharp, 2007). Research on self-modification has been conducted in a wide variety of health problems, a few of which include arthritis, asthma, cancer, cardiac
disease, substance abuse, diabetes, headaches, vision loss, nutrition, and self-health care (Cormier et al., 2009).

**Multimodal Therapy: Clinical Behavior Therapy**

Multimodal therapy is a comprehensive, systematic, holistic approach to behavior therapy developed by Arnold Lazarus (1976, 1986, 1987, 1989, 1992a, 1992b, 1997a, 2005, 2008). It is grounded in social learning and cognitive theory and applies diverse behavioral techniques to a wide range of problems. This approach serves as a major link between some behavioral principles and the cognitive behavioral approach that has largely replaced traditional behavioral therapy.

Multimodal therapy is an open system that encourages technical eclecticism. New techniques are constantly being introduced and existing techniques refined, but they are never used in a shotgun manner. Multimodal therapists take great pains to determine precisely what relationship and what treatment strategies will work best with each client and under which particular circumstances. The underlying assumption of this approach is that because individuals are troubled by a variety of specific problems it is appropriate that a multitude of treatment strategies be used in bringing about change. Therapeutic flexibility and versatility, along with breadth over depth, are highly valued, and multimodal therapists are constantly adjusting their procedures to achieve the client’s goals. Therapists need to decide when and how to be challenging or supportive, cold or warm, formal or informal, and tough or tender (Lazarus, 1997a, 2008).

Multimodal therapists tend to be very active during therapist sessions, functioning as trainers, educators, consultants, and role models. They provide information, instruction, and feedback as well as modeling assertive behaviors. They offer constructive criticism and suggestions, positive reinforcements, and are appropriately self-disclosing.

Lazarus (2008) contends: “Multimodal therapists subscribe to no dogma other than the principles of theoretical parsimony and therapeutic effectiveness” (p. 396). Techniques are borrowed from many other therapy systems. They recognize that many clients come to therapy needing to learn skills, and they are willing to teach, coach, train, model, and direct their clients. Multimodal therapists typically function directly by providing information, instruction, and reactions. They challenge self-defeating beliefs, offer constructive feedback, provide positive reinforcement, and are appropriately self-disclosing. It is essential that therapists start where the client is and then move into other productive areas for exploration. Failure to apprehend the client’s situation can easily leave the client feeling alienated and misunderstood (Lazarus, 2000).

**THE BASIC I.D.** The essence of Lazarus’s multimodal approach is the premise that the complex personality of human beings can be divided into seven major areas of functioning: B = behavior; A = affective responses; S = sensations; I = images; C = cognitions; I = interpersonal relationships; and D = drugs, biological functions, nutrition, and exercise (Lazarus, 1989, 1992a, 1992b, 1997a, 1997b, 2000, 2006, 2008). Although these modalities are interactive, they can be considered discrete functions.
<table>
<thead>
<tr>
<th>Modality</th>
<th>Behaviors</th>
<th>Questions to Ask</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior</td>
<td>Overt behaviors, including acts, habits, and reactions that are observable and measurable</td>
<td>What would you like to change? How active are you? What would you like to start doing? What would you like to stop doing? What are some of your main strengths? What specific behaviors keep you from getting what you want?</td>
</tr>
<tr>
<td>Affect</td>
<td>Emotions, moods, and strong feelings</td>
<td>What emotions do you experience most often? What makes you laugh? What makes you cry? What makes you sad, mad, glad, scared? What emotions are problematic for you?</td>
</tr>
<tr>
<td>Sensation</td>
<td>Basic senses of touch, taste, smell, sight, and hearing</td>
<td>Do you suffer from unpleasant sensations, such as pains, aches, dizziness, and so forth?  What do you particularly like or dislike in the way of seeing, smelling, hearing, touching, and tasting?</td>
</tr>
<tr>
<td>Imagery</td>
<td>How we picture ourselves, including memories, dreams, and fantasies</td>
<td>What are some bothersome recurring dreams and vivid memories? Do you have a vivid imagination? How do you view your body? How do you see yourself now? How would you like to be able to see yourself in the future?</td>
</tr>
<tr>
<td>Cognition</td>
<td>Insights, philosophies, ideas, opinions, self-talk, and judgments that constitute one’s fundamental values, attitudes, and beliefs</td>
<td>What are some ways in which you meet your intellectual needs? How do your thoughts affect your emotions? What are the values and beliefs you most cherish? What are some negative things you say to yourself? What are some of your central faulty beliefs? What are the main ‘shoulds,’ ‘oughts,’ and ‘musts’ in your life? How do they get in the way of effective living?</td>
</tr>
<tr>
<td>Interpersonal relationship</td>
<td>Interactions with other people</td>
<td>How much of a social being are you? To what degree do you desire intimacy with others?</td>
</tr>
</tbody>
</table>

