Units of Competency

CHCCSL506A Apply counselling therapies to address a range of client issues

CHCCSL507A Support clients in decision-making processes
ACAP regularly revises its course materials, including assessment 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 unit.

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

© 2011
Australian College of Applied Psychology
Developed and produced by the Australian College of Applied Psychology
Level 5, 11 York Street, Sydney NSW 2000

No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by means electronic, mechanical, photocopy, recording or otherwise without the prior written permission of the publisher.

Copyrighted materials reproduced herein are used under the provision of the Copyright Amendment Act (1989)

Readings indicated in this work have been copied under section VB of the Copyright Amendment Act 1989, for private study only by students.

V34201107
Support Clients

Overview

This module aligns with two units of competency:

- CHCCSL506A  Apply counselling therapies to address a range of client issues
- CHCCSL507A  Support clients in decision-making processes

This module is designed to enable you to use a range of counselling therapies to assist clients in dealing with a variety of life issues. You will also develop the knowledge and skills required to support clients in planning a course of action.

Skills and knowledge developed in this module are intended to be applied in the context of counselling work and in delivery of a range of community services. Additional knowledge may be required to address specific workplace requirements.

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

- use a range of counseling therapies to assist clients with a variety of life issues
- help clients plan a course of action for changes in their lives

This unit covers the skills and knowledge required for effective counselling. You will learn to use the techniques of five common counselling therapies. These skills will build on your existing counselling skills and enable you to apply them in a counselling context.

Elements

The unit of competency CHCCSL506A Apply counselling therapies to address a range of client issues contains three elements or learning outcomes. You will learn to:

- use techniques from a range of counselling therapies
- confirm suitability of counselling techniques in specific situations
- apply counselling techniques to address specific client issues and / or needs

The unit of competency CHCCSL507A Support clients in decision-making processes contains two elements or learning outcomes. You will learn to:

- assist clients in clarifying their aims and requirements
- enable clients to explore possible courses of action

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.

 الخارطة Activity

Various activities have been incorporated into this module to assist you in improving your 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.

Group work or online discussion board activities

There are three group work (for on-campus students) or online discussion board (for flexible delivery students) activities for this module. These activities are intended to provide you with opportunities to practise, 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 task 4 of this module which is a Reflective report.

📚 Reading

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

📁 Case study

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 Support clients 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). This module also has a co-requisite requirement to attend Diploma of Counselling Workshop 1 for flexible delivery students who have not previously attended the workshop.

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 practise, 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.

<table>
<thead>
<tr>
<th>Week</th>
<th>Content</th>
<th>Activities/Readings</th>
<th>Assessments due</th>
</tr>
</thead>
</table>
| 1.   | Counselling therapies  
• Historical development of counselling therapies  
• Common aspects of effective therapies  
• Studying counselling theory | Activity: 'Your experience as a client'  
| 2.   | Cognitive-behaviour therapy  
• Principles of CBT  
• The counsellor-client relationship  
• CBT techniques  
• Advantages and limitations | Activity: ‘Cognitive-behavioral therapy’ video |  |
<table>
<thead>
<tr>
<th></th>
<th>Support Clients</th>
</tr>
</thead>
</table>
| 3. | **Person-centred counselling**  
- Principles of person-centred counselling  
- The counsellor-client relationship  
- Person-centred counselling techniques  
- Advantages and limitations  
  Activity: Group work (on-campus students) or Online discussion board 1 (flexible delivery students) to be completed this week.  
| 4. | **Gestalt therapy**  
- Principles of gestalt therapy  
- The counsellor-client relationship  
- Gestalt therapy techniques  
- Advantages and limitations  
  Activity: ‘Psychotherapy with the unmotivated client’ video |
| 5. | **Family counselling**  
- Principles of family counselling  
- The counsellor-client relationship  
- Family counselling techniques  
- Advantages and limitations  
  Activity: Group work (on-campus students) or Online discussion board 2 (flexible delivery students) to be completed this week.  
| 6. | **Brief therapy**  
- Principles of brief therapy  
- The counsellor-client relationship  
- Brief therapy techniques  
- Advantages and limitations  
  Activity: The miracle question  
  Activity: ‘Brief counselling: The basic skills’ video |
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7.</td>
<td>Selecting appropriate counselling techniques</td>
<td>Assessment task 1: Short-answer questions due</td>
</tr>
<tr>
<td></td>
<td>• Help clients feel at ease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Clarifying client needs and issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Supporting clients to set practical goals</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Working with specific issues</td>
<td>Activity: Domestic violence</td>
</tr>
<tr>
<td></td>
<td>• Domestic violence</td>
<td>Activity: Group work (on-campus students) or Online discussion board 3 (flexible delivery students) to be completed this week</td>
</tr>
<tr>
<td></td>
<td>• Suicide</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Alcohol and other drugs</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Social, legal and ethical issues in counselling</td>
<td>Assessment task 2: Case study due</td>
</tr>
<tr>
<td></td>
<td>• Counsellor competence and responsibility</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Identify clients' issues requiring referral</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Meeting legal requirements</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Maintaining cultural awareness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Managing personal values</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Identifying personal strengths and limitations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Maintaining a non-judgemental approach</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Counsellor supervision and support</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Managing stress and burnout</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Identifying supervision needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Counsellor self-reflection</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Assessment task 3: Video skills practice session due</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.</td>
<td>Counselling therapies review</td>
</tr>
<tr>
<td></td>
<td>• Choosing a counselling approach</td>
</tr>
<tr>
<td></td>
<td>• Maintaining core counselling skills</td>
</tr>
<tr>
<td></td>
<td>• Selecting appropriate techniques</td>
</tr>
<tr>
<td></td>
<td>Activity: Self-assessment</td>
</tr>
<tr>
<td></td>
<td>Assessment task 4: Reflective report due</td>
</tr>
</tbody>
</table>
Elements and performance criteria

This module contains two units of competency: Unit CHCCSL506A Apply counselling therapies to address a range of client issues and Unit CHCCSL507A Support clients in decision-making processes.

Following are the elements and performance criteria relevant to these units.

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

CHCCSL506A - Apply counselling therapies to address a range of client issues

<table>
<thead>
<tr>
<th>Element</th>
<th>Performance criteria</th>
</tr>
</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. Use techniques from a range of counselling therapies</td>
<td>1.1 Apply knowledge of at least five counselling therapies</td>
</tr>
<tr>
<td></td>
<td>1.2 Identify the applications, benefits and limitations of common counselling therapies in the context of own work role</td>
</tr>
<tr>
<td></td>
<td>1.3 Demonstrate the application of counselling techniques and processes from these therapies</td>
</tr>
<tr>
<td></td>
<td>1.4 Combine counselling techniques and processes from different therapies in an effective way</td>
</tr>
<tr>
<td>2. Confirm suitability of counselling techniques in specific situations</td>
<td>2.1 Clarify specific client needs and issues and agreed desired changes to be addressed, including analysis of client’s developmental status and response to change</td>
</tr>
<tr>
<td></td>
<td>2.2 Identify application and limitations of identified counselling techniques in addressing client needs, issues and goals</td>
</tr>
<tr>
<td></td>
<td>2.3 Identify client and counsellor roles in therapeutic process in relation to a range of counselling techniques</td>
</tr>
<tr>
<td></td>
<td>2.4 Identify own level of comfort and/or issues in relation to using identified counselling techniques</td>
</tr>
<tr>
<td></td>
<td>2.5 Select most appropriate counselling technique/s for application in identified situations</td>
</tr>
</tbody>
</table>
### CHCCSL506A - Apply counselling therapies to address a range of client issues

<table>
<thead>
<tr>
<th>Element</th>
<th>Performance criteria</th>
</tr>
</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>3. Apply counselling techniques to address specific client issues and/or needs</td>
<td>3.1 Demonstrate appropriate and effective use of counselling techniques in assisting clients to deal with a range of issues</td>
</tr>
<tr>
<td></td>
<td>3.2 Use counselling skills appropriately in the context of each counselling modality and technique</td>
</tr>
<tr>
<td></td>
<td>3.3 Explain rationale for using specific techniques and evaluate effectiveness of the technique in context</td>
</tr>
<tr>
<td></td>
<td>3.4 Review own role as counsellor and in applying each technique and identify areas for improvement and/or changes in approach for the future</td>
</tr>
<tr>
<td></td>
<td>3.5 Identify indicators of client issues requiring referral and report or refer appropriately, in line with organisation requirements</td>
</tr>
</tbody>
</table>

### CHCCSL507A - Support clients in decision-making processes

<table>
<thead>
<tr>
<th>Element</th>
<th>Performance criteria</th>
</tr>
</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. Assist clients in clarifying their aims and requirements</td>
<td>1.1 Clearly explain to clients the policy on record keeping and confidentiality</td>
</tr>
<tr>
<td></td>
<td>1.2 Encourage clients to identify and explore overall aims and requirements and ideas for meeting them</td>
</tr>
<tr>
<td></td>
<td>1.3 Encourage clients to feel at ease and express themselves</td>
</tr>
<tr>
<td></td>
<td>1.4 Identify practical goals and requirements, and discuss with clients how these might be modified</td>
</tr>
<tr>
<td></td>
<td>1.5 Identify with clients potential courses of action for meeting individual aims and requirements</td>
</tr>
<tr>
<td></td>
<td>1.6 Where aims and requirements of clients cannot be met, refer clients to appropriate alternative sources of guidance and support</td>
</tr>
<tr>
<td></td>
<td>1.7 Identify indicators of client issues requiring referral and report or refer appropriately, in line with organisation requirements</td>
</tr>
</tbody>
</table>
## Support Clients

<table>
<thead>
<tr>
<th>2. Enable clients to explore possible courses of action</th>
<th>2.1 Explore with clients factors which could influence the preference for and ability to achieve a course of action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.2 Explore with clients features of and likely consequences of possible courses of action</td>
</tr>
<tr>
<td></td>
<td>2.3 Check client understanding of what is involved in each course of action</td>
</tr>
<tr>
<td></td>
<td>2.4 Help clients to assess advantages and disadvantages of each possible course of action and their overall appropriateness for meeting particular client requirements</td>
</tr>
<tr>
<td></td>
<td>2.5 Encourage clients to decide on a course of action and to consider alternatives which could be used if necessary</td>
</tr>
<tr>
<td></td>
<td>2.6 Document decisions and agreed support within organisation guidelines</td>
</tr>
</tbody>
</table>
Week 1 – Counselling therapies

Over four hundred different approaches to counselling are in use today. The various schools of counselling propose different perspectives for working with clients. When counsellors make their initial contact with clients, their theoretical perspective or orientation determines what they look for and what they see. It determines their focus and influences their choice of therapeutic interventions and techniques. In many ways, the counselling approach selected is an expression of the counsellor’s own life experiences and beliefs. It is therefore important that client and counsellor are well matched.

Most present-day counsellors borrow methods from other theoretical backgrounds that are congruent with their philosophical beliefs. They use an integrative framework of methods from the various approaches that seem to work with the client and the situation at hand. This does not mean however that they choose their interventions and techniques randomly or because they become ‘stuck’ with a client and therefore decide to change tack. They select methods carefully and use them in an integrated and appropriate way. They do not move hastily from one method to another.

Full understanding of these different perspectives can only be achieved with practice – linking ideas and methods with the needs of clients in the counselling relationship. Practice will give you insight in how to use the approaches appropriately, ethically and discriminately.

Each of the approaches we will discuss in this module has a different philosophy about human nature. Understanding this may help you become aware of your own philosophy and therefore help you discover the approach that best fits your needs. As you read, focus on understanding the macro-perspective of each approach rather than memorising the details. You may discover a personal preference for one or several approaches and eventually choose to integrate aspects of each approach.

Historical development of counselling therapies

The development of theoretical knowledge of psychology begins with a scientist, like Freud, proposing a working hypothesis. This is tested by clinicians and practitioners who trial this hypothesis with their clients. They often come back after working with clients and offer criticisms, extending or refuting the validity of the hypothesis. The literature is full of uncertainty, tenuous understanding and criticisms of theoretical positions.

The first approach to counselling was psychoanalysis, which was developed by Freud and later amended and modified to become the more commonly used psychodynamic approach to counselling. Psychoanalysis was based on the theory that human beings are driven by unconscious needs and wishes and therapy was traditionally a long and costly process of exploring the client’s past and making connections with their present problems. Psychoanalysis was known as the first force in the development of approaches to counselling and all approaches to counselling that have developed since are either based on, or in opposition to, psychoanalytic theory.
One group of theorists who believed psychoanalysis was unhelpful was the scientists who looked at human behaviour and environmental issues as the cause of problems in life. They believed that instead of exploring the past and unconscious motivations, it was better to work with a client’s current behaviours and experiences. This idea led to the development of cognitive-behavioural approaches to counselling, now known as cognitive behaviour therapy, or CBT, the second force in counselling.

A third force or approach to counselling also developed around the same time as CBT, known as the existential-humanistic school, which includes person-centred counselling, existential counselling and Gestalt therapy. This approach to counselling is much more interested in the client’s here-and-now experience, and emphasises the relationship between the client and counsellor as one of the most important aspects of counselling. As such, these approaches are often referred to as relationship therapies.

Table 1.1 provides a summary of these approaches to counselling as we know them today.

Table 1.1: Summary of theoretical approaches to counselling

<table>
<thead>
<tr>
<th>Theoretical orientation</th>
<th>Founder and/or major contributors</th>
<th>Theory base</th>
<th>Key characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>First force: Psychodynamic therapies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychodynamic therapy</td>
<td>Sigmund Freud</td>
<td>Psychoanalysis</td>
<td>Deterministic, developmental, analytical, historical, unconscious, relational</td>
</tr>
<tr>
<td>Object relations therapy</td>
<td>Melanie Klein Margaret Mahler John Bowlby</td>
<td>Psychoanalysis</td>
<td>Relational, family of origin-focused, past-oriented</td>
</tr>
<tr>
<td>Second force: Cognitive behavioural therapies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioural counselling</td>
<td>B.F. Skinner Joseph Wolpe Arnold Lazarus</td>
<td>Behaviourism</td>
<td>Behaviour based, pragmatic, scientific, experimental, goal-oriented</td>
</tr>
<tr>
<td>Cognitive behavioural therapy</td>
<td>Aaron Beck Donald Meichenbaum</td>
<td>Cognition behaviourism</td>
<td>Cognitive-based, thought and behaviour-oriented, environmental</td>
</tr>
<tr>
<td>Rational emotive behavioural therapy</td>
<td>Albert Ellis</td>
<td>Behaviourism cognition</td>
<td>Cognitive, decisional, here-and-now-oriented, action-oriented</td>
</tr>
</tbody>
</table>
Other significant approaches to counselling that have since been developed include family counselling, which focuses on the client as part of a family system rather than an independent entity, and brief therapy, which attempts to work with clients to help them address their problems on a time-limited schedule.

### Common aspects of effective therapies

Despite the development of so many different approaches to counselling, it is interesting to note that several decades of outcome research in the field of counselling and psychotherapy has found that no meaningful difference can be identified between the various approaches in providing a positive therapeutic outcome for the client.

Instead, research has shown that the effectiveness of counselling lies in certain aspects of the process that are common to all approaches. These aspects of effective counselling have come to be known as the ‘common factors’ (Duncan, Hubble & Miller, 2008, p. 6). They are now considered to be the key to effective counselling and therapy. These common factors are:

- **client/extratherapeutic factors**: the client’s experiences outside the counselling room that contribute to the success of the counselling – events, conversations and other experiences that happen in the client’s everyday life. According to Duncan et al (2008) examples of these factors include “faith, a supportive grandmother, membership in a religious community, sense of personal responsibility, a new job, a good day at the tracks, [or] a crisis successfully managed” (p. 9).

These non-therapeutic experiences are considered to account for 40% of the effectiveness of counselling. This makes them the most powerful influence on successful counselling, which is perhaps not so surprising when we consider that clients spend one hour of their week in counselling compared to the 167 hours over the rest of the week as they go about their daily lives.

---

**Third force: Existential-humanistic therapies**

<table>
<thead>
<tr>
<th>Third force: Existential-humanistic therapies</th>
<th>Rollo May</th>
<th>Existentialism</th>
<th>Phenomenological, existential, here-and-now, meaning of life, responsibility for self, supportive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existential counselling</td>
<td>Victor Frankl</td>
<td>Emmy Van Deurzen</td>
<td>Ernesty Spinelli</td>
</tr>
<tr>
<td>Person-centred counselling</td>
<td>Carl Rogers</td>
<td>Person-centred therapy</td>
<td>Phenomenological, existential, here-and-now, self-responsible, self-healing</td>
</tr>
<tr>
<td>Gestalt therapy</td>
<td>Frederick (Fritz) Perls</td>
<td>Gestalt, psychoanalytic behavioural</td>
<td>Phenomenological, existential, here-and-now, awareness, evocative, confrontive</td>
</tr>
</tbody>
</table>

• **relationship factors**: the relationship between the client and counsellor, acknowledged as the second most influential factor in successful counselling, accounting for approximately 30% of effectiveness. This includes factors such as empathy and warmth, encouragement, acceptance and caring.

Developing and maintaining such a relationship with clients is therefore essential, regardless of which method of counselling you choose to work with. Without a respectful and empathic relationship, counselling is unlikely to be successful no matter how skilled you may be in techniques or how familiar with theory.

• **placebo, hope and expectancy**: the client and counsellor’s belief that counselling works. If they both believe, and hope, that it will work then the likelihood of success is increased by up to 15% (Duncan et al, 2008). The actual method of counselling used is not influential in this factor, but rather it is the faith of both the client and counsellor that the counselling will work that contributes to a successful outcome.

• **the therapy model**: the counselling method used, accounting for approximately 15% of a successful counselling outcome. The common link between successful methods of counselling is that, whichever one is used, they all include an underpinning rationale or theory, a way to explain the client’s problems and a procedure to follow to help the client. The contribution of the particular method or approach however is also dependent on the counsellor’s skill in using the associated techniques.

---

**Reading**


This article discusses the question of whether therapy is effective and identifies the key factors common to all effective therapies.

---

**Activity**

Reflect on your own experience as a client in counselling and try to relate it to the ‘common factors’ discussed above.