(continues)
TABLE 9.1 The BASIC I.D. Assessment Process (continued)

<table>
<thead>
<tr>
<th>Modality</th>
<th>Behaviors</th>
<th>Questions to Ask</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal</td>
<td>What do you expect from the significant people</td>
<td>What do you expect from the significant people in your life?</td>
</tr>
<tr>
<td>relationship</td>
<td>in your life?</td>
<td>What do they expect from you?</td>
</tr>
<tr>
<td>(continued)</td>
<td>Are there any relationships with others that</td>
<td>Are there any relationships with others that you would hope to change?</td>
</tr>
<tr>
<td></td>
<td>you would hope to change?</td>
<td>If so, what kinds of changes do you want?</td>
</tr>
<tr>
<td>Drugs/biology</td>
<td>Drugs, and nutritional habits, and exercise</td>
<td>Are you healthy and health conscious?</td>
</tr>
<tr>
<td></td>
<td>patterns</td>
<td>Do you have any concerns about your health?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do you take any prescribed drugs?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What are your habits pertaining to diet, exercise, and physical fitness?</td>
</tr>
</tbody>
</table>

Multimodal therapy begins with a comprehensive assessment of the seven modalities of human functioning and the interaction among them. A complete assessment and treatment program must account for each modality of the BASIC I.D., which is the cognitive map linking each aspect of personality. Table 9.1 outlines this process using questions Lazarus typically asks (1989, 1997a, 2000, 2008).

A major premise of multimodal therapy is that breadth is often more important than depth. The more coping responses a client learns in therapy, the less are the chances for a relapse (Lazarus, 1996a, 2008; Lazarus & Lazarus, 2002). Therapists identify one specific issue from each aspect of the BASIC I.D. framework as a target for change and teach clients a range of techniques they can use to combat faulty thinking, to learn to relax in stressful situations, and to acquire effective interpersonal skills. Clients can then apply these skills to a broad range of problems in their everyday lives.

The preliminary investigation of the BASIC I.D. framework brings out some central and significant themes that can then be productively explored using a detailed life-history questionnaire. (See Lazarus and Lazarus, 1991, for the multimodal life-history inventory.) Once the main profile of a person’s BASIC I.D. has been established, the next step consists of an examination of the interactions among the different modalities. For an illustration of how Dr. Lazarus applies the BASIC I.D. assessment model to the case of Ruth, along with examples of various techniques he uses, see Case Approach to Counseling and Psychotherapy (Corey, 2009a, chap. 7).

Mindfulness and Acceptance-Based Cognitive Behavior Therapy

Over the last decade, the “third wave” of behavior therapy has evolved, which has resulted in an expansion of the behavioral tradition. Newer facets of cognitive behavior therapy have emerged that emphasize considerations that were considered off limits for behavior therapists until recently, including mindfulness, acceptance, the therapeutic relationship, spirituality, values, meditation,
being in the present moment, and emotional expression (Hayes, Follette, & Linehan, 2004). Mindfulness is a process that involves becoming increasingly observant and aware of external and internal stimuli in the present moment and adopting an open attitude toward accepting what is rather than judging the current situation (Kabat-Zinn, 1994; Segal, Williams, & Teasdale, 2002). The essence of mindfulness is becoming aware of one’s mind from one moment to the next, with gentle acceptance (Germer, Siegel, & Fulton, 2005). In mindfulness practice clients train themselves to focus on their present experience. Acceptance is a process involving receiving one’s present experience without judgment or preference, but with curiosity and kindness, and striving for full awareness of the present moment (Germer, 2005b). The mindfulness and acceptance approaches are good avenues for the integration of spirituality in the counseling process.

The four major approaches in the recent development of the behavioral tradition include (1) dialectical behavior therapy (Linehan, 1993a, 1993b), which has become a recognized treatment for borderline personality disorder; (2) mindfulness-based stress reduction (Kabat-Zinn, 1990), which involves an 8- to 10-week group program applying mindfulness techniques to coping with stress and promoting physical and psychological health; (3) mindfulness-based cognitive therapy (Segal et al., 2002), which is aimed primarily at treating depression; and (4) acceptance and commitment therapy (Hayes, Strosahl, & Ilona, 2005; Hayes, Strosahl, & Wilson, 1999), which is based on encouraging clients to accept, rather than attempt to control or change, unpleasant sensations. It should be noted that all four of these approaches are based on empirical data, a hallmark of the behavioral tradition.

**DIALECTICAL BEHAVIOR THERAPY (DBT)** Developed to help clients regulate emotions and behavior associated with depression, this paradoxical treatment helps clients to accept their emotions as well as to change their emotional experience (Morgan, 2005). The practice of acceptance involves being in the present moment, seeing reality as it is without distortions, without judgment, without evaluation, and without trying to hang on to an experience or to get rid of it. It involves entering fully into activities of the present moment without separating oneself from ongoing events and interactions.

Formulated by Linehan (1993a, 1993b), DBT is a promising blend of behavioral and psychoanalytic techniques for treating borderline personality disorders. Like analytic therapy, DBT emphasizes the importance of the psychotherapeutic relationship, validation of the client, the etiologic importance of the client having experienced an “invalidating environment” as a child, and confrontation of resistance. The main components of DBT are affect regulation, distress tolerance, improvement in interpersonal relationships, and mindfulness training. DBT employs behavioral techniques, including a form of exposure therapy in which the client learns to tolerate painful emotions without enacting self-destructive behaviors. DBT integrates its cognitive behaviorism not only with analytic concepts but also with the mindfulness training of “Eastern psychological and spiritual practices (primarily Zen practice)” (Linehan, 1993b, p. 6).

DBT skills training is not a “quick fix” approach. It generally involves a minimum of one year of treatment and includes both individual therapy and
skills training done in a group. DBT requires a behavioral contract. To competently practice DBT, it is essential to obtain training in this approach.

MINDFULNESS-BASED STRESS REDUCTION (MBSR) The skills taught in the MBSR program include sitting meditation and mindful yoga, which are aimed at cultivating mindfulness. The program includes a body scan meditation that helps clients to observe all the sensations in their body. This attitude of mindfulness is encouraged in every aspect of daily life including standing, walking, and eating. Those who are involved in the program are encouraged to practice formal mindfulness meditation for 45 minutes daily. The MBSR program is mainly designed to teach participants to relate to external and internal sources of stress in constructive ways. The program aims to teach people how to live more fully in the present rather than ruminating about the past or being overly concerned about the future.

ACCEPTANCE AND COMMITMENT THERAPY (ACT) Another mindfulness-based approach is acceptance and commitment therapy (Hayes et al., 1999, 2005), which involves fully accepting present experience and mindfully letting go of obstacles. In this approach “acceptance is not merely tolerance—rather it is the active nonjudgmental embracing of experience in the here and now” (Hayes, 2004, p. 32). Acceptance is a stance or posture from which to conduct therapy and from which a client can conduct life (Hayes & Pankey, 2003) that provides an alternative to contemporary forms of cognitive behavioral therapy (Eifert & Forsyth, 2005). In contrast to the cognitive behavioral approaches discussed in Chapter 10, where cognition is challenged or disputed, in ACT the cognition is accepted. Clients learn how to accept the thoughts and feelings they may have been trying to deny. Hayes has found that challenging maladaptive cognitions actually strengthens rather than reduces these cognitions. The goal of ACT is to allow for increased psychological flexibility. Values are a basic part of the therapeutic process, and ACT practitioners might ask clients “What do you want your life to stand for?”

In addition to acceptance, commitment to action is essential. Commitment involves making mindful decisions about what is important in life and what the person is willing to do to live a valued life (Wilson, 2008). ACT makes use of concrete homework and behavioral exercises as a way to create larger patterns of effective action that will help clients live by their values (Hayes, 2004). For example, one form of homework given to clients is asking them to write down life goals or things they value in various aspects of their lives. The focus of ACT is allowing experience to come and go while pursuing a meaningful life. According to Hayes and Pankey (2003), “there is a growing evidence base that acceptance skills are central to psychological well-being and can increase the impact of psychotherapy with a broad variety of clients” (p. 8).

ACT is an effective form of therapy (Eifert & Forsyth, 2005) that continues to influence the practice of behavior therapy. Germer (2005a) suggests “mindfulness might become a construct that draws clinical theory, research, and practice closer together, and helps integrate the private and professional lives of therapists” (p. 11). According to Wilson (2008), ACT emphasizes common processes
across clinical disorders, which makes it easier to learn basic treatment skills. Practitioners can then implement basic principles in diverse and creative ways.

For a more in-depth discussion of the role of mindfulness in psychotherapeutic practice, two highly recommended readings are *Mindfulness and Acceptance: Expanding the Cognitive-Behavioral Tradition* (Heyes et al., 2004) and *Mindfulness and Psychotherapy* (Germer et al., 2005).