• Would you say that your counselling was successful for you, or did you feel that it was not a helpful experience?

• Which of the common factors were present?

• Were some factors missing?

• How did that impact on your experience?
Studying counselling theory

Despite the common factors research, which may seem to make the study of counselling methods and theory largely irrelevant, a counsellor’s knowledge and application of specific methods remains important. Theory helps counsellors develop attitudes and 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 counsellors (Hansen, 2002).

Studying counselling methods is therefore essential for a counsellor. As you work through this it is important to consider 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?
Week 2 – Cognitive behaviour therapy

Cognitive behaviour therapy, or CBT, is an umbrella term for a number of different approaches to counselling that draw from both behavioural and cognitive approaches to counselling. As the names suggest, behavioural approaches focus on clients’ observable behaviour. They work from the hypothesis that the way we learn can explain our behaviour. Cognitive approaches, on the other hand, focus on clients’ thoughts and how they are related to their difficulties.

Today, most practitioners who are interested in this area of counselling integrate the two approaches: those interested in behavioural change have developed a more cognitive orientation, while those interested in cognitive approaches have integrated behavioural techniques to develop a broader treatment base. As a result, these approaches to counselling are often discussed as though they are one: CBT.

In this section we will introduce the basic theory and techniques of CBT. You will already be familiar with the core ideas of CBT from the discussion on behaviourism in the module Counselling Theories.

Principles of CBT

Aaron Beck (b. 1921) is one of the most influential theorists and practitioners of Cognitive Therapy, and his theory is at the core of CBT. Beck maintains that negative beliefs (dysfunctional schemas) people hold about themselves, the world and the future cause depression and other emotional disorders. Beck distinguishes between schemas (core beliefs) and automatic thoughts (intermediate beliefs). Automatic thoughts are the set of thoughts that make up our internal dialogue and are created from core beliefs, which may be faulty or unhealthy. For example, someone with a deeply held schema that says, ‘I am helpless’, may manifest this belief through fear of abandonment and develop an automatic thought such as ‘Everyone leaves me’.

These automatic thoughts are said internally to self, rather than aloud to the other person: they are our internal running commentary. They are thoughts triggered by particular stimuli, leading us towards a particular emotional response. Automatic thoughts produce emotions and become part of our internal dialogue or self-talk. These are at the edge of our awareness. They may be expressed verbally, non-verbally or via our behaviour.

Becoming aware of the automatic thoughts that are generated by schemas can be effective in helping clients change their thought patterns, and so identification of automatic thoughts is an important aspect of CBT.

The overall goal of CBT is to bring about client change. The focus is not on understanding the client’s deep-seated issues or exploring the past, as in psychodynamic counselling, but on the immediate problem the client is experiencing. The aim is to help the client to develop positive and helpful thinking, and appropriate and self-enhancing behaviours and feelings.
The CBT focus is on the here-and-now, rather than the past. Interventions are highly biased towards observable change. They are designed to reduce or eliminate the presenting problem and its symptoms. The counsellor will begin by asking the client questions about four different aspects of the problem:

- **cognitions**: whatever comes to mind for the client when they experience the problem; this may include words, thoughts or images
- **emotions**: what the client is feeling when they experience the problem
- **behaviour**: what the client does when the problem happens (including behaviours preceding, during and after the event)
- **psychical responses**: any bodily responses the client experiences that they associate with the problem. (McLeod, 2009)

While developmental history can be relevant to the presenting problem in CBT, the main focus is on understanding and changing ways in which the problem is maintained. For example, a client who has a problem with overeating will be encouraged to focus on concrete details: what happens just before they start to eat, what they say to themselves when they eat, what happens when they eat, and what happens just after they eat. They will not be asked to go back into their childhood experiences and try to make connections – the focus is on the here-and-now problems. The fundamental assumptions of CBT include the following:

- faulty or maladaptive thinking leads to unhelpful or negative behaviours
- positive behaviours can be developed by helping the client to generate positive thoughts
- clients can be taught to develop positive and self-enhancing thoughts and behaviour. (Gilliland & James, 2003)

### The counsellor-client relationship

As we discussed at the beginning of this module, the quality of the working relationship between the client and counsellor is one of the most significant factors in effective counselling. This applies in CBT as it does in other approaches to counselling however the CBT perspective is clear that the relationship, while important, is not enough to effect client change. Westbrook, Kennerly and Kirk (2007) compare the therapeutic relationship in CBT to a “useful laboratory for working on problems” (p. 25) in which clients learn new skills that can then be transferred to the real world.

CBT is a very skills-based approach to counselling, in which the client is taught new ways to think and behave by the counsellor. The client is expected to contribute to counselling and try out new skills and behaviours – they must be an active participant in the process.

### CBT techniques

One of the most significant differences between CBT and other approaches to counselling is that it involves more than talking – the client is often asked to undertake tasks and enact specific behaviour. For example, in the counselling room a client who has difficulty with close relationships may be asked to sit closer to the counsellor; in the real world, a client who is afraid to travel alone may be asked to attempt short bus journeys alone (McLeod, 2009).
As well as using techniques aimed specifically at changing behaviour, CBT counsellors are also interested in the cognitive element of client experience, and will assess and address problem thoughts and irrational beliefs.

Common techniques used in CBT are discussed below.

In **Socratic dialogue** the counsellor asks questions to help the client understand and make connections between thoughts and behaviours. The counsellor uses questions and clarifications to understand the client’s beliefs and to explore other possible ways of thinking. Questions are used to:

- clarify and define problems
- assist the client to identify their thoughts, images and assumptions
- examine the client’s meanings assigned to various events
- assess the consequences of the client’s specific thoughts and behaviours

Specific questions help clients become aware of their thoughts so that they can eventually examine them for cognitive distortions without the direction and guidance of the counsellor. Examples of directive questions include:

- Where is the evidence?
- What is the logic?
- What do you have to lose?
- What do you have to gain?
- What would be the worst thing that could happen?
- What can you learn from this experience?
- What is another way of looking at the situation?

**Exposure techniques**, such as **systematic desensitisation** – a useful technique for solving more complex problems involving anxiety and tension – originally developed for clients who suffer from anxieties and phobias. The underpinning idea of systematic desensitisation is that anxiety is a learned phenomenon (classical conditioning) in that people associate either an object, such as a spider, or a situation, such as falling from a height, with the onset of unpleasant feelings or pain. Then on future occasions the two components combine, evoking fear.

The goal of systematic desensitisation is to train the client to have an automatic relaxation response when faced with a previously feared object. Systematic desensitisation has proven successful with examination anxiety, sexual difficulties, dealing with nightmares, eating disorders, obsessions, depression, stuttering and phobias about snakes, heights and death (McLeod, 2009).

---

**Prescribed text**


Please complete the following reading from the prescribed textbook:

- Systematic desensitization (pp. 366–375)

This chapter explains the process of systemic desensitisation.
Relaxation training

Many clients who enter counselling are experiencing some form of anxiety or physical body tension so relaxation training is often incorporated into behavioural counselling. According to Ivey, Ivey, D’Andrea and Simek-Morgan (2007), body tensions manifest in many ways, such as:

- statements of fear
- tension in social situations
- direct complaints of sore, constantly tense muscles
- impotence and frigidity
- sleep difficulties
- high blood pressure

Rather than attempt to discover the roots of these problems, CBT counsellors believe that it is more effective to teach the client relaxation techniques to alleviate tension. Relaxation training involves teaching clients how to progressively relax their muscles, including their mind.

Social skills and assertiveness training

Social skills training involves teaching clients specific ways of responding to others. It can include training in communication skills, life skills and marital skills.

Social skills training involves the following:

- building rapport with the client and preparing them for instruction
- explaining the rationale and need for the skill(s)
- modelling the skill(s) through skills practice sessions, videotapes, audiotapes and demonstrations to help clients see and hear the skills in action
- giving clients the opportunity to practise the skills, supplementing their efforts with constructive feedback and positive reinforcement
- offering practice of the skill(s) outside the counselling environment (also known as generalisation), enabling the client to anticipate barriers and/or obstacles that might interfere with the effective use of their new skills

Assertiveness training is a form of social skills training. It helps people relate and interact on a social level. It encourages socially inhibited people to express their feelings, thoughts and beliefs openly and spontaneously while respecting the rights of others.

Sometimes clients do not know how to interact with others socially: they simply lack knowledge of what to say in social situations. Counsellors can help supply this information by discussing social protocol.

Some clients fear something terrible will happen if they are assertive, in which case systematic desensitisation can help reduce anxiety. Others hold personal values that prevent or discourage them from being assertive. Identification of the distinction between assertion and aggression can be helpful in this case as it helps the client recognise that assertiveness is ethically acceptable if used appropriately.
The basic assumption is that people have the right to express their feelings, thoughts, beliefs and so forth. One of the main goals of assertiveness training is to increase their skills so they can choose when to be assertive and understand how to be assertive. There are six stages involved in assertiveness training:

1. developing rapport
2. gathering information and pinpointing the problem
3. determining desirable outcomes
4. generating alternative solutions and rehearsing things like tones, speech fluency, the volume of one’s voice, facial expressions and eye contact
5. generalising the behaviour in other situations
6. continual assessment and follow up

Homework assignments, such as diary writing, keeping records of certain behaviours, thoughts or feelings, or practising new skills.

---


Please complete the following reading from the prescribed textbook:

- Negotiate homework (pp. 376–380)

This chapter discusses the skills required to set and manage homework assignments with clients.

---

**Role-playing and modelling**

CBT counsellors will often ask clients to tell their story and then role-play a problem situation. During the role-play, the counsellor asks the client to identify all feelings associated with concerns raised by the situation.

For example, a client may be asked to play out an activity that normally provokes anxiety. They may pretend to make a phone call which they have been avoiding. As they perform the activity, the counsellor asks: ‘What is going through your mind while doing this?’ If it seems important during the role-play, the counsellor may ask the client to stay with a key scene, keeping the image in focus. The client is asked to describe exhaustively what occurs in their mind during this key scene. This forces the client to focus inward and to peel back the layers of any underlying emotions.

The counsellor then works with the client to generate a rational approach to the situation. It is important that the counsellor is sensitive to the client’s gender, culture and religious framework in this process. At first, the client identifies one specific concern; later, they identify more. The counsellor looks for patterns or themes and beliefs to work on.

Please complete the following reading from the prescribed textbook:

- Interventions for communication and actions – 2 (pp. 329–345)

This chapter discusses some other ways to use activities and action-focused techniques in counselling.

## Advantages and limitations of CBT

One of the main criticisms of CBT is whether it is capable of producing deep changes in clients or whether it is superficial and therefore likely to be a short-term solution to problems. Some counsellors argue that CBT’s focus on the here-and-now is too narrow and that real, long-lasting change can only come from a deeper exploration of the root cause of the client’s problems. They argue that working on changing the symptoms does not cure the problem.

On the other hand, CBT is one of the most popular approaches to counselling and there has been much research to show that it is an effective form of counselling. CBT has gained a dominant standing in the treatment of problems such as depression, phobias, and anxiety. Some research has also indicated that the application of CBT may be promising in treating personality disorders such as borderline personality disorder. CBT in its many forms is now practised by a large number of helping professionals, including:

- psychologists
- psychiatrists
- nurses
- teachers
- counsellors
- social workers
- and in self-help contexts
Activity

Video

This week you will be required to view the video ‘Cognitive-behavioural theory in practice’.

You can find this video by:

- Login to my.acap
- On the left hand side you will find the Quick Links box
- Click on Library eResources within the Quick Links box
- Look for the heading Counselling and Therapy in Video
- Click on the link below this title for CTIV Alexander Street: http://ctiv.alexanderstreet.com
- Type the name of the video (i.e. Cognitive-behavioural theory in practice) in the search bar
- Click on Search for cognitive-behavioural theory in practice in playlist
- Click on the name of the video (CBT) and this will bring you to the viewing page.

This video is an example of a counselling session in which the counsellor uses CBT. As you watch the video, note how the counsellor uses a chart to help the client identify his automatic thoughts and begin to recognise that his irrational thoughts are impacting his behaviour and emotions.
# Week 3 – Person-centred counselling

The person-centred approach to counselling is a humanistic approach to counselling based on the ideas of Carl Rogers (1902–1987). Humanistic psychology is characterised as a non-directive, non-interventionist approach to counselling that focuses on the personal experience of each person.

In this section we will introduce the basic ideas of person-centred counselling and discuss the ways in which person-centred counselling is practiced.

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

## Principles of person-centred counselling

Rogers believed that people are essentially trustworthy and that they have the potential to resolve their own problems once they understand them. He believed that people have one single motivating force in their lives, known as the **actualising tendency**. Every person has the drive to continually develop towards wholeness and fulfilment of their potential. The actualising tendency is basically a positive force that is based on the premise of trust: people grow when conditions are favourable, trustworthy and respectful.

For person-centred counsellors, psychological difficulties are caused by blockages to the actualising tendency. When this fundamental drive is blocked, it is the counsellor’s task to help unblock it. A metaphor for the actualising tendency is the way in which an acorn will always grow towards becoming an oak tree (its actualisation) if the conditions for growth are positive. If the acorn is deprived of water or sunlight however its growth will be stunted and it will not reach its full potential as an oak tree.

The overall goal of person-centred counselling is to help clients become more integrated and independent. Rogers believed that once clients achieved this, they could manage their problems better and so the goal of counselling is to make the client a more functioning person and help them in their actualising tendency, not to directly solve problems. For Rogers, a person who is more actualised will have:

- an openness to experience
- a trust in themselves
- an internal source of evaluation
- a willingness to continue growing (Corey, 2009, p. 170)

The therapeutic aim is to encourage clients to get deeper and closer to themselves, to recognise and resolve any incongruence they feel.

Blockages to self-actualisation happen when the client becomes incongruent – when their **real self** is different to how they perceive themselves (**self-concept**).
Our self-concept begins to develop when we are born and is heavily dependent on the attitudes and behaviours of those closest to us. From earliest infancy, our need for approval from others is of utmost importance. Rogers (1974) offers an example of a young girl whose self-concept is that of a good girl, loved by her parents. As a child, she became fascinated with trains, wanting to become a railway engineer and eventually a president of a rail line as an adult. Her parents want her to pursue a traditional profession, not one they perceive is exclusively for men. As her desire runs contrary to what they want, they openly disapprove of her interest in trains. Their disapproval leads her to revise her self-concept because she perceives herself as a bad daughter for not wanting what her parents want. Whatever ‘traditional career’ she chooses, her self-concept is now out of tune with her actual self-experience.

Rogers (1974) notes that if she gives up her desire to become an engineer, something she truly values, herself will become divided. She will not know who she truly is and what she truly wants. If denial becomes her style, there will be a continual misfit between her real self and her self-concept. The distorted self-concept will feel threatened and this will produce anxiety. To avoid feeling this way, she may do things like projecting unwanted feelings onto others or she may demean herself in order to maintain the conviction of self-worthlessness. This feeling of low self-worth will affect her relations with others.

Like parents who accept their children for who they are with love and total acceptance, effective counsellors, too, accept people as they are and help them revise their structures of self. The ideal self, or the self we would like to be, is our goal for self-development. This is where we place our ideal values.

When clients come into therapy, they are generally in a state of incongruence. There is a discrepancy between their perception of self and their actual experience. For example, a student may aspire to be a doctor in the future but the reality is that their marks are not sufficient to gain entry into medical school. There is a discrepancy between:

- how they perceive their self-concept
- their future role, the ideal-self they strive to become
- their perception of their academic performance, their real self, which is causing them to experience anxiety

The counsellor-client relationship

The counsellor’s role in person-centred counselling is a facilitative one, aimed at helping clients discover themselves and grow towards fulfilling their potential. The counsellor is a real and caring person, not seen as a remote professional who relies on techniques or theory (Corey, 2009). The person-centred counsellor focuses on being with the client and understanding their perspective, following where the client leads. They do not take a development history, make diagnoses or take responsibility for the client through the creation of treatment plans, etc.
For the client, this approach allows them to explore their own feelings and inconsistencies and to find new ways of managing their problems. Archer and McCarthy (2007) provide the following example of a client’s experience in person-centred counselling:

I really felt that my counsellor understood what I was saying. The second I sat down with her I could tell she really cared about me and understood how I was feeling. I admit at first that I felt a little frustrated that she wouldn’t give me answers to my problems but she really hung in there and helped me figure things out for myself. I find myself thinking a lot about our sessions, and I really feel like I learned to trust myself (p. 96).

**Person-centred counselling techniques**

There are no ‘techniques’ in person-centred counselling in the same way that there are in other counselling approaches such as CBT. The role of the counsellor is to create a trusting and warm relationship with the client so that the client is able to develop as a person. In order to achieve this, the counsellor will ensure that three core counselling conditions are in place:

1. Congruence (genuineness)
2. Accurate empathic understanding
3. Unconditional positive regard

**Congruence**

Rogers (1967) considers congruence to be the most important of these three elements. Being congruent implies that the counsellor is real, genuine, integrated and authentic. The counsellor is without a false front and their inner and outer experiences match. They can openly express both negative and positive feelings and attitudes that are present in the relationship.

Being congruent may mean the counsellor shows anger, frustration, liking, attraction, concern, boredom and annoyance. This does not mean the counsellor discloses all these to clients, blurtting out what they feel at any given moment. This may be inappropriate. Rather, the counsellor expresses a feeling only when it persists and seems to interfere with their ability to be fully present with the client. When communicated, it is done carefully with warmth, respect and empathy for the client.

Rogers (1967) explains that when a counsellor experiences a feeling of annoyance, for example, towards the client, but is unaware they are feeling annoyed (i.e. they are not congruent), they find their communication contains contradictory messages. For example, the counsellor may verbally empathise with the client but their body language and tone are not empathic. This makes the client distrustful. Therefore counsellors need to be sensitively aware and accepting of their own feelings.
Rogers (1967) says:

… if I am to facilitate the personal growth of others in relation to me, then I must grow; and while this is often painful, it is also enriching (p. 51).

Some people try too hard to be genuine. They share their feelings because they think it will be good for the client, but this is not always helpful. The important factor is that the counsellor is as congruent as possible, feeling and acting in the same way towards the client. No-one, including counsellors, can be totally congruent and we are all more likely to fall somewhere on a continuum between incongruent and congruent.