**Integrating Behavioral Techniques With Contemporary Psychoanalytic Approaches**

Certain aspects of behavior therapy can be combined with a number of other therapeutic approaches. For example, behavioral and cognitive behavioral techniques can be combined with the conceptual framework of contemporary psychoanalytic therapies (see Chapter 4). Morgan and MacMillan (1999) developed a three-phase integrated counseling model based on theoretical constructs of object-relations and attachment theory that incorporates behavioral techniques.

In the first phase, object-relations theory serves as the conceptual basis for the assessment and relationship-building process. What children learn from early interactions with parents clearly affects personality development and may result in problematic adult relationships. For meaningful assessment to occur, it is essential that the counselor is able to hear the stories of their clients, to grasp their phenomenological world, and to establish rapport with them. During this phase, therapists provide a supportive holding environment that offers a safe place for clients to recall and explore painful earlier memories. At this phase counseling includes an exploration of clients' feelings regarding past and present circumstances and thought patterns that influence the clients' interpretation of the world.

In the second phase, the aim is to link insights gleaned from the initial assessment phase to the present to create an understanding of how early relational patterns are related to present difficulties. This insight often enables clients to acknowledge and express painful memories, feelings, and thoughts. As clients are able to process previously repressed and dissociated memories and feelings in counseling, cognitive changes in perception of self and others often occur. Both experiential and cognitive techniques are utilized in the second phase. As clients engage in the process of cognitively restructuring life situations, they acquire new and adaptive ways of thinking, feeling, and coping.

In the third and final phase of treatment, behavioral techniques with goal setting and homework assignments are emphasized to maximize change. This is the action phase, a time for clients to attempt new behaviors based on the insight, understanding, and cognitive restructuring achieved in the prior phases of counseling. Clients take action, which leads to empowerment.

According to Morgan and MacMillan (1999), there is increasing support in the literature that integrating contemporary psychodynamic theory with behavioral and cognitive behavioral techniques can lead to observable, constructive client changes. Establishing clear goals for each of the three phases of their integrative model provides an efficient framework within which to structure
the counseling interventions. Morgan and MacMillan claim that if these treatment goals are well defined it is possible to work through all three phases in a reasonable amount of time. Adapting the conceptual foundation of psychoanalytic thinking to relatively brief therapy makes this approach useful in time-limited therapy.

Application to Group Counseling

Group-based behavioral approaches emphasize teaching clients self-management skills and a range of new coping behaviors, as well as how to restructure their thoughts. Clients can learn to use these techniques to control their lives, deal effectively with present and future problems, and function well after they complete their group experience. Many groups are designed primarily to increase the client's degree of control and freedom in specific aspects of daily life.

Group leaders who function within a behavioral framework may develop techniques from diverse theoretical viewpoints. Behavioral practitioners make use of a brief, active, directive, structured, collaborative, psychoeducational model of therapy that relies on empirical validation of its concepts and techniques. The leader follows the progress of group members through the ongoing collection of data before, during, and after all interventions. Such an approach provides both the group leader and the members with continuous feedback about therapeutic progress. Today, many groups in community agencies demand this kind of accountability.

Behavioral group therapy has some unique characteristics that set it apart from most of the other group approaches. The distinguishing characteristic of behavioral practitioners is their systematic adherence to specification and measurement. The specific unique characteristics of behavioral group therapy include (1) conducting a behavioral assessment, (2) precisely spelling out collaborative treatment goals, (3) formulating a specific treatment procedure appropriate to a particular problem, and (4) objectively evaluating the outcomes of therapy. Behavioral therapists tend to utilize short-term, time-limited interventions aimed at efficiently and effectively solving problems and assisting members in developing new skills.

Behavioral group leaders assume the role of teacher and encourage members to learn and practice skills in the group that they can apply to everyday living. Group leaders are expected to assume an active, directive, and supportive role in the group and to apply their knowledge of behavioral principles and skills to the resolution of problems. Group leaders model active participation and collaboration by their involvement with members in creating an agenda, designing homework, and teaching skills and new behaviors. Group leaders carefully observe and assess behavior to determine the conditions that are related to certain problems and the conditions that will facilitate change. Members in behavioral groups identify specific skills that they lack or would like to enhance. Assertiveness and social skills training fit well into a group format (Wilson, 2008). Relaxation procedures, behavioral rehearsal, modeling, coaching, meditation, and mindfulness techniques are often incorporated in behavioral groups. Most of the other techniques described earlier in this chapter can be applied to group work.
There are many different types of groups with a behavioral twist, or groups that blend both behavioral and cognitive methods for specific populations. Structured groups, with a psychoeducational focus, are especially popular in various settings today. At least five general approaches can be applied to the practice of behavioral groups: (1) social skills training groups, (2) psychoeducational groups with specific themes, (3) stress management groups, (4) multimodal group therapy, and (5) mindfulness and acceptance-based behavior therapy in groups.

For a more detailed discussion of cognitive behavioral approaches to groups, see Corey (2008, chap. 13).

Behavior Therapy From a Multicultural Perspective

Behavior therapy has some clear advantages over many other theories in counseling culturally diverse clients. Because of their cultural and ethnic backgrounds, some clients hold values that are contrary to the free expression of feelings and the sharing of personal concerns. Behavioral counseling does not generally place emphasis on experiencing catharsis. Rather, it stresses changing specific behaviors and developing problem-solving skills. Some potential strengths of the behavioral approaches in working with diverse client populations include its specificity, task orientation, focus on objectivity, focus on cognition and behavior, action orientation, dealing with the present more than the past, emphasis on brief interventions, teaching coping strategies, and problem-solving orientation. The attention given to transfer of learning and the principles and strategies for maintaining new behavior in daily life are crucial. Clients who are looking for action plans and specific behavioral change are likely to cooperate with this approach because they can see that it offers them concrete methods for dealing with their problems of living.

Behavior therapy focuses on environmental conditions that contribute to a client’s problems. Social and political influences can play a significant role in the lives of people of color through discriminatory practices and economic problems, and the behavioral approach takes into consideration the social and cultural dimensions of the client’s life. Behavior therapy is based on an experimental analysis of behavior in the client’s own social environment and gives special attention to a number of specific conditions: the client’s cultural conception of problem behaviors, establishing specific therapeutic goals, arranging conditions to increase the client’s expectation of successful therapeutic outcomes, and employing appropriate social influence agents (Tanaka-Matsumi et al., 2002). The foundation of ethical practice involves a therapist’s familiarity with the client’s culture, as well as the competent application of this knowledge in formulating assessment, diagnostic, and treatment strategies.

The behavioral approach has moved beyond treating clients for a specific symptom or behavioral problem. Instead, it stresses a thorough assessment of the person’s life circumstances to ascertain not only what conditions give rise
to the client's problems but also whether the target behavior is amenable to change and whether such a change is likely to lead to a significant improvement in the client's total life situation.

In designing a change program for clients from diverse backgrounds, effective behavioral practitioners conduct a functional analysis of the problem situation. This assessment includes the cultural context in which the problem behavior occurs, the consequences both to the client and to the client's sociocultural environment, the resources within the environment that can promote change, and the impact that change is likely to have on others in the client's surroundings. Assessment methods should be chosen with the client's cultural background in mind (Spiegler & Guvremont, 2003; Tanaka-Matsumi et al., 2002). Counselors must be knowledgeable as well as open and sensitive to issues such as these: What is considered normal and abnormal behavior in the client's culture? What are the client's culturally based conceptions of his or her problems? What kind of information about the client is essential in making an accurate assessment?

Shortcomings From a Diversity Perspective

According to Spiegler and Guvremont (2003), a future challenge for behavior therapists is to develop empirically based recommendations for how behavior therapy can optimally serve culturally diverse clients. Although behavior therapy is sensitive to differences among clients in a broad sense, behavior therapists need to become more responsive to specific issues pertaining to all forms of diversity. Because race, gender, ethnicity, and sexual orientation are critical variables that influence the process and outcome of therapy, it is essential that behavior therapists pay greater attention to these factors than they often do. For example, some African American clients are slow to trust a European American therapist, which may be a response to having experienced racism. However, a culturally insensitive therapist may misinterpret this "cultural paranoia" as clinical paranoia (Ridley, 1995).

Some behavioral counselors may focus on using a variety of techniques in narrowly treating specific behavioral problems. Instead of viewing clients in the context of their sociocultural environment, these practitioners concentrate too much on problems within the individual. In doing so they may overlook significant issues in the lives of clients. Such practitioners are not likely to bring about beneficial changes for their clients.

The fact that behavioral interventions often work well raises an interesting issue in multicultural counseling. When clients make significant personal changes, it is very likely that others in their environment will react to them differently. Before deciding too quickly on goals for therapy, the counselor and client need to discuss the challenges inherent in change. It is essential for therapists to conduct a thorough assessment of the interpersonal and cultural dimensions of the problem. Clients should be helped in assessing the possible consequences of some of their newly acquired social skills. Once goals are determined and therapy is under way, clients should have opportunities to talk about the problems they encounter as they become different people in their home and work settings.
Behavior Therapy Applied to the Case of Stan

In Stan’s case many specific and interrelated problems can be identified through a functional assessment. Behaviorally, he is defensive, avoids eye contact, speaks hesitantly, uses alcohol excessively, has a poor sleep pattern, and displays various avoidance behaviors. In the emotional area, Stan has a number of specific problems, some of which include anxiety, panic attacks, depression, fear of criticism and rejection, feeling worthless and stupid, and feeling isolated and alienated. He experiences a range of physiological complaints such as dizziness, heart palpitations, and headaches. Cognitively, he worries about death and dying, has many self-defeating thoughts and beliefs, is governed by categorical imperatives (“shoulds,” “oughts,” “musts”), engages in fatalistic thinking, and compares himself negatively with others. In the interpersonal area, Stan is unassertive, has an unsatisfactory relationship with his parents, has few friends, is afraid of contact with women and fears intimacy, and feels socially inferior.