When the counsellor communicates these attitudes, the client becomes less defensive and more open to exploring themselves and their world. They begin to take more risks, disclosing more because they know that when they do, they will still be accepted. They learn the importance of listening to their own feelings, to be in tune with their real self.

They begin to accept and understand their reality. From there, they move forward in constructive ways.

Rogers (1967) views this as a freeing process. Once clients are free, they find their own way to healing. This positive view means that counsellors allow the client to take responsibility for themselves. It also means that we never stop growing; there is never one point where we are completely self-actualised. Hence, we are always in the process of actualising.

**Accurate empathic understanding**

One of the main tasks of the counsellor in the person-centred approach is to understand the client’s experiences and feelings from their point of view and as they are revealed in the here-and-now. What is important is the client’s subjective experience of their immediate interaction.

Empathy is used to help the counsellor sense the client’s feelings as if they were their own. It is stepping into the private world of the client to discover their point of view, feelings and the conflicts which threaten them. The counsellor does not get lost in them, however. It is important that counsellors do not lose their own sense of separateness.

By empathising with the client’s experience the counsellor shows that they understand what is already being expressed. They also voice other meanings of which the client may be dimly aware. They need to detect nuances and sense deeper meaning. Accurate empathy is therefore more than simple reflecting. It is more than objective knowledge of the client’s problem. It is an evaluative understanding of the client with the client – a sense of personal identification. It is more than a cognitive understanding; it also encompasses an emotional, experiential component.

When a counsellor communicates empathy, they need to be aware of how their tone and manner comes across and whether it reflects a serious intention towards the helping relationship. They need to fine-tune their language to the client’s current feelings so the language fits the client’s mood and content. The message they strive to convey to the client is: ‘I am with you. I am viewing your life in your terms, not my own.’
Unconditional positive regard

This is a deep and genuine caring for the client. It is unconditional in that it is not contaminated by any kind of judgement or evaluation of the client’s feelings, thoughts and behaviours. It is an attitude of ‘I accept you as you are’, not ‘I will accept you when …’

Through the experience of unconditional positive regard from the counsellor, the client feels they are valued and that they are free to have and express their feelings and experiences, without risking the loss of the counsellor’s acceptance.

Acceptance is a key notion here: the client has the right to have their feelings. This is different from approval because we cannot receive approval for all behaviour, but we can receive acceptance. So, if a client is violent, the counsellor does not have to approve of it but they do need to accept that the client has these feelings without judging them for it.

It is also important that the counsellor’s caring is genuine, not possessive or to fulfil his or her own need to be liked or appreciated. The client does not need to conform to the counsellor’s ideas, nor to model after them; they need the freedom and confirmation to be.

Reading


This reading explains the core concepts and values of the person-centred approach through discussion and examples of dialogue from counselling sessions.

Advantages and limitations

One of the main contributions of person-centred counselling is the idea that the therapeutic relationship is more important than techniques in helping clients feel better, and this is in line with the research into the therapeutic ‘common factors’ discussed at the beginning of this module. Each person is different and person-centred counselling allows clients to find their own way, assuming that they are the experts on their own lives, rather than telling them what to do.

On the other hand, person-centred counselling has been criticised for its lack of techniques, on the basis that clients need more help to change and that they benefit from techniques that have been proven to work in other therapies.
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 the concept of congruence and answer the following question:

- Rogers believed that clients are in a state of incongruence when they come to counselling: what do you think he meant by that and how is incongruence addressed in counselling?

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 4 – Gestalt therapy**

Gestalt therapy is an approach to counselling that was developed by Fritz Perls (1893–1970). Gestalt is a German word that means ‘whole’ or ‘complete’. The basic premise of gestalt therapy is that human beings are born ‘whole’ and that as we grow and develop we tend to disown or become alienated from parts of ourselves. Perls believed that if we pay attention to ourselves and the way we interact with the world – what we are doing and how we are doing it – we can reclaim those lost parts of ourselves and become whole again (Corey, 2009).

Gestalt therapy is known for its experiential approach to helping clients become more aware of their present experience, and in this section we will introduce the basic concepts and typical ‘experiments’ that are commonly used in gestalt counselling.

**Principles of gestalt therapy**

The first goal of gestalt therapy is to help the client gain awareness of what they are experiencing and doing in the present. The aim is to foster the client’s ability to be autonomous. Only through awareness will they gain self-understanding and realisation that they can change their life experiences (Corey, 2009).

Counselling is based on the here-and-now experience as perceived and interpreted by the client’s subjective reality. Perceptions of the past are raised so they can be directly experienced in the present. Perls argued that only through understanding of the present can the client move forward into the future. Thus, the counsellor seeks to understand how and what the client thinks, sees, hears, smells, tastes and feels in the present moment with the counsellor.

There are several principles that underpin gestalt therapy.

**Holism**

Holism involves the idea that human beings are an integrated whole and should not be divided into ‘parts’. As such, no particular emphasis is placed on any one part of the client’s experience. All aspects of the client are explored, including memories, feelings, thoughts, their physical body, dreams, etc.

**Integration**

Essentially, gestalt therapy aims to integrate various conflicting aspects of a person. It does not get rid of feelings, but it helps to re-own parts of self that have been discarded along the path. It is a process of integration. The aims are to experience and then integrate all the factions of one’s personality.

**Awareness**

From a gestalt perspective, awareness is viewed as curative. It is achieved in the present by opening the client’s awareness to what they feel, sense and do. It highlights and emphasises all their senses; and by doing this, it allows them to realise when and how they avoid their senses.
Gestalt therapy focuses on clients’:
- movements
- postures
- language patterns
- voice
- gestures

It involves a total self-focusing on the matter at hand. For example, a counsellor may ask question such as:
- What are you doing with your feet now?
- Are you aware of your smile?
- Are you aware that your eyes are moist?

Contact

Contact refers to interacting with other people and the environment while still maintaining individuality. The meeting place between individuals and the environment is referred to as the contact boundary.

In a healthy individual, this boundary is flexible and they fully engage in the process of interacting. In an unhealthy individual, there may be fear of loss through contact; hence they do not allow themselves to have full contact, they remain fixed in their behaviours and perceptions, especially when faced with threatening situations.

In gestalt therapy, good contact is seen as the lifeblood of growth. It means having clear awareness, energy and the ability to express oneself. Extending exposure boundaries involves risk but also extends and releases the individual, leading to trust.

The counsellor-client relationship

The key role of the counsellor in gestalt therapy is to be open and present with the client and to help the client stay in the present. Gestalt theory places more importance on the quality of the relationship between the client and counsellor than on the use of techniques. Corey (2009) notes that contemporary gestalt counsellors emphasise:
- staying present with the client
- using authentic and direct language
- being gentle with the client
- trusting in the ability of the client to become self-aware

Gestalt therapy techniques

Gestalt counsellors draw heavily on experiential techniques that aim to intensify the here-and-now experience for the client, helping them to become more aware of their experiences and behaviours. The design of these techniques helps the client focus on what is happening within their body and emphasises whatever they feel. The counsellor invites the client to experiment and try out new behaviours to see what these teach them.
The emphasis of this approach is on the client-counsellor relationship, not on interpretations or techniques, though Perls recommends several techniques to help clients facilitate experiences in the present. These techniques bring about greater awareness of alternative possibilities which clients may consider for themselves. In this way, it is the client who offers interpretations or insights into their personal experiences.

Some common gestalt techniques are explained below.

**Here-and-now experiencing**

In gestalt therapy, nothing exists except the here-and-now, the present. The past is gone and the future has not yet arrived. Therefore, the emphasis in gestalt therapy is on learning to fully experience the present moment.

Most people act with a focus on the past, either remembering their past mistakes or fantasising aspects of their past. Some people act with an anticipation of the future, making endless plans for what they will do. All of us organise what we do in relation to time. Living in both the past and in the future constrain the present; it tends to avoid living in and for the moment. The task of the counsellor is to help clients with this constraint by experiencing the present. Counsellors do this by asking ‘how’ and ‘what’ questions:

- What is happening now?
- What are you experiencing now?
- How are you experiencing your fear? How are you attempting to withdraw from it?

**Experiments**

These are ways in which people make discoveries about themselves by attempting new activities. According to Corey (2009), experiments may be used to focus on a person’s awareness of how they behaved in a previous situation. They are designed to bring the client’s experience into the present, to bring out their internal conflict by making their struggle an active process. This approach does not focus on intellectualising problems but on trying action-oriented techniques and experiments to intensify what the client is experiencing. This generally produces insight into how some past experiences relate to present feelings of being stuck.

Experiments are conceived in the here-and-now through the client-counsellor relationship. They take many forms, such as:

- imagining a future event that might be perceived as threatening
- setting up a dialogue with a significant person
- dramatising a painful event
- talking about the identity of someone else, such as a mother or father
- focusing on body language
**The empty chair technique**

This is a common gestalt experiment and is often used to explore an existing conflict between the client and another person in their life. The counsellor asks the client to sit in one chair and to imagine that the other person is sitting in another chair. They role-play a dialogue with that person. They are asked to speak their thoughts to the empty chair facing them; then they move to the empty chair and respond to the comments they just made, taking the other person’s perspective. For example, the empty chair may represent the client’s father. The client sits in their own chair and says what they really want to say to their father (the empty chair); they then move to the empty chair and respond as their father.

The purpose of this activity is to help the client become more aware of their own feelings and they often recognise that they are projecting their own feelings or assumptions onto the other person. The technique can also be used to help clients to talk to different parts of themselves. For example, a client who is trying to decide whether to move to a new city may sit in one chair and talk as though they have made the decision not to move. They then sit in the other chair and talk as though they have made the decision to move. Similar experiments include asking the client to talk as though they were their own stomach butterflies or clenched fists.

**Language changes**

To encourage awareness in the here-and-now, gestalt counsellors ask clients to reframe their statements or questions from an ‘I’ perspective. When the client talks about sadness, pain or confusion, for instance, the counsellor makes every attempt to have the client experience these emotions in the here-and-now. For example, if the client says “It’s sad not to have a good relationship with your father”, the counsellor will ask the client to change the statement to “I feel sad not to have a relationship with my father”.

**Dream work**

In gestalt therapy, each part of a dream is understood to represent different aspects of the dreamer. By acting out the different parts of a dream, the client can begin to integrate different parts of themselves.

The counsellor will first be asked to recount the dream as if it were happening in the present. Rather than say, “I sat in the window and gazed out over the lake”, the client is asked to say, “I sit in the window, gazing out over the lake”. The use of present-tense language helps the client experience the dream with greater clarity and force. The client is then asked to talk about the dream as different parts of the dream, e.g. the lake and the window.

Every dream has a message for the dreamer, especially when dreamers discover it from within themselves rather than through the counsellor’s interpretation. Gestalt counsellors do not interpret any aspects of the dream with the client.
Support Clients

Video

This week you will be required to view the video ‘Psychotherapy with the unmotivated patient’.

You can find this video by:

- Login to my.acap
- On the left hand side you will find the Quick Links box
- Click on Library eResources within the Quick Links box
- Look for the heading Counselling and Therapy in Video
- Click on the link below this title for CTIV Alexander Street: http://ctiv.alexanderstreet.com
- Type the name of the video (i.e. Psychotherapy with the unmotivated patient) in the search bar
- Click on Transcripts (1)
- Click on the name of the video and this will bring you to the viewing page.

This video is an example of a counselling session in which the counsellor uses a gestalt approach. As you watch the video, note how the counsellor attempts to help the client become more aware of the way he interacts with the world using techniques such as here-and-now experiencing.

Advantages and limitations

One of the main strengths of gestalt therapy is the creative ways it brings a client’s experience to life in the present moment while emphasising the quality of the client-counsellor relationship. Clients are given a variety of tools to understand themselves better and to integrate conflicting parts of themselves.

The gestalt approach to counselling is a holistic, positive approach that believes in clients’ ability to gain awareness. The focus is on gaining that awareness, not on trying to ‘change’ the client and as such all parts of the client are equally accepted (Corey, 2009).

One criticism of gestalt therapy is that the counsellor using this approach needs to be highly self-aware and have extensive training. Without this, techniques are often misused as stop-gaps when the counsellor is ‘stuck’ or unsure what to do next. Gestalt experiments can open up deep feelings for the client and the inability to stay with the client as they work through those feelings is a potential danger for client and counsellor.
Week 5 – Family counselling

Before the 1950s, counselling was mostly one-on-one. It was only during the 1950s that family therapy began and was considered to be a revolutionary approach to counselling. Since then, there have been many developments in family counselling based on a common theme that human beings cannot be understood in isolation – we are all connected to others in systems (like our family) and our actions and behaviours impact on others just as the actions and behaviours of others in our environment can impact on us.

In this section we will introduce the basic concepts and techniques of family counselling.

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

Principles of family counselling

Family counsellors see each client as part of a system – their family. They assume that whatever happens to one member of a family impacts on another. Instead of focusing on the client’s individual problems, the family counsellor will explore the client’s problems in the larger context of the family system. They will try to identify ways in which aspects of the family system are impacting on or contributing to the client’s problems.

In family counselling all members of the family are seen as component parts of a system, interacting with one another. A family has the properties of a small group and every member has their own strategies to help maintain or break down their relationships with other members of the system. Families establish their own rules and they communicate and negotiate differences between them. When there is a change in one member of the family system, there is a noticeable effect on other members of that system.

Corey (2009) identifies four principles of family counselling. A client’s problematic behaviour/s may:

- serve a function or purpose for the family
- be unintentionally maintained by family processes
- be a function of the family’s inability to operate productively, especially during developmental transitions
- be a symptom of dysfunctional patterns handed down across generations (Corey, 2009, p. 412)
Consider case study below.

The case study of Ann

Ann is 22 years old and comes to counselling because she is depressed. She has been feeling this way for more than two years and as a result has struggled to keep her friends and do well at work.

In counselling, the counsellor discovers that Ann is still living at home with her parents, who are in their 60s. She has an older sister who is a very successful lawyer in the same town. Many of Ann’s former friends have married and moved away, leaving her isolated and lonely.


In the case study of Ann, a counsellor who works with individuals could understand Ann’s depression from a number of different ways. Overall though, they are likely to start counselling with Ann with the aim of gaining greater understanding of her experiences, including her cognitive, behavioural and emotional processes. They may help Ann to find ways to cope with her depression and isolation and help her make changes that will eliminate the problems.

A family counsellor, on the other hand, will see Ann in the context of her family and environment. The counsellor will clarify with Ann the ways in which her family ‘works’ as a system by asking about family rules (formal and informal), how communication happens within the family, and what part culture, generation and gender play in the family. The counsellor may also ask Ann to bring her parents and sister to counselling to try and understand how her depression and isolation are related to the family: how they are maintained and what impact they have on other family members. The counsellor will then find ways to help Ann and her family change some aspects of the family dynamic to help them all benefit (Corey, 2009).

The counsellor-client relationship

The family member who is the main reason for the family seeking counselling (e.g. because of their problematic behaviour) is known as the identified client in family counselling. Given that there are other members of the family in the counselling room however the most important part of the client-counsellor relationship is for the counsellor to acknowledge and develop a relationship with each family member present. Sometimes called joining, the counsellor needs to ensure that each family member feels that they are being listened to and that their concerns are recognised. Equally, the identified client needs to feel that they are not being singled out for blame or ‘picked on’ in counselling.

When starting work with a new family, the counsellor will ask themselves some internal questions about the family functioning. These questions help guide the counsellor to know what is and what is not relevant. They are only specifically raised with the family when confirmation is needed. These questions cluster around four dimensions: impetus, behaviour definition, from behaviour to presenting problem, and change.
Impetus

Impetus refers to the reasons for the family seeking counselling. Family counsellors will ask themselves questions such as:

- What is gained by the presenting problem?
- Who gains by it?
- Why does it occur now?
- What is its function in relation to family patterns or structure?
- How does it maintain the existing pattern?
- What are the consequences of the presenting problem?

Behaviour definition

This refers to understanding the problematic behaviour of the identified client. Questions counsellors will ask themselves include:

- How is the presenting problem defined? Is it defined by actual behaviour, family consensus or family myth?
- Who reinforces or confirms the definition, e.g. other families with similar problems, media, TV shows, self-help books, medications, other health care workers?

From behaviour to presenting problem

Here we aim at understanding the attitudes and experiences of the family towards the problem behaviour. Counsellors ask themselves:

- What makes the behaviour a problem? Is it the behaviour, the timing or its consequences?
- For whom is it a problem – other family members, school, neighbours?

Change

Change refers to what needs to change for the family to function more effectively. The counsellor will consider:

- What patterns need to be altered?
- Who needs to be present?
- Does the identified client view the presenting issue as a problem?
- Do all family members view the presenting issue as a problem?
- Who gains by not viewing the presenting issue as a problem?
- Who is most invested in change?
- Who is least invested in change?
- What happens if change does not occur?
- Who can be the best ally for counselling?
Family counselling techniques

In family counselling, the counsellor may work in multi-disciplinary teams. The team often includes a range of experts, such as counsellors, social workers, psychologists, psychiatrists and advocacy workers. They meet together on a periodic basis to discuss the family and to consult on ways to proceed.

A therapeutic team offers a wider point of view than an individual counsellor, as each member uses different conceptual models and methods relevant to their various fields.

Working collaboratively in a team helps facilitate a higher level of objectivity and it prevents members from becoming too enmeshed in the family dynamics. Although the use of therapeutic teams is an ideal way of doing family counselling, many do not have the resources available to work in a team.

Interventions are designed to work with the family’s patterns of behaviour. The team suggests interventions and comments on family patterns in a collaborative way with the family. The goal is to construct meaning together and to find new ways of dealing with problems. The focus of the team’s feedback is based on observable patterns and the family’s ideas – although there is recognition that the team’s ideas and descriptions are also subjective. Even with a team, every description is subjective and the team and the family are collaboratively involved in constructing meaning. This ideally challenges the notion of expert knowledge.

In an initial family counselling session, the family, which is anyone the identified client considers to be family, is brought in together to meet with one or two team members.