After completing this assessment, Stan’s therapist focuses on helping him define the specific areas where he would like to make changes. Before developing a treatment plan, the therapist helps Stan understand the purposes of his behavior. The therapist then educates Stan about how the therapy sessions (and his work outside of the sessions) can help him reach his goals. Early during treatment the therapist helps Stan translate some of his general goals into concrete and measurable ones. When Stan says: “I want to feel better about myself,” the therapist helps him define more specific goals. When he says: “I want to get rid of my inferiority complex,” she replies: “What are some situations in which you feel inferior?” “What do you actually do that leads to feelings of inferiority?” Stan’s concrete aims include his desire to function without drugs or alcohol. She asks him to keep a record of when he drinks and what events lead to drinking.

Stan indicates that he does not want to feel apologetic for his existence. The therapist introduces behavioral skills training because he has trouble talking with his boss and coworkers. She demonstrates specific skills that he can use in approaching them more directly and confidently. This procedure includes modeling, role-playing, and behavior rehearsal. He then tries more effective behaviors with his therapist, who plays the role of the boss and then gives feedback on how strong or apologetic he seemed.

Stan’s anxiety about women can also be explored using behavior rehearsal. The therapist plays the role of a woman Stan wants to date. He practices being the way he would like to be with his date and says the things to his therapist that he might be afraid to say to his date. During this rehearsal, Stan can explore his fears, get feedback on the effects of his behavior, and experiment with more assertive behavior.

In vivo exposure is appropriate in working with Stan’s fear of failing. Before using in vivo exposure, the therapist first explains the procedure to Stan and gets his informed consent. To create readiness for exposure, he first learns relaxation procedures during the sessions and then practices them daily at home. Next, he lists his specific fears relating to failure, and he then generates a hierarchy of fear items. Stan identifies his greatest fear as sexual impotence with a woman. The least fearful situation he identifies is being with a female student for whom he does not feel an attraction. The therapist first does some systematic desensitization on Stan’s hierarchy before moving into in vivo exposure. Stan begins repeated, systematic exposure to items that he finds frightening, beginning at the bottom of the fear hierarchy. He continues with repeated exposure to the next fear hierarchy item when exposure to the previous item generates only mild fear. Part of the process involves exposure exercises for practice in various situations away from the therapy office.

The goal of therapy is to help Stan modify the behavior that results in his feelings of guilt and anxiety. By learning more appropriate coping behaviors, eliminating unrealistic anxiety and guilt, and acquiring more adaptive responses, Stan’s presenting symptoms decrease, and he reports a greater degree of satisfaction.

(continues)
Summary and Evaluation

Behavior therapy is diverse with respect not only to basic concepts but also to techniques that can be applied in coping with specific problems with a diverse range of clients. The behavioral movement includes four major areas of development: classical conditioning, operant conditioning, social learning theory, and increasing attention to the cognitive factors influencing behavior (see Chapter 10). A unique characteristic of behavior therapy is its strict reliance on the principles of the scientific method. Concepts and procedures are stated explicitly, tested empirically, and revised continually. Treatment and assessment are interrelated and occur simultaneously. Research is considered to be a basic aspect of the approach, and therapeutic techniques are continually refined.

A cornerstone of behavior therapy is identifying specific goals at the outset of the therapeutic process. In helping clients achieve their goals, behavior therapists typically assume an active and directive role. Although the client generally determines what behavior will be changed, the therapist typically determines how this behavior can best be modified. In designing a treatment plan, behavior therapists employ techniques and procedures from a wide variety of therapeutic systems and apply them to the unique needs of each client.

Contemporary behavior therapy places emphasis on the interplay between the individual and the environment. Behavioral strategies can be used to attain both individual goals and societal goals. Because cognitive factors have a place in the practice of behavior therapy, techniques from this approach can be used to attain humanistic ends. It is clear that bridges can connect humanistic and behavioral therapies, especially with the current focus of attention on self-directed approaches and also with the incorporation of mindfulness and acceptance-based approaches into behavioral practice.
Reading


**The Overbooked Child**
By David Elkins

**Summary: Are We Pushing Our Kids Too Hard? How overworking children affects their development. Why parents push their children too hard. Ways to resolve the problem.**

The perfect picture of a balanced childhood, one in which our kids go to school, do a little homework and play fort, is a myth for many youngsters. More and more children, like adults, are involved in far too many activities.