The first step in family counselling is to define the presenting problem. All family members are invited to the first session where this discussion takes place. Sometimes it is appropriate to include extended family members, who influence or are impacted by the presenting problem. Sometimes it is useful for the team to work with sub-systems of the family as a follow up to a whole family meeting, such as the parents.

Family counsellors are flexible in their approach. They may change the seating arrangements in the counselling room so different members can talk to each other. When a member is not present during a session, they may leave a chair empty in the room to symbolise the missing family member.

The counsellor needs to understand how family members assign meaning to the presenting problem. Often some or all members have an inaccurate perception or they may have conflicting views of the problem. Their communication is often based on their interpretations; in a crisis situation, these are generally misunderstood. One of the counsellor’s tasks is to understand the whole family scene and the ways each family member perceives the problem. They ideally help clear up these misunderstandings as part of counselling.

In family counselling there is no linear cause and effect as to why a problem has emerged in a family: problems arise because of the interrelationship between various members. Problems are viewed as circular and repetitive. This is called circular causality. When a problem emerges, it is difficult to break the circular pattern because there is no starting point.
The aim of family counselling is to create a context where family members can begin to think differently about the presenting problem. The counsellor does this by introducing different ways for members to think about the family system and the problem(s). By listening carefully and asking questions, the counsellor helps the family subtly shift their original beliefs and adopt new behavioural patterns.

### Using the genogram

One therapeutic tool for understanding the family system is to map the family tree with a **genogram**. A genogram is a map of the family history, showing individual personalities and relationships among the client’s family of origin. The family is perceived as an emotional unit with a network of interlocking relationships. It can be understood within its historical frame. It begins with the present family and works backwards, including all members of the wider family network over several generations.

Genograms are used to understand the genesis of a presenting problem. A genogram provides access to some of the family’s emotional issues, highlighting some of the patterns which continue to emerge across generations. Thus, an historical, multi-generational description of a client's family shows how family behaviours, thoughts and feelings are passed from one generation to another.

A genogram includes the following:

- births
- deaths
- miscarriages
- dates of divorce
- leaving home
- marriages
- separations
- religion, when applicable

Table 5.1 shows some common symbols used in creating genograms.

<table>
<thead>
<tr>
<th>Table 5.1: Common genogram symbols</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Marriage</td>
</tr>
<tr>
<td>Separation</td>
</tr>
<tr>
<td>Divorce</td>
</tr>
<tr>
<td>De facto relationships</td>
</tr>
<tr>
<td>Death</td>
</tr>
</tbody>
</table>
Advantages and limitations

Goldenberg and Goldenberg (2000) identify some advantages of family counselling over individual counselling:

Family counselling:

- more closely resembles reality – counsellors interact with a client’s extended family or partner, rather than hear about them via the filtered and subjective views of the client
- reduces social isolation – counselling helps reduce the feelings of self-consciousness and isolation by listening to others share in the session
- leads to greater cohesion and self-esteem – family members tend to support and lean on one another, generating a feeling of ‘we’ are working together to resolve our problem/s
- offers opportunities for role-modelling – there is more opportunity to observe and role-model problem-solving and coping skills in a group
- leads to a greater exchange of feelings and insight – expression of positive and negative feelings and listening to others is encouraged
- insight and understanding of motives and beliefs

On the other hand, some theorists argue that while we are part of various groups, we also need to work with clients individually to prevent them from being overwhelmed or coerced by other family members.

Reading


This reading explains the development and key concepts of family counselling, including the benefits and limitations of the approach. An example of a genogram is also provided.
**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).

For this activity you will need to:

- draw up a genogram for your own family or someone that you know. Discuss the insights gained form this exercise and whether you believe that genograms could be helpful in counselling.

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 6 – Brief therapy

Solution-focused brief therapy is a client-centred approach. The focus is not on the presenting problem and the client’s past but on the present and future solutions. Brief therapy attempts to overcome the presenting problem in a short time frame by redirecting the client into a new direction through different goals. Brief therapy is a directive approach. The client works out their own goals and the counsellor helps them learn ways of behaving and acting to achieve their goals.

In this section we introduce the basic concepts and techniques used in brief therapy.

Principles of brief therapy

Rather than trying to stop existing problematic behaviours, brief counsellors look for solutions that will make a difference. By constructing workable solutions, they help clients repeat already successful behaviours. Counselling emphasises change in the client’s perception of self by paying attention to their personal strengths and resources. Rather than looking at problems and disappointments, the client and counsellor look at achievements, skills, strengths and coping mechanisms, which is an empowering focus.

Essentially, brief therapy is based on the optimistic assumption that clients have the ability to solve their own problems. This positive focus is taken further by looking at what already works for the client (not on problems and bad experiences) and then finding ways to harness that positive experience to help in the future. A common approach in brief therapy is to ask the client: “Tell me about times when you felt a little better and when things were going your way” (Corey, 2009, p. 379).

Corey (2009) identifies five steps involved in brief therapy:

1. The counsellor helps the client to clearly describe the problem by listening and asking questions.
2. The counsellor and client work together to develop clear goals for counselling. To help clarify goals, the counsellor asks the client: “What will be different when your problems are solved?”
3. The counsellor asks the client to recall times when they were happy or when the problem was not present, with emphasis on how the client helped this to come about.
4. The counsellor summarises the goals, provides encouragement and suggests actions for the client to take before the next session.
5. The counsellor and client assess progress by using a rating scale for improvement. They then identify next steps.
The counsellor-client relationship

Although brief therapy is time-limited, the counsellor will still ensure that an effective working relationship develops with their client. They use communication and counselling techniques to develop rapport and engender trust. Without this, as with any approach to counselling, the client is unlikely to benefit from the process. One way the brief counsellor can help a productive therapeutic relationship to develop is by helping the client to recognise their own strengths and how they already use their personal resources to help themselves (Corey, 2009).

The counsellor encourages the client to engage in problem-free talk about themselves, although it is predictable that clients will want to talk about their problems. As the client feels heard and understood, rapport and trust begin to develop. The counsellor respects the client’s need to talk through their problems to some degree; but at the same time, they limit and control the focus on the past and on problems, keeping that focus to a minimum. Complimenting the client on previous success and redirecting the discussion to exceptions to the rule accomplish this.

It is not easy to persuade clients to reverse their attempted solutions for they are likely to be emotionally invested in their ways, and may even back their strategy with logic, reasoning, tradition and common sense. Furthermore, their solutions may have worked at other times and in other circumstances. The more clients are locked into their position, both intellectually and emotionally, the harder they find it to relinquish their position. However, if the counsellor demonstrates a trust, respect and concern for the client’s position, they can ask the client to stop what is not working and to expand the range of behavioural choices available to them by trying, even cautiously, something new.

Once the client feels comfortable and supported in the therapeutic environment, they are introduced to new ideas which may help them. Ideas are based on successful solutions used by the client to arrest other problems.

Brief therapy techniques

The aim of brief solution-focused therapy is to initiate a solution process, rather than to stop the self-reinforcing complaint pattern. When the client describes their problem, they give clues to aspects of the situation they haven’t considered. This forms the basis of a solution to the original problem. Counsellors ask questions which propose the possibility of change and life without the problem such as:

- How would you know the problem had gone?
- What would be different?

A solution does not require an exhaustive, detailed account of the situation. A number of plausible alternatives are considered and the client selects whichever appeals most. Any change no matter how small, has an impact and has the potential to lead to profound differences.

Some common techniques used in brief therapy are explained below.
The miracle question

This technique involves the client imagining that they wake up from a night’s sleep to find that their problem has miraculously disappeared. They have been asleep, though, so have no idea what happened to make this amazing change. The client is then asked to explain to the counsellor how they would know that the problem is gone – what would be different in their life. The client’s answer to the miracle question helps the counsellor and client set goals for change and get a greater sense of the solution.

Exception-finding questions

Working from the assumption that problematic situations are not entirely bad, the counsellor will ask the client to identify exceptions to the problem. For example, if the client comments that they always argue with their mother, the counsellor might ask: “Are there times when you don’t argue?” or “So you notice that you argue less when you see her on weekends than during the week?” Identifying the exception to the problem helps direct the client and counsellor towards a solution.

Scaling questions

This type of questioning involves asking the client where, on a scale of 0 (being the worst) to 10 (being the best), they think they are now and where they want to be when the problem is resolved. Scales can be applied to many aspects in a client’s life, such as self-esteem and self-confidence. Scaling for the future fixes the overall goal of the therapy and enables the client to define his or her own goals. They also provide a benchmark for small changes and show the client that making changes of a notch or two is possible.

Once the client experiences a small but definite change, this has a knock-on effect, which leads to further self-induced changes in other areas of life.

Coping questions

Coping questions are based on the concept that despite the problem, the client is able to survive, and are an attempt to harness the client’s current resources and abilities. An example of a coping questions is: “So despite feeling really depressed every day, how have you managed to keep your job and still get good feedback from your boss?”

Tasks

The counsellor is also likely to ask the client to undertake an activity between counselling sessions. Tasks can be small ways to think about changes, such as asking the client to note the things that made them feel good during the week; or they may be larger, such as trying out new ways of behaving.
The miracle question

Ask someone to help you by playing the role of your client while you take the role of a brief therapy counsellor. Spend some time exploring the client’s problems and then ask them the miracle question. Consider the following questions:

- Did the client’s response to the miracle question help them clarify their problem more readily?
- In what other ways was the miracle question helpful?
- What did you find challenging about asking the question?

Advantages and limitations

Given the time and financial constraints that many people and counselling organisations have, brief therapy is a commonly used approach to counselling today. The time-limited aspect and future focus make it a desirable and accessible form of therapy for many people.

The focus on what works already however does not appeal to the clients who want to understand the nature of their problems as brief therapy does not provide a framework for understanding the nature of change or why problems happen in the first place.

Video

This week you will be required to view the video ‘Brief counseling: The basic skills’.

You can find this video by:

- Login to my.acap
- On the left hand side you will find the Quick Links box
- Click on Library eResources within the Quick Links box
- Look for the heading Counselling and Therapy in Video
- Click on the link below this title for CTIV Alexander Street: http://ctiv.alexanderstreet.com
- Type the name of the video (i.e. Brief counseling: The basic skills) in the search bar
- Click on Title (1)
- Click on the name of the video and this will bring you to the viewing page.

This video is an example of a counselling session in which the counsellor uses a brief solution-focused approach. As you watch the video, note how the counsellor uses the various techniques described above to help the client identify his strengths and focus on the future, including exception questions and the miracle question.
Week 7 – Selecting appropriate counselling techniques

Don’t forget that Assessment task 1: Short-answer questions is due this week.

The techniques that you choose to help clients will depend on the approach to counselling that you are working from. This is because the techniques associated with each approach are based on the theory associated with that approach. For example, asking the miracle question is based on the idea from brief therapy that clients need to focus on solving their problems in the future and that by clearly identifying what needs to change they can start to work towards positive change. This technique would not be used by a counsellor working from a psychodynamic approach, for example, as theory behind the techniques is at odds with psychodynamic theory that presupposes we need to look to the past and our unconscious to resolve problems in the present. Similarly, asking a client to undertake homework is unlikely to be a technique used in person-centred counselling, which focuses on the relationship between client and counsellor as the most important therapeutic tool, rather than actions and experiments on the part of the client.

Prescribed text


Please complete the following reading from the prescribed textbook:

- Plan interventions (pp. 225–243)

This reading explains some of the issues counsellors need to be aware of when choosing interventions for a client.

Help clients feel at ease

It is important to develop rapport with clients early in the relationship so their sense of comfort, feelings of security and trust of the counselling situation are felt immediately. Once rapport has been established, respect, trust and shared purpose are present in the relationship and the client and counsellor can begin to work together effectively.

The ability to establish rapport is one of the most important skills a counsellor can develop. Counsellors who develop rapport with clients form a common bond; this bond helps counsellors and clients respond to each other. Ways to help develop rapport include:

- appropriate body language, such as leaning forward and facing towards the client
- using a friendly and encouraging tone of voice
- non-verbal affirmations, such as a head nod, smile or gesture
- using minimal encouragers to help the client tell their story, such as ‘mmm’ or ‘ok’
- explaining to the client what to expect in counselling
- active listening and reflection of feelings
Clarifying client needs and issues

Once rapport is developing and the client begins to feel comfortable to tell their story and express their concerns, it is important to clarify the problem(s) they are seeking help with and understand their perspective of the problem(s).

It is important to recognise that not all clients need a counsellor to accompany them through all stages of the helping process. For a significant group of clients, simply telling their story fully and deeply, with the sensitive attention of the counsellor, is actually all they need to do.

They may, for example, need to tell a story of trauma or suffering, and experience it being heard for the first time. This may take one session or several. It may take many sessions over a period of months. Once the telling is complete, some clients have no need to go further. In these cases, their goal is to tell their story fully and freely in a safe and trusting atmosphere. They need an atmosphere which is not interrupted, railroaded or coerced. The counsellor does not need to persuade these clients to explore options or movement into action. Sometimes clients will do so using their own initiative because they have been fully understood and attended to as they told their stories.

This is what Carl Rogers means when he writes repeatedly that when counsellors listen with enough freedom from judgement, empathy and trust in the basic goodness of their client, they need to do no more. The client’s healing will occur from within, rather as a plant grows once it has been provided with warmth, sunlight, water and the right soil conditions.

Consider the exchange below:

Counsellor: Let’s review some of the options you were talking about earlier. I get the sense you really want to lay all your cards on the table, and see which dreams you want to turn into reality.

Client: [reluctantly but compliantly] Yes, I suppose that’s a good idea, really. [long pause, then changes the subject] My child came home from school yesterday, and their teacher apparently told them that the project they’d been doing was over. The class is heartbroken. They got so much out of the project, and they lived in it for weeks and weeks. Now the teacher suddenly tells them it is over. It is all my child talks about. The teacher doesn’t seem to appreciate the class enjoyed the project so much.

Counsellor: When I suggested we look at your options, you sounded reluctant. Am I imposing my own agenda by asking you to do that?

Client: Well, yes, I guess you are. I know there are options, and I know I’ve talked about them. I really do need to explore them, but I actually feel scared at the thought of doing anything about them just now. I felt safe the last few sessions, just talking about things as they are now. The future seems remote.
Supporting clients to set practical goals

Egan (2009) defines goal setting as helping clients come to grips with what they want. Goals are statements in specific terms that state what clients want and need. Goals need to be viable and are generally considered to have specific characteristics. Goals should be:

- stated as outcomes rather than activities
- specific enough to be verifiable and drive action
- substantive and challenging
- both venturesome and prudent
- realistic in regard to resources needed to accomplish them
- sustainable in regard to resources needed to accomplish them
- flexible without being wishy-washy
- congruent with the client’s values
- set in a reasonable time frame

It is important that goals are stated as outcomes rather than activities. Outcomes state accomplishments where activities keep the client directionless, with nothing set to measure achievement. The outcome of the goal must manage the original problem.

Goals tend to emerge naturally through the client-counsellor dialogue. Counsellors help clients identify goals when they emerge and later they help clients explore ways to implement their goals.

When clients discover goals, most are creative and energised about creating a better future. Counsellors can release a client’s dormant creativity by asking them to:

- be optimistic and confident
- accept some ambiguity and uncertainty
- enlarge their range of interests
- be flexible, and break fixed habits and patterns
- be tolerant of complexity
- be curious
- persist
- take reasonable risks, even to be nonconforming

Counsellors create a safe environment to discuss creative and divergent ideas. Divergent thinking helps clients ‘think outside the square’ where they think there is only one answer to a problem. They help clients focus more on opportunities and less on problems. Divergent thinking helps them break their self-restricting mindsets.

Brainstorming is one way of helping clients think divergently and creatively. It helps clients who are not future oriented and those who have a restricted imagination. The client and counsellor do it together. The client considers what they want and need by generating a list of possibilities and choices.
Support Clients

The rules of brainstorming are as follows. The counsellor:

• uses an idea to stimulate more new ideas
• encourages the client to offer as many ideas as possible
• encourages the client to include ‘wild and crazy’ ideas

There is one rule to brainstorming: each person must suspend judgement of the other’s ideas.

Clients are often inhibited in the course of brainstorming or when they form a list of goals. They may devalue what they suggest, saying: “That’s a silly one” or “There’s no point, I could never do that”. When this happens, counsellors can gently discourage clients from discounting or demeaning their own ideas. It may be necessary to probe and/or challenge them, for example:

• I notice you made what seemed to be a perfectly sound suggestion, and then you crossed it off the list. What’s that about?

The client may decide to explore one possibility in depth before proceeding with their list, effectively stopping the flow of ideas. The counsellor wants to encourage them to continue listing possibilities. For example:

• They sound like important things you’re saying, but could you just put that aside for the moment and concentrate on generating more ideas?

When the client claims they cannot think of anything to contribute, the counsellor can prompt them. For example:

• If your partner were here, what ideas would they have? [The client lists them.] What do you think of those? Do you think any of them would work? Can you do any better?

Just like the whole counselling process, the skills of brainstorming possibilities and goal setting normally first broaden the client’s initial suggestions, and later narrow them down to a particular focus. Broadening the client’s range of possibilities is essential because clients often limit themselves to a few, self-defeating ideas to solve their problems. Clients need to review their set boundaries and perhaps widen their options and when they do it can often result in added energy and creativity.

After all the client’s ideas have been listed, each idea is checked for practicality. Common ideas are grouped together. Broad ideas are converted to clear and specific ones. The client’s ideas must be tailored to their abilities and capabilities. Ideas must also stretch the client to help them rise to the challenge of moving forward.

Once this has occurred, the counsellor can help the client focus on one or two achievable goals. Irrational and impractical ideas are eliminated from consideration. Ideas inconsistent with the client’s values are eliminated. Ideas that may be blocked by obstacles or situations beyond the client’s control also need to be eliminated. Some goals may exceed resources, so they must be downsized or eliminated.

Egan (2009) suggests that goal setting is an important way clients exercise their power. Goals help clients proceed in the right direction, serving as channels for action. Setting goals may mean the client must make some difficult choices.
Once goals are identified, the next step involves deciding which goal to proceed with. Some counsellors use a balance sheet strategy to help clients choose between difficult goals. They list the advantages and disadvantages in each goal. When a counsellor evaluates these advantages and disadvantages, the client’s resources must be taken into account, as their resources help stimulate and support them when they take action.