Nine-year-old Kevin* was anxious, having trouble sleeping and complaining that he was tired all the time. A medical exam revealed no physical problems, so the pediatrician suggested his mother talk to a psychologist. When we met, I asked about Kevin's schedule. His mother told me that, in addition to school, he was involved in three team sports, church activities, scouts and had piano lessons twice a week. Finding nothing else to explain the child's symptoms, I suggested his stressful schedule might be the cause.

His mother looked at me as though I were crazy. "Give me a break," she said. "Kevin doesn't have any stress. He loves everything he's doing." She, too, was under pressure. She worked full-time, and because her husband's job required him to travel, she was responsible for most of the household chores and child care. Yet despite her own grueling schedule, she had enrolled Kevin in a dizzying number of extracurricular activities. "My parents never did anything with me," she explained. "So I want Kevin to know I'm there for him. No matter what it takes, he's going to have a good childhood."

But Kevin wasn't having a good childhood. He was overscheduled and on the brink of clinical depression. When I talked to him on his own, he confided that he missed playing with his friends in the neighborhood. They used to ride bikes, have water-balloon fights and build forts out of cardboard boxes. Now there wasn't time for those activities. "I really like being in sports and everything," he said. "But not all that much."

Kevin is not unusual. Millions of children across America feel overwhelmed and pressured. Alvin Rosenfeld, M.D., a child psychiatrist and author of The Over-Scheduled Child: Avoiding the Hyper-Parenting Trap, believes that enrolling children in too many activities is a nationwide problem. "Overscheduling our children is not only a widespread phenomenon, it's how we parent today," he says. "Parents feel remiss that they're not being good parents if their kids aren't in all kinds of activities. Children are under pressure to achieve, to be competitive. I know sixth-graders who are already working on their résumés so they'll have an edge when they apply for college."

Other child experts echo Rosenfeld's concerns. Andrée Aelion Brooks, author and former New York Times journalist, was one of the first to call attention to the overscheduled child. For her book Children of Fast-Track Parents she interviewed 80 mental health professionals and educators, in addition to 60 parents and some 100 children. Brooks concluded that exposing children to extracurricular activities too early is not necessarily a good idea. Some children are not able to function well with so many responsibilities and can develop stress disorders.

"Middle-class children in America are so overscheduled that they have almost no 'nothing time.' They have no time to call on their own resources and be creative. Creativity is making something out of nothing, and it takes time for that to happen," says Diane Ehrensaf, Ph.D., a developmental and clinical psychologist and professor at The Wright Institute in Berkeley, California. "In our efforts to produce Renaissance children who are competitive in all areas, we squelch creativity."

Early-childhood-education specialist Peggy Patten, M.A., agrees and notes that children today have many wonderful opportunities, but they need time to explore things in depth. When they are involved in too many different things, they sacrifice breadth for depth.
"Many children today don't have time to breathe. Parents think their kids will grow up and remember all the wonderful activities they were involved in," adds Melanie Coughlin, M.A., a licensed marriage and family therapist and adjunct professor at California's Pepperdine University. Coughlin, who counsels parents and children in private practice, thinks children "will remember how exhausted they were and how their parents were constantly yelling at them to hurry up and get ready for the next activity."

**Stress: Is it always a bad thing?**

Stress is a natural response that occurs when we are threatened or overwhelmed. Imagine you are on safari and an elephant charges you at full speed. Your body would react with what has been called the "fight-flight" response. Your heart rate shoots up, adrenaline floods your bloodstream, your muscles tense and you learn that you can run a lot faster than you thought. Such an experience would be intensely stressful, but your body's response would be normal and might even save your life.

Even in ordinary situations, stress is not always bad. Hans Selye, M.D., one of the pioneers in stress research, believed that moderate amounts of stress are actually good for us. He described two kinds of stress: eustress and distress. Eustress is the pleasant stress we feel when we confront the normal challenges of life. A child who enjoys soccer, for example, may thrive on the pressure associated with practice and games. Distress, on the other hand, occurs when we feel overwhelmed. The same child who thrives on soccer may become overwhelmed if he is also involved in four or five other activities.

**What Johnny is missing**

Not only are overscheduled children prone to stress, but they often miss out on important childhood experiences. Here are some examples:

**Time to Play in a Natural, Creative Way**

Unstructured play allows children to pursue their interests, express their personalities and learn how to structure their time. Play is the natural mode of learning for young children, but when their lives are dominated by adult-organized activities, there may be little time left to just be kids.

**Family Relationships**

Children need downtime with parents-time to relax, talk, read, play games and just hang out. Families that are constantly running from one extracurricular activity to the next have little opportunity for these experiences.

**Extended-Family Relationships**

Kids need contact with extended family. It may not always take a village to raise a child, but such family relationships can give children a sense of who they are and a network of social support. Children whose calendars are filled with extracurricular activities may have trouble finding time for these relationships.

**Self-Awareness**

Children need time to read, write, think, dream, draw, build, create, fantasize and explore special interests. Such activities promote self-awareness by helping children clarify who they are and what they are truly interested in. Children who are involved in too many programmed activities may have little time for these experiments in self-discovery.

**Why do we push so hard?**

The truth is, most parents have good intentions. They enroll their children in activities because they want them to have a rich, happy childhood. They sacrifice their own time to make sure their children
are at practices and competitions. Of course, these parents love their children, and the last thing they would want is for them to feel stressed.

Yet for some, the motivation is not always noble. Some parents push their children to succeed in the interest of their own egos. Others use their children to relive their own childhood dreams. Still others are motivated by social pressure. Notes one father, "All the kids on our block are involved in four or five various activities. If I took my kids out, they'd feel left out, and I'd feel like a jerk around the other parents."

The grandfather of four overscheduled grandchildren reflects on his own childhood: "When I was a boy, I played football at school and a little baseball in the summer. That was it. I never felt deprived or thought my parents didn't love me. Today, it's different. I think a lot of young parents are scared to death that their kids will grow up and tell some psychotherapist, 'I'm here because my parents didn't love me. They limited my extracurricular activities.'"

What can parents do?

Perhaps the place to begin is to lighten up. When my wife, Sara, attended our granddaughter's soccer game, she was amazed at the seriousness of some parents. "Go for the ball!" "Run for the goal!" yelled several fathers at the sidelines. Halfway through, two obviously tired little girls stopped in the middle of the field and began talking as the game continued around them. "These two girls were just being kids in the midst of all the frenzy," she says.

One recovering soccer mom says Jessica*, her 8-year-old, was exhausted from too many activities. Her schedule was filled with dance, ice skating, piano lessons, swim team and soccer. "When the headaches started, that was the last straw," says her mom, who took her out of everything. When Jessica felt better, she chose one activity: swim team. "She's a normal kid again, and we actually have time to be a family."

Taking a child out of all activities is quite dramatic and not always necessary. For most families, simply limiting the amount of time spent in extracurricular activities may be all that's needed to eliminate a child's stress and put family life back on an even keel.

It's also important to remember that extracurricular activities per se are not the problem. As Maureen Weiss, Ph.D., at the University of Oregon, and other researchers have shown, children who are involved in such activities reap important benefits. Involvement in sports, for example, is correlated with higher levels of self-confidence and academic performance, more involvement with school, fewer behavior problems and lower likelihood of taking drugs or engaging in risky sexual behavior.

Such findings have inspired towns and cities across the country to support extracurricular activities. Businesses and private organizations have pitched in to buy uniforms, equipment and other supplies. During the past 10 years, the extracurricular establishment has grown into a major cultural force, shaping and defining childhood and family life.

But have we gone to an extreme? What happens to children who are involved in so many activities that they feel overwhelmed? What happens to marriages when spouses have no time for each other? What happens to family life? These are important questions that research must answer.

In the meantime, we might do well by following Aristotle's adage: everything in moderation. Child experts acknowledge that extracurricular activities can be a positive force in children's lives, but they also agree that overscheduling can put children at risk. Balance is key.

Alvin Rosenfeld, M.D., the leading expert on overscheduled children, is doing something about the problem. He and his colleagues have organized National Family Night, for which Americans are being encouraged to set one night a year aside for family. Hopefully, we will turn this time-without scheduled activities-into a monthly event.

The entire town of Ridgewood, New Jersey, is addressing the issue in its own way. Inspired by Rosenfeld's work, social worker Marcia Marra, M.A., organized Ridgewood Family Night. With the
support of school administrators and religious leaders, the town cancelled all sports activities, homework assignments and even religious classes so families could spend time together on March 26, 2002. Some 91 percent of families took part in the event, and 89 percent of that group are in favor of another Family Night next year.

"Parents need to relax. Slow down. Activities are fine, but don't go over the top. Research says that what children need most are relationships, not activities," says Rosenfeld. "Focus on building meaningful relationships with your children, not becoming their chauffeur."

* Identities have been changed.

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