Once the goal is determined, the client must work with the counsellor to assess how best to implement the goal. Strategies give shape to the goal and its possibilities. Discussing strategies may require another brainstorming session. The strategy must be sustainable and appealing. It must be specific enough to drive the action. The client must have a clear sense of direction with their strategy. This process helps clients discover their own resources for getting what they ultimately want. Finally, a reasonable time frame must be established and put into action to achieve the goal.

Greenburg (1986, cited in Egan, 2009) recommends time frames be stated as either:

- immediate – outcomes evident in the counselling sessions
- intermediate – outcomes involving a change in attitude or behaviour leading to further change
- final – outcomes which refer to the completion of an overall program for constructive change through which problems are managed and opportunities developed

The counsellor also helps the client consider if each strategy results in a desirable outcome. Solutions involving activities are only valuable if they produce outcomes. The client needs to be continually reminded of the impact each activity or solution will have. Clients must consider what they are willing to give for what they want to accomplish. They must deal with people who may resist them.
Week 8 – Working with specific issues

In this section we briefly introduce the key issues to be aware of when working with clients presenting with specific issues in counselling, such as grief and loss, domestic violence, thoughts of suicide, or misuse of alcohol or dependency on drugs. Remember that while there are various theories and specific approaches to working with these issues, and you may eventually choose to specialise in one of these areas, the core counselling skills required for working with all clients, such as empathy, listening, and respect, also apply in these situations.

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

Domestic violence

Domestic violence refers to a situation where one partner in a relationship is using violent and abusive behaviours in order to control and dominate the other. The Domestic Violence Resource Centre website (2009) indicates that the vast majority of domestic violence perpetrators are males and the victims are women.

The Centre lists five different types of abuse:

- physical assault: physical force with the intent to injure, control or intimidate
- sexual: coercive or unwanted sexual activity, i.e. rape or undesired, painful and humiliating sexual acts
- financial: controlling access to money to reinforce position of power
- psychological: emotional or verbal abuse and threatening or intimidating behaviours
- social: behaviour which aims to isolate people from family, friends and other support networks

Women who attempt to end a relationship of abuse usually experience considerable pressure, including threats of further harm from the perpetrator. Control and intimidation can be compounded by the absence of legal and social support systems. Many women believe there are or have had experiences of limited alternatives. For these reasons, abused women have trouble making sense out of a reality that is basically inconsistent: one minute their partner loves them, the next they are abusing them with words or actions of hatred. This is why women in domestic violence situations are prone to depression.

Women assaulted by intimate partners learn helplessness. The depression and helplessness makes it hard for them to decide to leave the relationship. Before they can leave, they need to know they will survive and be safe.
There are many opinions on the issues of why men assault their partners and why women remain in abusive relationships. For example, some women in abusive cycles who report their reasons state that their partner is violent to them but good to the children. It is not good counselling to force personal values and beliefs about relationships on clients who are experiencing domestic violence. It is important that counsellors and crisis workers realise that though we may not understand or agree with their decision to remain in an abusive relationship, people have their reasons and ultimately how they choose to live is their decision.

The Children and Domestic Violence Action Group (1999) offers suggestions for crisis intervention workers who work with victims of domestic violence:

• withhold judgement
• explain that the violence is not their fault
• give them permission to talk about the violence
• help them make a safety plan for the future
• let them know that others have similar experiences
• support and assist them to act in ways which protect them and their children
• provide them with written information on hotline numbers and support groups

**Activity**

**Domestic violence**

• Click on the link below to go to the website of the Domestic Violence Resource Centre and read the stories of women who have experienced domestic violence.


The women who wrote these stories share their experience and advice and explain what helped them.

• Reflect on your reactions to these stories and what you have learned from them that could help you in working with clients experiencing domestic violence.

**Grief and loss**

Loss is a common experience encountered throughout your lifetime. It does not discriminate against age, race, sex, education, economic status, religion, culture or nationality. We all experience loss throughout our lives. Not all loss results in grief however. There are many factors that influence how we respond to loss, including personal factors, family and community ties, and the extent of attachment to the person or thing that was lost. Importantly, loss does not just affect the individual most directly involved – it can affect family members, a community and even a nation or the world, such as with the 9/11 terrorist attacks. And loss can also echo across and within generations, such as with the Holocaust.

We need to understand then that loss affects people in different ways and that people will often respond differently to similar experiences. When counselling someone who is bereaved therefore it is good practice to ask yourself: “What is the meaning of this loss to this person at this time?”
Each element of this question is important:

- the particular loss that has been experienced
- the individual client
- the particular period in the client’s life when the loss was experienced
- the amount of time that has passed since the loss, and what has brought about the new sense of bereavement in the client now

When a person decides to seek counselling following bereavement, it may be important to the client to have any unusual feelings or behaviours they are experiencing normalised. One of the great fears of the bereaved is that they are ‘going mad’. The educative role of the counsellor may include advising the client about some of the commonly experienced feelings, behaviours, thoughts and physical symptoms during the grieving process.

Hooyman and Kramer (2006) suggest ten steps to assist clients to explore their needs and goals:

1. Help the bereaved actualise their loss – by telling their story of loss the client may achieve a more complete awareness.

2. Help the bereaved express their feelings – there may be unrecognised feelings such as anger or guilt. With empathic listening, guided questioning and normalisation those feelings can be identified and expressed.

3. Help the bereaved to live without their loved one – adapting to a new role, making decisions and solving problems can be difficult during the stage of acute grief. Counselling can assist the bereaved to test the functions in a logical fashion.

4. Help find meaning in the loss – meaning can be found in their belief systems or religious or spiritual convictions.

5. Help with the emotional relocation of their loved one – by internalising the relationship with their loved one, the bereaved may feel still connected to them while developing meaningful ties with the living.

6. Provide time to grieve – grief is an ongoing process and extreme emotions can be triggered by anniversary events.

7. Interrupt ‘normal’ behaviour – the emotional manifestations of grief may be overwhelming and need to be normalised.

8. Allow for individual differences – it is important for the counsellor to recognise and respect the many ways that grief is experienced.

9. Examine defences and coping styles – this may include excessive use of alcohol and drugs and requires exploration with the clients of what is behind their behaviour so that other strategies may be considered.

10. Recognise difficult problems that may require specialist intervention – recognising when medical or other professional assistance is required is important to ensure that the client does not become entrenched in their grief.
Suicide

Suicide is not a modern phenomenon. There have been suicide incidents recorded throughout history and within many cultures. Some well-known examples are the deliberate actions of the Kamikaze pilots who flew headlong into unredemable battle situations during the Second World War. These suicidal actions were deemed ‘honourable’ and the airmen hailed as heroes. Historically, in many cultures, shame, dishonour and failure were also often answered by an act of suicide. In some Christian societies you were doomed to hell if you committed suicide.

Movies, plays, operas and novels have romanticised suicide – *Anna Karenina*, *Romeo and Juliet*, *Madame Butterfly*. Others have illustrated the reality of the pain and sadness which accompanies a suicide event – *Dead Poets’ Society*, *Prince of Tides*. You could probably provide many other examples.

There are many reasons why people attempt suicide. In contemporary society, across cultures, both completed or thwarted attempts to commit suicide are based on feelings of utter hopelessness, usually preceded by depression. The person experiencing suicide ideation – imagining how they could best do away with themselves – holds the opinion that they are in such an intolerable situation that they cannot possibly put up with the intense feelings of distress any longer and cannot see their way out of their problems. These problems feel so serious and unresolvable to the sufferer that all they can imagine is how to get away from them.

It is vitally important for you as a counsellor to recognise the signs and symptoms in a client that may indicate they are potentially at risk of a suicide incident. The degree to which a person may be manifesting suicidal signs and symptoms needs to be assessed to determine whether the risk of suicide falls into the low, medium or high-risk category. This assessment necessarily provides a basis for choosing the intervention strategies and action to be taken by the counsellor.

You will judge if a person falls into the high-risk category by finding out if:

- they have ever attempted suicide previously
- anyone in their family has committed suicide
- they have a plan and the means to do it

During the actual encounter you will need to ask closed questions such as: “Have you ever tried to harm yourself before?” “Has anyone in your family ever killed themselves?” “Have you worked out how you are going to do this?” If you get a ‘yes’ answer to any of these questions, particularly the third, you know you have a high-risk situation to deal with.

In usual counselling situations, decision making rests with the client: questioning by the counsellor is normally very open-ended and the client is invited to attempt their own problem solving. The major difference in counselling suicidal people is that the counsellor has to assess the immediate needs of the client and act in the interest of preventing a suicide occurrence. In the case of medium or high-risk suicide potential, the client may need a more directive response from the counsellor and assistance obtained without their permission if their life is at risk.
Support Clients

The attitude the counsellor has towards the suicidal client is also very important. It is very important to take an **empathic** attitude with the client, and **not a sympathetic** attitude. Empathy can be demonstrated by statements such as: “I can see that you feel that your parents haven’t been there for you when you’d like them to be. Are they away at the moment?” Sympathy is expressed by statements such as: “You poor thing – that’s a terrible situation to find yourself in.”

Attention must be given to careful management of cases of potential suicide. Interviews and processes do not always go according to plan. However, it is important to have a general process to follow during your counselling of suicidal clients. Table 8.1 outlines a general process for managing suicidal clients.

**Table 8.1: Counselling a suicidal client**

<table>
<thead>
<tr>
<th>Stage 1: Build rapport</th>
<th>1. Establish a bond with the suicidal person</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Try to put them at ease</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 2: Understand and assess</th>
<th>1. Communicate empathy: “You feel... because...”</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Gather clues and information – listen for indicators of suicidal ideation</td>
</tr>
<tr>
<td></td>
<td>3. If suicide indicators are present, directly ask the client: “Are you thinking of suicide?”</td>
</tr>
<tr>
<td></td>
<td>4. If the client is thinking of suicide, assess the degree of danger:</td>
</tr>
<tr>
<td></td>
<td>• Is there a plan for the suicide?</td>
</tr>
<tr>
<td></td>
<td>• Is the means of suicide available (e.g. sleeping tablets)?</td>
</tr>
<tr>
<td></td>
<td>• Is a suicide attempt in progress?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 3: Intervention and action</th>
<th>1. Reduce the degree of danger.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Help the person expand his or her options.</td>
</tr>
<tr>
<td></td>
<td>3. Give positive reinforcement for other options.</td>
</tr>
<tr>
<td></td>
<td>4. Refer the person to other resources.</td>
</tr>
<tr>
<td></td>
<td>5. If the person is phoning you, try to establish where he or she is.</td>
</tr>
<tr>
<td></td>
<td>6. Get back-up help if high risk or if suicide attempt is in progress.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 4: Contract and close</th>
<th>1. Make a contract with the person that they will not suicide and that they will access further help with your assistance.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. End the interview positively.</td>
</tr>
<tr>
<td></td>
<td>3. Follow up on the contract – ensure you do what you say you will. Do not make promises or conditions that you cannot keep – you may not be able to fulfil them and underlying problems may need long-term commitment or medication.</td>
</tr>
</tbody>
</table>

This reading discusses ways to manage clients experiencing grief and loss issues and ways to work with suicidal clients.

**Alcohol and other drugs**

We live in a society where substances are widely used and their inappropriate use causes many problems. As counsellors we need to be able to assess clients for possible substance use and dependency.

When it comes to counselling, there is nothing unique about the field of alcohol and other drugs. The same skills that are effective for general counselling are also effective for counselling people with drug-related problems.

Research has shown that treatment for alcohol and other drug problems is more likely to be successful if the counsellor uses empathic counselling skills. We do not recommend that you confront your clients or argue with them in order to convince them of the need to change. Good counselling skills and the relationship itself can make a change in your client.

The ideal approach is to:
- show empathy and respect for clients
- develop a supportive relationship with clients
- have an organised approach to each case and take careful progress notes
- be creative and imaginative
- show self-awareness by not imposing personal concerns on clients
- have good common sense and social intelligence
- be action-oriented

The focus then needs to be engagement of the client in the process. Micro skills that enhance the engagement process are:
- empathy
- reflective listening
- rolling with resistance
- simple and amplified reflection
- double-sided reflection
- open-ended questions
- elaborating
- reframing
- affirming the positives
- summarising
Support Clients

Other issues to consider in the counselling process are ethical behaviour, professional boundaries and your own personal feelings in the counselling relationship. Working with substance-use clients can be personally challenging – whether you specialise in substance use and dependency or not. There is often a blurred line between professional knowledge, values and skills, and personal values, beliefs, experiences and myths.

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).

For this activity, you will need to click on the link below to read the Privacy Statement of Lifeline Australia, which includes information on confidentiality, information gathering, note taking and identity protection:


Imagine that you are a counsellor working for Lifeline Australia and a client tells you that she is experiencing severe depression after the death of her husband. In your group, discuss your understanding of the organisation’s policies and how this might impact on the way you work with that client. Your discussion should include:

- what organisational protocols on confidentiality, note-taking and client record-keeping you would need to be aware of as a Lifeline counsellor
- a short script of what you might say to a client at the beginning of the first counselling session regarding privacy; include information to the client on confidentiality and the organisation’s policy on record keeping
- how Lifeline’s organisational privacy protocols would influence the way you make referrals

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 definitions 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 9 – Social, legal and ethical issues in counselling

As counsellors, we need to be aware of a variety of issues and dilemmas which may arise in the counselling context. These dilemmas may be created by overlapping roles, issues of confidentiality, the enforcement of boundaries, inappropriate referrals, charging of fees and so forth. These areas are as important to managing counselling relationships as providing support to and understanding of the client’s psychological needs.

In this section we discuss some of the key social, legal and ethical issues to be aware of when working with clients.

Don’t forget that Assessment task 2: Case study is due this week.

Counsellor competence and responsibility

Counselling has the potential to be rewarding for both the client and practitioner; however, it can also be damaging and potentially dangerous when counsellors engage in poor standards of practice and unethical, immoral behaviours. This also applies to managers who are in positions of power and who are often responsible for making ethical decisions concerning the protection and welfare of other employees.

It is your responsibility as a professional to practise according to a relevant Code of Conduct of your organization or professional association and to ensure that every interaction with a client meets appropriate ethical principles. According to Carroll and Gilbert (2006) these are:

- beneficence (engaging in what is good for clients)
- non-malevolence (not doing harm to people)
- autonomy (the principle that people are free to act as they judge fit, provided this is not harmful to others)
- justice (being fair in the way you deal with people)
- fidelity (about keeping promises, being faithful, loyal) (p. 150)

Counsellors need to be aware of their competencies. Competency is not determined by a certificate, degree or licence. These represent achievement of knowledge and skills, however competency is more than a one-off achievement; it is ongoing. Individual counsellors have an ethical responsibility to seek out ways to remain current with new developments.

Further courses, in-services, workshops and participation in conferences and seminars help counsellors remain up to date with current knowledge and practices. Learning never ceases and new clients present new challenges. Learning comes from other students, colleagues, supervisors and facilitators – all of whom comprise a valuable professional resource network. Other resources include self-education from readings on select topics from the wide range of materials on counselling theories and practice. These help to sharpen skills and challenge attitudes.
New areas of counselling demand ongoing education and training. Counsellors who select a specialty area need to take advance training to upgrade skills and knowledge. For example, counselling families, school children, athletes and migrants are specialty areas that require specific knowledge and understanding. It is important for counsellors to keep up to date with developments in their area. They can do this by reading books, journals, attending conferences and workshops, and participating in a peer group.

Ethical counsellors do not extend themselves beyond the scope of their training. They know their boundaries and do not attempt to use unfamiliar interventions without proper training and experience. When a client’s difficulties fall outside the range of a counsellor’s competency or training, clients need to be referred to colleagues or specialists in related fields. Hence it is important to know how and to whom clients can be referred.

Identify client issues requiring referral

Your clients will come from a range of socio-economic backgrounds and will fall into various age ranges. They may experience particular physical, mental or emotional problems. You will not be able to work with every type of client and every kind of problem. Knowing when to make a referral to another practitioner is therefore essential in ensuring that clients access the best possible care.

Warning signs indicating that you may need to refer the client include:

- the presence of a serious mental illness
- the client needs specialised help that you feel unable to provide or are not sure how to work with, e.g. depression
- there are boundary issues with your client, e.g. you are already working with the client’s partner or you know them from another part of your life
- you have feelings towards the client or the issue they want to talk about that may get in the way of counselling, e.g. if the client’s values clash strongly with your own

If you have a network of contacts, help can be more easily facilitated for clients.

Medical practitioners, psychiatrists, and clinical psychologists are the appropriate people, in the first instance, for referral of high- and medium-risk cases. They can assist with physical, mental and emotional problems – especially the treatment of depression.

There are also other health practitioners who offer services in the way of complementary medicine – people like massage therapists, homoeopaths, naturopaths, Bowen technique therapists, etc. Talk to these people: find out what they can do and add them to your network.

Personal and spiritual development consultants and practitioners may offer clients a way to deal with pressing issues in their lives. For example, self-worth, self-esteem and self-confidence issues can underpin suicidal feelings. Church ministers, priests, other spiritual consultants and teachers could therefore be added to your list.

Community care agencies will need to appear on your list.
Sometimes people are without food, clothing or even a roof over their heads. A family’s refrigerator, washing machine or hot water system can break down without their having the means to replace it. A car breakdown could be the last straw in a string of difficult events in a person’s life if it prevents them from getting to work, for example. It is important that you have information about helping agencies at hand. This type of assistance could make a difference.

There are government and church organisations that help people out materially in times of dire need. Make sure you know who they are and what they can do for those in difficulty. Include them in your network of contacts.

During the course of your interviews with your clients you may find that they subscribe to undertaking experiences different from what you would pursue. So, be open-minded. Collect and keep as much diverse information as you are able to access. You never know what help your client may be willing to receive, and from whom.

Each organisation will have guidelines and protocols on referral, so it is important to familiarise yourself with your agency’s requirements to ensure that you follow appropriate procedures.

Meeting legal requirements

One of the key principles of counselling is confidentiality, which refers to a client’s own thoughts, emotions and secrets. It is the client’s privilege to own their own issues and when they reveal these to a counsellor in confidence, they must have the knowledge and trust that this information will not be used to harm them.

At no time should a client’s name or details of the encounter be divulged to any person other than professional helpers, e.g. ambulance, police, medical personnel. These cases are not for discussion – such discussion constitutes a betrayal of trust. If this trust is not upheld, the matter can do damage to the person’s state of mind, reputation and future confidence in asking for and receiving help. It could also result in a legal issue for the counsellor. Debriefing and supervision should be conducted only with other professionals to maintain confidentiality.

You are required by law to report to the relevant authorities details relating to a person who you know intends to harm, or is at definite risk of harming themselves or another. This in itself raises two dilemmas. The first is incurred when you break someone’s trust as a counsellor and inform the authorities either without the person’s permission or against the person’s permission. Therefore it is advisable to inform your client at the start of a counselling session that you have a duty of care towards them, and are under legal obligation to inform the authorities if they disclose to you intent to attempt suicide or harm others. It is important to keep in mind that if your client does not want you to inform the authorities, and they leave your practice and kill themselves or hurt someone else, you may still be liable for prosecution by the police.

The second dilemma is when you inform the authorities of your client’s intent and the client has no intention of harming themselves or others and denies that they were going to – then you could also be liable for law suits or malpractice.

There are no easy answers to these dilemmas, mostly due to ambiguities in the law and the conflict between client trust and needs and the law.
Confidentiality extends to records. Counsellors have a legal and ethical duty to secure their records in a safe place with restricted access. Additional security measures which some organisations take include:

- the use of codes, numbers or fictitious names to keep notes from identifying the client
- a split record-keeping system, i.e. one system of cards with names and addresses, a second system with lengthy records of sessions and a coding system which cross-references both
- an agency dual-record system: one simplified record which is accessed by other personnel, such as social workers, and one detailed record which is accessed only by the practitioner

Some consideration of what should be contained on these records needs to be made. Emotional statements and personal opinions on the part of the counsellor are not always included, as this could lead to allegations of malpractice should the client access their record and feel offended by what has been written.

Maintaining cultural awareness

Cultural norms and social systems tend to be culture specific, meaning that what one cultural group considers ‘normal’ behaviour may be rejected as strange by another culture. Cultures can be formed on the basis of:

- ethnicity
- religion
- beliefs and customs
- age
- disability
- sexuality
- special needs or interests

To be an effective professional, you must be aware of your own cultural values and worldview, be able to identify the worldviews of your clients, and understand how to use culturally appropriate intervention strategies.

Respect for cultural diversity is integral to both human services work and social cohesion overall. Such respect understands that cultural diversity is not only a natural occurrence but that it also contributes to the creation of rich, interesting and tolerant communities. Unfortunately, people are sometimes culturally inappropriate without even realising it. The most obvious example of this lies in the realm of racist or culturally degrading humour.
When working in human services it is important that we not only have respect for cultural diversity but that we also demonstrate this respect. This can be done in a number of ways, such as:

- ensuring that all of our communication with clients, co-workers and others is devoid of any culturally inappropriate remarks
- being inclusive in our dealings with clients and other service providers
- knowing the variety of services and support available to clients so that if and when we are unable to provide a particular service to a person, we are still able to direct them to the most appropriate person or organisation

Prescribed text


Please complete the following reading from the prescribed textbook:

- Ethics on practice and training (pp. 409-428)
- Diversity-sensitive counselling and helping (pp. 429-449)

Once you have completed this reading, write a summary of the ethical and cultural issues that you need to be aware of when working with clients.
Week 10 – Counsellor self-awareness

Everybody has private thoughts and feelings that differ from those they express publicly, and everybody behaves differently in different situations. Everybody also has more access to and interest in their own lives and feelings than they do with the lives and feelings of other people. Despite this however many people lack self-awareness. It is easy to criticise others but it takes a lot of strength and courage to look within. Self-awareness is a crucial skill in order to understand ourselves and communicate better with others. When we have a heightened self-awareness, we can have improved, more effective communication and relationships with others.

Self-awareness allows us to know our strengths and weaknesses in all areas of our life. We have to be self-aware in order to communicate effectively with others. The more we understand ourselves, the more we can accept who we are or what we want to change. By being self-aware we are able to have a continuous journey of self-discovery and growth.

People often lack self-awareness. As a result, they cannot make improvements or change things that they are unaware of. We need to have a balanced and realistic view of both our strengths and weaknesses if we are to know our true selves. If we are too hard on ourselves in terms of our weaknesses, this affects our self-esteem. If we overplay our strengths, this can lead to arrogance and over-confidence.

In today’s constantly changing world, we continually need to assess and upgrade our skills and knowledge. We also change and learn new skills depending on our life experiences and changes. Self-awareness takes honesty and courage!

In this section we discuss ways to improve your self-awareness and how this can impact on counselling.

Identifying personal strengths and limitations

The Johari Window is a model for understanding ourselves that was developed in 1955 by Joseph Luft and Harry Ingham. This model helps us to increase our self-awareness and becomes a tool for changing our behaviour as a result of our heightened self-awareness. By being self-aware we become aware of our strengths and weaknesses and are able to identify areas for improvement.

The Johari model introduces the concepts of disclosure and feedback, which are essential to building relationships. In this model there are four basic areas or quadrants, each containing a different aspect of a person’s self.

The four selves are:

1. The open self
2. The blind self
3. The hidden self
4. The unknown self
The open self includes what is known to us of ourselves and to others who know us. We tend to show more of our open self when we are in a comfortable context, free from threat. This occurs generally when we are with people whom we know and trust and with whom we feel at ease. To be open, a person must be receptive to feedback, as well as to disclosing themselves. Relationships are effective when there is a balance of feedback and self-disclosure.

The open self represents things that characterise us and are known to self and others, such as:
- information we possess
- our behaviours
- our attitudes
- our feelings
- our desires
- our open motives
- ideas we present

The blind self (also known as the blind spot) represents all the things about ourselves that others know but of which we are unaware. The more we know about our blind self, the better we will communicate because we tend to remove those behaviours which annoy or distract others. For example, areas which are blind to us might include our:
- habits
- defence mechanisms
- repressed experiences

We can improve our blind self by listening to and accepting feedback when given, as well as by asking for feedback. The concept of feedback will be discussed in more detail in a later section.

The hidden self contains all that we know of ourselves but that we keep private because we do not wish to reveal these aspects of ourselves to others. This includes all our successfully kept secrets, personal things we feel belong to only us, and the hopes, anxieties and desires which we keep to ourselves. Some aspects of our hidden self we may reveal to select others and some we may never reveal. This quadrant can be reduced by disclosing appropriately to others.
The **unknown self** represents truths that exist about ourselves that neither we, nor others, know or are aware of on a conscious level. They are the unconscious aspects of our personality over which we have no control.

We infer the existence of this unknown self from:

- dreams
- psychological tests
- counselling

We can visualise the entire Johari model as being of a constant overall size, with the size of each section (or quadrant) being variable. If the size of any quadrant is changed, the other quadrants will also experience a change in size. For example, if we enlarge the open self, this will decrease the hidden self.

In most cases, the aim is to develop and enlarge the open self area. This promotes self-awareness (and ultimately emotional intelligence), as well as enhancing relationships.

Having an increased open area promotes enhanced individual, relationship, and team effectiveness. The open area is the area where good communications and cooperation occur, based on trust, disclosure and feedback.

By encouraging healthy self-disclosure and sensitive, reciprocal feedback we can build stronger relationships and teams. We also maintain our own personal effectiveness by being aware of areas to improve and making the necessary changes.

### Managing personal values

Values are ideals that guide our behaviour and decisions and help us to distinguish between what is right and wrong. They are principles, standards, beliefs and qualities that we consider to be worthwhile or desirable. Values outline what is important to us in terms of our conduct, our interaction with others and how we might live our lives in a meaningful way. Our values are shaped by age, gender, occupation, religion, education, life experiences, etc.

Values give us a guiding framework by which to lead our lives. Values are only values if we live by them. Values are demonstrated by what we do when people are looking, as well as not looking! Developing good values gives us a framework to guide our conscience and help us make good choices. If we have strong values and are put in a challenging situation, we are more likely to make good decisions according to those values.

Each of us therefore has different core values and ideas of what we feel is good, bad, right, wrong, normal and abnormal, especially when we are dealing with human relationships. Our values determine what we move towards because we agree or what we move away from because we disagree.

Often, value differences can cause communication problems and conflicts with people. This is because we are not neutral about our values.
If we understand our own value system it will help us relate to others more effectively and may help us make more intelligent and appropriate choices. If we know what values are important to us and to others, we can recognise and appreciate that some of our values must be similar, but some may be very different.

Each person perceives the world differently. We each see the world and interpret what we see from our own point of view.

We need to be aware that we all have different perceptions, and that this influences how we communicate with others. When we lack awareness of perception differences, we assume that everyone must see things the way we do and we deny the diversity of thought and experience that makes each person different.

Counsellors cannot ignore the fact that their counselling role includes them as a real person in the therapeutic relationship. They need to have sufficient self-understanding to recognise how their personality and life experience affect their ability to be objective and to reduce any tendency to impose their own solutions on their clients.

When counsellors examine themselves, Hackney and Cormier (2009) suggest they seek awareness and understanding of:

- their needs, such as their need to nurture, to be critical, to be respected, to be liked, to please others, to receive approval, to be right and to control
- their motivations, such as what they get or take from others they help and how this helping makes them feel
- their feelings, such as happiness, satisfaction, hurt, sadness, disappointment, confusion and fear
- their personal strengths, limitations and coping skills

For example, what if a counsellor comes from a different cultural background to their clients? Should they assume that the way they examine and analyse issues and make decisions is the same as others? Can they apply their own cultural values to clients who are different to them in gender, sexual orientation, ethnicity, race and religion?

When different social and cultural variables come together in a counselling relationship, there are inherent complexities.

Consider yourself. Are you aware of how your values influence and perhaps interfere with the choice of people you would choose to counsel? To what degree have you internalised your culture so that you are unaware of or insensitive to cultural and social variations among people? Is your view the only real and legitimate one? Or, can you embrace different assumptions without proof?

These questions assess personal values which are rooted in the counsellor’s social and cultural orientation. Values, to some extent, are also based on moral codes of the society. No-one is born with values; they develop as the individual grows and learns from others in their environment.
## Maintaining a non-judgemental approach

Judgements are inevitable. All of us make judgements of one another. It is simply part of being human. Maybe we should not do this, but we do. It is no different in counselling. Counsellors find themselves making spontaneous judgements about their clients, whether they intend to do so or not.

There are many different judgements that we make about clients and their situations at initial meetings. Example include:

- He doesn’t really want to be in counselling and so he won’t do well in counselling.
- She wants to leave her husband but she’s too frightened.
- He’s really overweight and obviously eats too much.
- She’s too thin and is really preoccupied with her looks.

The trouble with judgements like these is that they are often made without respect for the unique perspective of the client – we haven’t asked the client! As a result, judgements are often wrong and hinder the counselling process.

As counsellors, we are neither to pass judgement nor to close down options for our clients. Rather, we are to facilitate and open up the list of viable options. This is why personal development is so important in the preparation of ethical and professional counsellors. If we are not committed to understanding ourselves, by looking objectively at our own biases, assumptions and unconscious expectations, then we are not ready to offer our services to help others in distress.

Counselling textbooks frequently refer to the ideal of a non-judgemental attitude to clients. This attitude was probably first given widespread popularity by Carl Rogers who called it **unconditional positive regard**, that is, a valuing of the client, despite anything we might know about him or her, and a deep trust in his or her capacity to deal positively with whatever comes up in the course of counselling.

As a counsellor, it is somewhat easier to achieve the goal of suspension of judgement than to refrain from making any judgements at all. This does not mean that we make no judgements; rather, we allow ourselves to be aware of them, putting them to one side or putting them on hold while we listen further to our clients.

### Activity

**Personal reflection**

- Think of a time when you made a judgement about someone you worked with that later turned out to be wrong. What could you have done to prevent this from happening in the first place? What questions might you have asked to clarify the situation?
Week 11 – Counsellor supervision and support

Reflection and supervision are essential for effective counselling. Supervision is one of the most important ways counsellors can ensure that they continue to work effectively with clients and learn from their experiences – good and bad.

In this section we look at why supervision is such an important part of counselling and how to effectively use supervision.

Don’t forget that Assessment task 3: Video skills practice session is due this week.

Managing stress and burnout

In order to effectively help others in any counselling situation, the counsellor needs to be free of prejudice and judgemental feelings and deal with any emotional issues they have in relation to often challenging client problems. Counsellors are advised to endeavour to keep emotionally and mentally healthy, and engender a general state of calm in their own lives to be best placed to help others. If they fail to do this, they may find themselves stressed or suffering from burnout – feeling emotionally and professionally drained and unable to work effectively with clients.

This is not an easy task in today’s society. Some ways to do this in your personal life include spending quiet time meditating, undertaking regular exercise, adhering to a sensible healthy diet and doing yoga, tai chi, or some other form of calming activity.

People who spend their time and life helping others and listening to problems on a continuous basis are open to ‘picking up’ on negativity. This is why it is so important to debrief after counselling sessions – and to take sensible breaks or periods of rest.

Some ways to prevent stress and burnout include the following.

**During counselling sessions:**
- concentrate on listening and responding appropriately
- use empathic – not sympathetic – communication
- stay alert for signs of danger to both the client and yourself
- do not hesitate to call on help if it is needed

**After the session:**
- evaluate the encounter and debrief with a supervisor or professional colleague if you are feeling upset or emotional
- ensure that you record case details in your case management file
- note any particularly challenging aspects of the session or feelings you have to discuss with your supervisor in formal supervision sessions
Support Clients

It is widely accepted that those working in the helping professions are at risk of stress and burnout caused by various aspects of therapeutic work, including close contact with emotional pain and suffering. Other likely sources of stress are when you feel caught between the needs of your clients and the structures and policies of the organisation in which you are working, uncertainty regarding expectations, and conflicting or incompatible roles. This can result in what we call burnout and is associated with a reduced sense of accomplishment and job effectiveness.

This is different to the kind of stress that you might experience in connection with a particular client’s case. This kind of stress is often referred to as ‘compassion fatigue’ and occurs when feelings and memories in your personal life are triggered and become overwhelming.

Feelings of unrelenting emotional stress can also lead to burnout. If you have unrealistically high expectations of what can be achieved through the helping process and do not take proper care of yourself, you may develop a sense of apathy and disillusionment, which are symptoms of burnout.

The best way to deal with burnout is to deal with it before it happens. Self-care is about looking after yourself. Often people in the helping professions neglect this aspect of their lives because they find it hard to make themselves a priority. We reduce our capacity to care for others if we fail to take proper care of ourselves.

For many, taking better care of themselves means learning how to say no to certain people, thinking about what their needs are and asking for what they want, or taking time to spend just on themselves. It is also about becoming aware of when you are under stress and some of the ways you can alleviate that stress.

Identifying supervision needs

The overall purpose of supervision of professional practice is to provide you with three crucial components of professional development:

1. support and encouragement
2. assistance with your integration of theory with practice (educative component)
3. assessment of your practice against professional standards (managerial component)

Supervision, like helping, is not a straightforward process and is even more complex than working with clients. There is no tangible product and very little evidence by which we can rigorously assess its effectiveness. You discuss a client with your supervisor, whom the supervisor has often never met, and report very selectively on aspects of the work. There may also be all sorts of pressure on either or both of you from the placement organisation. So as well as dealing with the client in question, you and your supervisor have to pay attention to your supervisory relationship and the wider systems in which you are both operating.
Carroll and Gilbert (2006) provide an overview of the seven tasks of supervision, which are described as:

1. creating a learning relationship
2. teaching
3. counselling
4. monitoring professional/ethical issues
5. evaluation (formal or informal)
6. consultation (counselling supervision)
7. administration (p. 53)

It is suggested that these generic or overall tasks underlie all supervision approaches, although the emphasis and/or time spent on each will vary considerably depending on the supervisor and their approach.

In order for supervision to achieve its purpose, you need to take an active role as the supervisee. This requires you to assume the responsibilities of:

- being clear about what you need from supervision, what your goals and learning needs are
- choosing relevant material from client cases and sharing your work with your supervisor honestly and openly
- being open to feedback and being prepared to monitor your work, bearing in mind the feedback
- ongoing assessment of your use of supervision and whether or not it is meeting your needs, i.e. taking responsibility for giving feedback to your supervisor about whether the process is useful to you and your clients
- remembering at all times that you have the resources to solve your own problems

**Counsellor self-reflection**

Reflection encourages you to explore your worldview and challenge your beliefs and attitudes in order to maximise your personal and professional development. It is answering the question:

- What are the underlying principles that explain why I said/did this?

Learning to use reflection in this way is a crucial part of professional development. Reflection helps you to make links between the ideal you planned or hoped for and the reality of what occurred. By expressing your real and ideal worlds in words, you begin to see patterns. To do this, you need to learn to make cause-and-effect statements. For example, you might reflect on a recent counselling session and say to yourself:

- I notice that when I think I see what the client needs to do to solve the problem, and I suggest this, they usually ignore my suggestion and go back to what they were saying before.
Over time, you will become more aware of how you work and this will help you to improve as a counsellor. For example, the statement above might help you to accept that listening is more important in counselling than giving advice!

The process of self-reflection requires four steps:
1. reflecting on the situation (generally this is done by describing it later, e.g. to your supervisor or writing about it in a diary)
2. obtaining feedback from others in relation to the situation (e.g. your supervisor)
3. analysing the reflection and feedback
4. planning action to change behaviour

Reflecting on practice is not an activity that you only need to do during training, on placement, or occasionally. It is an essential part of ongoing professional development and the skills of critical reflecting and thinking should be used consistently throughout your career.

At times throughout your professional life you may find that you are very busy with little time to reflect on your experiences and practice, but we strongly recommend that you commit to finding the time to ensure your ongoing development and effectiveness as a practitioner.

Similarly, it is important that you review your action plans regularly to ensure they remain appropriate.

**Prescribed text**


Please complete the following reading from the prescribed textbook:
- Personal counselling and continuing professional development (pp. 463–470)

Once you have completed this reading, write a paragraph explaining how personal counselling could help you become a better counsellor.
Week 12 – Counselling therapies review

In this module we have introduced you to the basic principles and techniques of several different approaches to counselling. These include:

- cognitive behaviour therapy (CBT)
- person-centred counselling
- gestalt therapy
- family counselling
- brief therapy

We also discussed various other aspects of the counselling process, including the ethical and legal issues involved in counselling, the importance of self-awareness, self-reflection, and supervision and how to choose appropriate techniques.

In this final section we encourage you to review the various topics covered in this module and work towards finding an approach to counselling that feels comfortable for you.

Don’t forget that Assessment task 4: Reflective report is due this week.

Choosing a counselling approach

A theoretical understanding of different approaches to counselling is essential in helping you to conceptualise client problems and in providing you with a ‘road map’ of how to work with clients. It is also essential in helping you identify your own preferred orientation. Through practice, you will develop your understanding of the approaches and your unique identity as a counsellor. Even though counsellors from the same theoretical orientation prescribe to the same assumptions and core concepts, their styles are diverse and the way they apply them in practice is unique.

Many counsellors use an integrated approach, by taking different aspect of several approaches to counselling and using them at different times with different clients for the most effective outcome. At this stage however we recommend that you focus on one counselling approach, as integration is a skill that comes with practice and extensive experience. The danger of integration without experience is that you choose interventions from different approaches because you are ‘stuck’ about what to do next or because one approach does not seem to be working quickly enough. It is more effective to have a pre-set, clear approach and set of principles to follow to help you know what to do and how to work with your client.

We suggest that you review the approaches to counselling discussed in this module, and in the previous module, Counselling Theories, to identify the approach that seems most aligned with your personal values and beliefs about counselling.
Maintaining core counselling skills

As we discussed in Week 1, the most influential factor in good counselling is the relationship between the client and counsellor. Regardless of the approach you choose to take, therefore, the use of core counselling skills is essential to engage the client, allow them to tell their story in a respectful way, and to help them clarify and reflect on their situation. These microskills are the skills or strategies the counsellor uses to assist the client along the counselling process. The microskills you have already learned about in this course include:

- attending and developing rapport
- active listening
- asking open and closed questions
- reflecting and paraphrasing
- summarising

Core counselling skills used in every effective approach to counselling are summarised in Table 12.1.

Table 12.1: Core counselling skills

<table>
<thead>
<tr>
<th>Skill</th>
<th>Description</th>
<th>Function in interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open questions</td>
<td>‘What’: facts</td>
<td>Brings out major data and facilitates conversation</td>
</tr>
<tr>
<td></td>
<td>‘How’: process or feelings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>‘Why’: reasons</td>
<td></td>
</tr>
<tr>
<td></td>
<td>‘Could’: general picture</td>
<td></td>
</tr>
<tr>
<td>Closed questions</td>
<td>Usually begin with ‘do’, ‘is’, ‘are’ and can be answered in a few words</td>
<td>Quickly obtains specific data; closes off lengthy answers</td>
</tr>
<tr>
<td>Encouraging</td>
<td>Repeating back to the client a few of the client’s main words</td>
<td>Encourages detailed elaboration of specific words and their meanings</td>
</tr>
<tr>
<td>Paraphrasing</td>
<td>Repeating back the essence of a client’s words and thoughts using the client’s own main words</td>
<td>Acts as promoter for discussion; shows understanding; checks on clarity of counsellor understanding</td>
</tr>
<tr>
<td>Reflection of feeling</td>
<td>Selective attention to emotional content of interview</td>
<td>Results in clarification of emotion underlying key facts; promotes discussion of feelings</td>
</tr>
<tr>
<td>Summarisation</td>
<td>Repeating back of client’s facts and feeling (and reasons) to client in an organised form</td>
<td>Clarifies where the interview has come to date; useful in beginning interview, periodically throughout session and to close session</td>
</tr>
</tbody>
</table>

Prescribed text


Please review the following sections from the prescribed textbook:

- Listening skills (pp. 80–97)
- Show understanding skills (pp. 101–125)
- Clarify problems skills (pp. 147-174)

These chapters will help you to revisit and refresh on the basic counselling microskills that are essential in any approach to counselling.

Activity

Self-assessment

Complete the Performance criteria checklist at the end of this module to assess your competency against the performance criteria for these units. Comment on ways in which you might revise your practice in the future to continuously improve in your use of interventions and in supporting your clients.
**Performance criteria checklist**

This checklist outlines the key skills and knowledge required to achieve competence in the elements of these units, 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.

**CHCCSL506A - Apply counselling therapies to address a range of client issues**

<table>
<thead>
<tr>
<th>Performance criteria</th>
<th>Examples of what I currently know &amp; can do</th>
<th>Examples of skills &amp; knowledge I need to develop further</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 I can apply knowledge of at least five counselling therapies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 I can identify the applications, benefits and limitations of common counselling therapies in the context of my own work role</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 I am able to demonstrate the application of counselling techniques and processes from these therapies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4 I can combine counselling techniques and processes from different therapies in an effective way</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 I can clarify specific client needs and issues and agreed desired changes to be addressed, including analysis of client’s developmental status and response to change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2 I can identify application and limitations of identified counselling techniques in addressing client needs, issues and goals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3 I can identify client and counsellor roles in therapeutic process in relation to a range of counselling techniques</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Support Clients

<table>
<thead>
<tr>
<th>2.4</th>
<th>I can identify my own level of comfort and/or issues in relation to using identified counselling techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5</td>
<td>I can select the most appropriate counselling technique/s for application in identified situations</td>
</tr>
<tr>
<td>3.1</td>
<td>I am able to demonstrate appropriate and effective use of counselling techniques in assisting clients to deal with a range of issues</td>
</tr>
<tr>
<td>3.2</td>
<td>I can use <em>counselling skills</em> appropriately in the context of each counselling modality and technique</td>
</tr>
<tr>
<td>3.3</td>
<td>I can explain rationale for using specific techniques and evaluate effectiveness of the technique in context</td>
</tr>
<tr>
<td>3.4</td>
<td>I am able to review my own role as counsellor in applying each technique and identify areas for improvement and/or changes in approach for the future</td>
</tr>
<tr>
<td>3.5</td>
<td>I can identify indicators of client issues requiring referral and report or refer appropriately, in line with organisation requirements</td>
</tr>
</tbody>
</table>

### CHCCSL507A - Support clients in decision-making processes

<table>
<thead>
<tr>
<th>1.1</th>
<th>I can clearly explain to clients the policy on record keeping and confidentiality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2</td>
<td>I know how to encourage clients to identify and explore overall aims and requirements and ideas for meeting them</td>
</tr>
<tr>
<td>1.3</td>
<td>I can encourage clients to feel at ease and express themselves</td>
</tr>
<tr>
<td>1.4</td>
<td>I can identify practical goals and requirements, and discuss with clients how these might be modified</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1.5</td>
<td>I can identify with clients potential courses of action for meeting individual aims and requirements</td>
</tr>
<tr>
<td>1.6</td>
<td>I am able to refer clients to appropriate alternative sources of guidance and support where aims and requirements of clients cannot be met</td>
</tr>
<tr>
<td>1.7</td>
<td>I can identify indicators of client issues requiring referral and report or refer appropriately, in line with organisation requirements</td>
</tr>
<tr>
<td>2.1</td>
<td>I can explore with clients factors which could influence the preference for and ability to achieve a course of action</td>
</tr>
<tr>
<td>2.2</td>
<td>I know how to explore with clients features of and likely consequences of possible courses of action</td>
</tr>
<tr>
<td>2.3</td>
<td>I can check client understanding of what is involved in each course of action</td>
</tr>
<tr>
<td>2.4</td>
<td>I am able to help clients to assess advantages and disadvantages of each possible course of action, and their overall appropriateness for meeting particular client requirements</td>
</tr>
<tr>
<td>2.5</td>
<td>I can encourage clients to decide on a course of action and to consider alternatives which could be used if necessary</td>
</tr>
<tr>
<td>2.6</td>
<td>I am able to document decisions and agreed support within organisation guidelines</td>
</tr>
</tbody>
</table>
References and further reading


Videos


Websites

Module review

- Over four hundred different approaches to counselling are in use today. Most present-day counsellors borrow methods from other theoretical backgrounds that are congruent with their philosophical beliefs.
- The first approach to counselling was psychoanalysis, which was developed by Freud and later amended and modified to become the more commonly used psychodynamic approach to counselling.
- Research has shown that the effectiveness of counselling lies in certain aspects of the process that are common to all approaches.
- Theory helps counsellors develop attitudes and 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.
- Cognitive behaviour therapy, or CBT, is an umbrella term for a number of different approaches to counselling that draw from both behavioural and cognitive approaches to counselling.
- The overall goal of CBT is to bring about client change. The aim is to help the client to develop positive and helpful thinking, and appropriate and self-enhancing behaviours and feelings.
- CBT is a very skills-based approach to counselling, in which the client is taught new ways to think and behave by the counsellor.
- One of the main criticisms of CBT is whether it is capable of producing deep changes in clients or whether it is superficial and therefore likely to be a short-term solution to problems.
- The person-centred approach to counselling is a humanistic approach to counselling based on the ideas of Carl Rogers (1902–1987). Rogers believed that people are essentially trustworthy and that they have the potential to resolve their own problems once they understand them.
- The counsellor’s role in person-centred counselling is a facilitative one, aimed at helping clients discover themselves and grow towards fulfilling their potential.
- There are no ‘techniques’ in person-centred counselling in the same way that there are in other counselling approaches such as CBT.
- The three core conditions for counselling in the person-centred approach are congruence, empathy and unconditional positive regard.
- Person-centred counselling has been criticised for its lack of techniques, on the basis that clients need more help to change and that they benefit from techniques that have been proven to work in other therapies.
- Gestalt therapy is an approach to counselling that was developed by Fritz Perls (1893–1970).
- The first goal of gestalt therapy is to help the client gain awareness of what they are experiencing and doing in the present. Counselling is based on the here-and-now experience as perceived and interpreted by the client’s subjective reality.
Gestalt theory places more importance on the quality of the relationship between the client and counsellor than on the use of techniques.

One criticism of gestalt therapy is that the counsellor using this approach needs to be highly self-aware and have extensive training. Without this, techniques are often misused as stop-gaps when the counsellor is ‘stuck’ or unsure what to do next.

Before the 1950s, counselling was mostly one-on-one. It was only during the 1950s that family therapy began and was considered to be a revolutionary approach to counselling.

Family counsellors see each client as part of a system – their family. They assume that whatever happens to one member of a family impacts on another.

The family member who is the main reason for the family seeking counselling (e.g. because of their problematic behaviour) is known as the identified client in family counselling.

Some theorists argue that while we are part of various groups, we also need to work with clients individually to prevent them from being overwhelmed or coerced by other family members.

Solution-focused brief therapy is a client-centred approach. The focus is not on the presenting problem and the client’s past but on the present and future solutions.

Rather than trying to stop existing problematic behaviours, brief counsellors look for solutions that will make a difference. By constructing workable solutions, they help clients repeat already successful behaviours.

The aim of brief solution-focused therapy is to initiate a solution process, rather than to stop the self-reinforcing complaint pattern.

The brief therapy focus on what works already does provide a framework for understanding the nature of change or why problems happen in the first place.

The techniques that you choose to help clients will depend on the approach to counselling that you are working from.

It is important to develop rapport with clients early in the relationship so their sense of comfort, feelings of security and trust of the counselling situation are felt immediately.

Once rapport is developing and the client begins to feel comfortable to tell their story and express their concerns, it is important to clarify the problem(s) they are seeking help with and understand their perspective of the problem(s).

Goals are statements in specific terms that state what clients want and need.

Domestic violence refers to a situation where one partner in a relationship is using violent and abusive behaviours in order to control and dominate the other.

It is important that counsellors and crisis workers realise that though we may not understand or agree with their decision to remain in an abusive relationship, people have their reasons and ultimately how they choose to live is their decision.

Loss affects people in different ways and people will often respond differently to similar experiences. When counselling someone who is bereaved therefore it is good practice to ask yourself: “What is the meaning of this loss to this person at this time?”
Support Clients

- Attempts to commit suicide are based on feelings of utter hopelessness, usually preceded by depression.
- It is vitally important for you as a counsellor to recognise the signs and symptoms in a client that may indicate they are potentially at risk of a suicide incident.
- The major difference in counselling suicidal people is that the counsellor has to assess the immediate needs of the client and act in the interest of preventing a suicide occurrence.
- The same skills that are effective for general counselling are also effective for counselling people with drug-related problems.
- Research has shown that treatment for alcohol and other drug problems is more likely to be successful if the counsellor uses empathic counselling skills.
- It is your responsibility as a professional to practise according to a relevant Code of Conduct of your organization or professional association and to ensure that every interaction with a client meets appropriate ethical principles.
- You will not be able to work with every type of client and every kind of problem. Knowing when to make a referral to another practitioner is therefore essential in ensuring that clients access the best possible care.
- One of the key principles of counselling is confidentiality, which refers to a client’s own thoughts, emotions and secrets.
- Respect for cultural diversity is integral to both human services work and social cohesion overall.
- Self-awareness allows us to know our strengths and weaknesses in all areas of our life. We need to have a balanced and realistic view of both our strengths and weaknesses if we are to know our true selves.
- Values are ideals that guide our behaviour and decisions and help us to distinguish between what is right and wrong.
- As counsellors, we are neither to pass judgement nor to close down options for our clients. Rather, we are to facilitate and open up the list of viable options.
- In order to effectively help others in any counselling situation, the counsellor needs to be free of prejudice and judgemental feelings and deal with any emotional issues they have in relation to often challenging client problems.
- Supervision is an essential part of working as a counsellor. Reflection encourages you to explore your worldview and challenge your beliefs and attitudes in order to maximise your personal and professional development.
- A theoretical understanding of different approaches to counselling is essential in helping you to conceptualise client problems and in providing you with a ‘road map’ of how to work with clients.
- Regardless of the approach you choose to take, the use of core counselling skills is essential to engage the client, allow them to tell their story in a respectful way and to help them clarify and reflect on their situation.
CHCCSL506A and CHCCSL507A – 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 7

Short-answer questions (maximum 500 words)

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. List the common aspects of effective counselling therapies.
2. Identify five common counselling therapies and briefly explain the principles of each.
3. Identify the key techniques used in each of the five common counselling therapies listed in question 2 and briefly explain their impact on the client.
4. Identify the benefits of each of the five common counselling therapies listed in question 2 in working with clients.
5. Identify the limitations of each of the five common counselling therapies listed in question 2 in working with clients.

Assessment task 2: Due – Week 9

Case study (1200 words)

Read the case study below. 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.

Case study

Sally is a 41-year-old woman with two school-age children. Sally tells her counsellor that she experiences a lot of conflict in her relationship with her partner, which began when Sally was 14 years old.

At 20, Sally threatened to commit suicide when her partner wanted to leave the relationship. Sally confirms that this was not the first time she had threatened suicide. Throughout her childhood, Sally was very concerned about other people’s opinion of her – how she looked, what she ate, who she had as friends, and eventually her choice of partner.
At times, Sally finds it almost impossible to contain her emotions and often goes from being extremely angry to very tearful within minutes.

1. Briefly explain how you would go about identifying this client’s needs and issues.
2. Identify issues that may be causing difficulties for this client.
3. Briefly explain how you would help this client identify practical goals.
4. Explain what techniques you would use in working with this client and why.

**Assessment task 3: Due – Week 11**

**Video skills practice session (15–20 minutes) and self-critique (1500 words)**

To complete this assessment task you will need to complete a skills practice session of a simulated counselling session and video-tape the session which will be submitted to your educator along with a reflective report.

In conducting the video-taped skills practice session you must organise a simulation that allows you to demonstrate counselling techniques. The skills practice session should be between 15 and 20 minutes in duration. You may work with another student to complete the skills practice session if you wish, but must work alone to write the self-critique.

You will take the role of a counsellor. Your interviewee will take the role of a client seeking counselling.

During the interview, you will need to demonstrate the ability to:
- explain your position on confidentiality and record keeping to the client
- effectively apply a range of counselling techniques from the counselling therapies discussed in this module
- select and apply techniques appropriate to the situation and the client
- assist the client to identify needs, issues and goals
- assist the client to choose practical goals and action
- make an appropriate referral if required

**Self-critique**

Review your recorded counselling session and identify examples of the skills listed in the assessment requirements (i.e. in the list of bullet points above).

Transcribe or paraphrase appropriate dialogue and comment on how effectively you manage that part of the interaction, including suggestions for improvement.

Conclude your reflective report with a summary of your future development needs as far as communication strategies are concerned.
Support Clients

Attach the checklist on the next page when you submit this assessment task.

Assessment task 3: Video skills practice session observation checklist

<table>
<thead>
<tr>
<th>Student name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Educator name:</td>
<td></td>
</tr>
</tbody>
</table>
| Unit of competency: | CHCCSL506A Apply counselling therapies to address a range of client issues  
CHCCSL507A Support clients in decision-making processes |

<table>
<thead>
<tr>
<th>Did the student satisfactorily perform the following during the period of observation:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ability to clearly explain confidentiality and record keeping to the client</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The ability to put the client at ease and help them explore their issues</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The ability to effectively apply a range of counselling techniques from the counselling therapies discussed in this module</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The ability to select and apply techniques appropriate to the situation and the client</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The ability to assist the client to identify needs, issues and goals</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The ability to assist the client to choose practical goals and action</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Where appropriate, referral is made or assistance sought if presence indicated of significant other issues or variations from normal functioning</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Comments:

Educator signature:
Assessment task 4: Due – Week 12

Reflective report on group work activities (on-campus students OR discussion board activities (flexible delivery students) (500 words)

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

**CHCCSL506A**  
Apply counselling therapies to address a range of client issues

**CHCCSL507A**  
Support clients in decision-making processes

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 common aspects of effective counselling therapies</td>
<td></td>
</tr>
<tr>
<td>Question 2</td>
<td>Identification of five common counselling therapies and the key principles of each sufficiently explained</td>
<td></td>
</tr>
<tr>
<td>Question 3</td>
<td>Correct identification of key techniques of each of the five common counselling therapies and their impact on the client sufficiently explained</td>
<td></td>
</tr>
<tr>
<td>Question 4</td>
<td>Correct identification of key benefits of each of the five common counselling therapies in working with clients</td>
<td></td>
</tr>
<tr>
<td>Question 5</td>
<td>Correct identification of key limitations of each of the five common counselling therapies in working with clients</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 2: Case study

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Student clearly explains how to identify the client’s needs and issues</td>
<td>□</td>
</tr>
<tr>
<td>2. Student accurately identifies issues that may be causing difficulties for this client</td>
<td>□</td>
</tr>
<tr>
<td>3. Student accurately describes how they would help this client identify practical goals</td>
<td>□</td>
</tr>
<tr>
<td>4. Student clearly describes what techniques would be appropriate in working with the client and justifies their choice</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 3: Skills practice session and self-critique

**Skills practice session criteria**

<table>
<thead>
<tr>
<th>Satisfactory</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>● Student uses appropriate range of basic counselling skills, including demonstrating:</strong></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>○ attending and listening skills</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>○ non-judgemental attitude</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>● Student clearly explains policy on confidentiality and record keeping to the client</strong></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>● Student effectively applies a range of counselling techniques from the counselling therapies discussed in this module</strong></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>● Student selects and applies techniques appropriate to the situation and the client</strong></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>● Student assists the client to identify needs, issues and goals</strong></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>● Student assists client to choose practical goals and action</strong></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>● Student manages own values so they do not impede effective work with the client</strong></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>● Student makes an appropriate referral if required</strong></td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Self-critique criteria**

<table>
<thead>
<tr>
<th>Satisfactory</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>● Student provides effective self-critique of the techniques and skills used in the counselling session</strong></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>● Student demonstrates adequate knowledge of therapies and techniques to be able to self-critique effectively</strong></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>● Student demonstrates adequate knowledge of goal setting to be able to self-critique effectively</strong></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>● Student accurately identifies own strengths in conducting the counselling session</strong></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>● Student accurately identifies own areas for development in conducting counselling sessions.</strong></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>● Student explains and/or applies ethical conduct as required in addressing counselling dilemmas</strong></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>● Student explains referral process if appropriate</strong></td>
<td>☐</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 4: Reflective report on group work activities (on-campus students OR discussion board activities (flexible delivery students))

#### Assessment task 4: Reflective report

<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>N</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>N</td>
</tr>
<tr>
<td>3. Student identifies at least one of own biases or assumptions that student has questioned as a result of the activities undertaken</td>
<td>N</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

90  CHCCSL506A Apply counselling therapies to address a range of client issues
CHCCSL507A Support clients in decision-making processes
READING


COMMONWEALTH OF AUSTRALIA

Copyright Regulations 1969

THIS MATERIAL HAS BEEN REPRODUCED AND COMMUNICATED TO YOU BY OR ON BEHALF OF
THE AUSTRALIAN COLLEGE OF APPLIED PSYCHOLOGY
PURSUANT TO DIVISION 2A, PART VB OF THE COPYRIGHT ACT 1968 (THE ACT)

THE MATERIAL IN THIS COMMUNICATION MAY BE SUBJECT TO COPYRIGHT UNDER THE ACT. ANY FURTHER REPRODUCTION OR COMMUNICATION OF THIS MATERIAL BY YOU MAY BE THE SUBJECT OF COPYRIGHT PROTECTION UNDER THE ACT.

Do not remove this notice.

CAL LICENSED COPY – UNAUTHORISED COPYING PROHIBITED
The facts are friendly

A vast body of empirical evidence exists to support a wide range of psychological practices. But it's not just what research tells us to do that is important - it's how it can challenge us to reflect on our personal and theoretical assumptions and be more responsive to our clients.

Which therapies produce the best outcomes? Are directive practices more effective than non-directive ones? What is the relative contribution of the therapist and the client to the outcomes of therapy? There are increasing demands for counsellors and psychotherapists to answer questions such as these and to base their practice on a comprehensive body of research knowledge. For instance, in its Standards of Education and Training, the UK's Health Professions Council, which looks set to regulate counselling and psychotherapy, stipulates that courses will need to assist students in the development of evidence-based practice( n1). And the recently launched Improving Access to Psychological Therapies programme, responsible for the allocation of £173 million to the development of mental health services in the UK, will focus exclusively on those therapies for which there is clear evidence of effectiveness through randomised clinical trials( n2).

For counsellors and psychotherapists, then, it is becoming less and less sufficient to justify practice on the grounds that, 'I know that what I do works.' And, to some extent, why should it be? Snake oil salespeople and advocates of now-abandoned treatments, such as insulin coma therapy for schizophrenia, would claim much the same thing.

The reality is, therapists do get it wrong. For instance, ninety per cent of therapists put themselves in the top 25 per cent in terms of service delivery( n3). So therapists' perceptions, experiences or beliefs that their therapies are effective do not necessarily
make them so. Even direct positive feedback from clients has its limitations: research into the phenomenon of client deference shows that clients will often withhold more critical or negative judgements from their therapists, such that clients who have not found their therapy helpful may still tell their therapists how useful it was(n4).

The good news for counsellors and psychotherapists is that a vast body of empirical evidence does exist to support their practice - and not just CBT, but a wide array of psychological practices. The bad news is that very few therapists are actually aware of this evidence, or draw on it to develop their work. One survey of American psychotherapists found that only four per cent ranked research literature as the most useful source of information on how to practise; with 48 per cent giving top ranking to 'ongoing experiences with clients'; 10 per cent ranking theoretical literature as the most useful source; and eight per cent ranking their own experience's as clients most highly(n5).

One reason why counsellors and psychotherapists seem not to draw on the research evidence is because it is seldom communicated in a 'clear and relevant fashion(n5)'. Hence there is a need for texts that can communicate research findings in an accessible and jargon-free way. In 2005 BACP funded me to write such a book -- Essential Research Findings in Counselling and Psychotherapy: The Facts are Friendly. This article summarises some of its key findings.

Before beginning, however, it is worth saying a few words about my own background. Clearly, it is not possible to present an entirely objective summary of the data, and knowing where an author 'comes from' can help to identify potential biases and omissions in any account. In recent years I have come to see that the touchstone for my therapeutic work is a progressive political outlook(n6), and I am particularly drawn towards those therapies that advocate a relatively egalitarian client-therapist relationship, such as person-centred and existential therapies. At the same time, coming from a position that wants to emphasise the uniqueness of each individual client, I believe passionately that there is no one 'best' therapy for everyone(n7).

To some extent, this pluralistic bias also comes from my own experiences as a client, where I have experienced, and found helpful, a wide range of different therapies, including behavioural, person-centred and psychodynamic. Finally, with respect to research, I see it as having a valuable role to play in informing, challenging and stimulating therapists, because it can give voice to clients' experiences, preferences and needs. That is not to say that engaging with the research findings is always comfortable or reassuring. But, as Carl Rogers wrote over 50 years ago, 'the facts are always friendly,' for 'Every bit of evidence one can acquire, in any area, leads one that much closer to what is true(n8).'

**Overall effectiveness**

Does therapy work?

Fortunately there is a simple answer to this question: yes. Studies which look at clients' behaviours, feelings or psychological functioning before and after therapy nearly always find that, on average, they are better off by the end of it. For instance, one study found that prior to a course of family therapy, clients with anorexia nervosa weighed, on average, 40kg. After 12 months of therapy they weighed, on average, 48.2kg(n9).

Of course, the problem with such evidence is that we do not know whether the clients would have got better anyway without therapy, and so a more rigorous test comes from conducting controlled trials in which changes over a course of therapy are compared with changes over a similar period of time for people who do not have any...
therapy. What does the research show here? Pretty much the same thing. For instance, King and colleagues found that depressed clients who received non-directive therapy dropped 13.9 points on a measure of depression, while individuals who received treatment as usual from their GPs dropped by only 9.3 points.\(^\text{n10}\)

Combining findings from a wide range of controlled trials, meta-analytic studies have shown that, on average, counselling and psychotherapy has a large positive effect - greater, indeed, than the average surgical or medical procedure.\(^\text{n12}\) Put more precisely, research shows that approximately 80 per cent of people will do better after therapy than the average person who has not had therapy.

To illustrate, imagine 'Frank' going to his GP with depression and being encouraged to wait and see how things improve. Now imagine Frank two months down the line, possibly feeling a little better, but still relatively depressed. And now imagine another 10 people going to their GP, but this time being referred to therapy. So the research shows that in two months time approximately eight of these people will be feeling better than Frank, while two of them will be feeling worse.

In terms of general effectiveness, what we also know from the research evidence is that:

* improvements in mental health tend to be maintained one or two years after therapy has ended, though the longer-term impact of psychological interventions is less clear;\(^\text{n13}\)

* talking therapies are generally as effective as pharmacological treatments for psychological distress, and seem to have lower relapse and drop-out rates;\(^\text{n14}\)

* counselling and psychotherapy are relatively cost-effective forms of mental health treatment - particularly for more psychologically distressed individuals - with an economic advantage above and beyond their contribution to psychological health and well-being;\(^\text{n15}\)

* approximately five to 10 per cent of clients deteriorate as a result of therapy.\(^\text{n16}\)

**Orientation and technique factors**

In general, then, therapy is effective. But is this true for all therapies, or are some therapies more effective than others? This is probably the most controversial question in the counselling and psychotherapy research field and, to a great extent, can be answered in very different ways depending on how you read the evidence.

If, on the one hand, you look at the particular therapies that have been shown to be effective for particular psychological problems - as advocates of empirically supported treatments have done - there is no question that the evidence base is strongest for CBT. While, for instance, there are scores of high-quality controlled trials demonstrating the effectiveness of CBT for depression,\(^\text{n17}\) there are just a handful of studies demonstrating the same thing for person-centred therapy. And while CBT has been shown to be effective for numerous psychological difficulties - such as phobias, panic, PTSD, bulimia, sexual problems and deliberate self-harm - there is little equivalent evidence for the vast array of non-CBT practices.\(^\text{n18}\)

At the same time, it is essential to note that 'greater evidence of effectiveness' is not the same as 'evidence of greater effectiveness' and, in the vast majority of instances, the reason why non-CBT therapies are not considered effective for particular psychological problems is simply because no one has studied them yet. As Westen and colleagues write: 'Perhaps the best predictors of whether a treatment finds its way to
the empirically supported list are whether anyone has been motivated (and funded) to test it and whether it is readily testable in a brief manner (n19).

Indeed, when studies are carried out to compare the effectiveness of different psychological therapies, the almost unanimous finding is that they are of about equivalent - or only marginally different - effectiveness (n11) (this is particularly the case when the studies are carried out by independent bodies, and when bona fide therapies are compared (n20)). Within the counselling and psychotherapy research literature, this finding has come to be known as the dodo bird verdict - after the dodo bird in Alice in Wonderland who, having judged a race around a lake, declares that 'Everyone has won and so all must have prizes.'

The dodo bird verdict is a remarkably ubiquitous finding in the counselling and psychotherapy research field. Not only, for instance, do different therapies seem to be of about equivalent effectiveness, but relatively similar outcomes tend to be found when comparing group therapies against individual therapies (n21); 'complete' therapies against specific components of those therapies (for instance, a full CBT package against just its behavioural element (n22)); professionally-delivered therapies against paraprofessionally-delivered therapies (n23); and self-help practices against interpersonal therapies (n24).

**Therapist factors**

So if therapeutic orientation is not the principal determinant of whether or not therapies are effective, what is? One possibility, as argued by Scott Miller and colleagues in the April 2008 edition of therapy today (n25) is that it is something to do with the therapists themselves: their personalities, openness to feedback, or personal and professional experiences. In support of this hypothesis, research shows substantial differences in outcomes across therapists. One study, for instance, found that the clients of the most effective therapist in a university counselling centre showed a rate of improvement 10 times that of the average, while the clients of the least effective therapist showed an average worsening of problems (n26).

Across a range of studies research suggests that around five to 10 per cent of the variance in outcomes is related to differences across therapists (n27), and this compares to just one per cent or so attributable to the therapists' particular orientations (n11). This means that the differences in effectiveness from one CBT practitioner to another, or from one psychodynamic therapist to another, is considerably greater than the differences in effectiveness between all CBT practitioners and all psychodynamic therapists, or all therapists of any other orientation.

Less clear, however, are the particular therapist characteristics that relate to outcomes. Research suggests, for instance, that the following therapist characteristics are only moderately related to therapists' effectiveness: personality traits; levels of psychological wellbeing; demographic characteristics (gender, ethnicity, age, sexual orientation); amount of professional training; experience as a therapist; life-experience (n28).

With respect to therapists' characteristics, however, one somewhat stronger finding to emerge from the research is that clients from marginalised social groups (such as lesbian clients) and clients with strong values do seem to do better with, stay in therapy for longer with, and express a preference for therapists with matching characteristics. One study found that African American clients averaged 17 sessions with white therapists, compared with 25 sessions with African American therapists (n29). What the research also indicates, however, is that the key issue here may be a perception that such therapists will be, or are, more accepting, rather than the particular characteristics, per se.
One study found that 45 per cent of Orthodox Jewish respondents would prefer to see an Orthodox Jewish therapist, and much of this was to do with fears that non-Orthodox therapists would react negatively to them. One respondent said, 'Someone not frum [Orthodox] would try to channel me in non-frum directions.' Interestingly, however, those respondents who expressed a preference not to see an Orthodox Jewish therapist (20 per cent of respondents) did so for similar reasons - they feared that an Orthodox Jewish therapist would judge or criticise them. For instance: 'I really chose someone... who was really "off-the-wall" in Judaism, because I kind of felt I could say some of the things I wanted to without any fear of... "How can you even think of such things?"'

Relational factors
Such evidence suggests that the key contribution that therapists make to the outcomes of therapy may be less to do with who they are and more to do with how they relate to their clients. Consistent with this, Michael Lambert, one of the world’s leading psychotherapy researchers, estimates that the therapeutic relationship accounts for as much as 30 per cent of the variance in outcomes. And, while other reviewers have given more modest figures, such as seven to 17 per cent, there are few authorities in the field who would question the importance of the relationship altogether.

It is also important to note that relational qualities appear to be as important in non-relationally-oriented therapies (e.g. CBT) as they are in relationally-oriented ones. In fact, in a review of five retrospective studies in which clients were asked what had been the most helpful aspect of their CBT, it was consistently found that clients rated their relationship with their therapist as more helpful than the cognitive-behavioural techniques employed.

In terms of which aspects of the therapeutic relationship are most closely linked to outcomes, an extensive review of the research by a Task Force of the American Psychological Association’s Division of Psychotherapy identified four 'demonstrably effective' elements and seven 'promising and probably effective elements'. These are presented below in roughly descending order of how strong the relationship with outcomes was rated as being (i.e. strongest predictors first).

Demonstrably effective:

* goal consensus and collaboration;
* cohesion in group therapy;
* therapeutic alliance;
* empathy.

Promising and probably effective:

* management of countertransference;
* feedback;
* positive regard;
* congruence;
* self-disclosure;
* relational interpretations;

* repair of alliance ruptures.

So does this mean that Carl Rogers got it all basically right back in 1957(\textsuperscript{[35]}, when he hypothesised that a set of therapist-provided relational conditions (empathy, acceptance and congruence), alongside psychological contact, client vulnerability and the communication of these conditions to the client, are necessary and sufficient for therapeutic personality development to occur?

On the basis of today's evidence, the answer to this question is almost certainly no, and this is for a number of reasons. First, there is clear evidence that many non-interpersonal therapies, such as web-based therapeutic programs and self-help manuals, can be highly efficacious(\textsuperscript{[24, 36]}). Second, the fact that relational factors (or, indeed, any other factors) are related to outcomes does not prove that the former caused the latter. It may be that clients who feel they are doing well in therapy then start to feel more positive about their therapists. Third, while a good therapeutic relationship is predictive of good therapeutic outcomes, it is essential to remember that this is not something that therapists 'provide' for clients, but something that emerges in the client-therapist interaction. Indeed, there is actually more evidence that clients' contributions to the therapeutic relationship predict outcomes than there is for therapists' contributions(\textsuperscript{[37]}). For instance, while 56 per cent of studies show a positive relationship between therapists' affirmation of their clients and outcomes, 69 per cent show a positive relationship between clients' affirmation of their therapists and outcomes(\textsuperscript{[37]}).

Client factors

Paradoxically, then, client-centred therapists such as Rogers may have actually underestimated the contribution that clients make to the outcomes of therapy; for what the research suggests is that client factors are probably the most important determinants of therapeutic outcomes, accounting for 70 per cent or more of the overall effectiveness of counselling and psychotherapy(\textsuperscript{[28]}).

Here, a particularly strong predictor of effectiveness seems to be the extent to which clients actively participate in therapy. Reviewing the evidence across a vast range of client, therapist and relational variables, Orlinsky and colleagues suggest that client participation is possibly 'the most important determinant' of outcomes(\textsuperscript{[38]}), accounting for 20 per cent or more of improvement alone(\textsuperscript{[39]}).

A good example of this comes from an early study by Heine and Trosman(\textsuperscript{[40]}), who found that 67 per cent of clients who saw themselves as having an active part to play in the therapeutic process continued with psychotherapy beyond six weeks, compared with just 28 per cent of clients who placed responsibility completely in the hands of their therapists. As with relational factors, this association would seem to be as strong in the more technique-orientated therapies as it is in the less directive ones(\textsuperscript{[41]}).

Closely related to client participation, more positive outcomes have also been associated with clients who are more proactive in choosing to enter therapy; are more willing to adopt the client role; have higher (but not unrealistically high) expectations of therapeutic outcomes; believe that psychological treatments will be of help to them; and have realistic expectations about what will happen in therapy(\textsuperscript{[28]}).

What the research also indicates is that clients who have higher levels of psychosocial functioning tend to get the most out of therapy. More specifically, better therapeutic outcomes have been associated with clients who have more secure styles of attachment; are more able to think about themselves in psychological terms.
(psychological mindedness); are not diagnosed with personality disorders; are less perfectionist; and have greater social support( n28).

Why this is the case is not clear, but it may be that clients who come into therapy with good relational and psychological abilities are more able to form strong therapeutic alliances and engage effectively in the therapeutic process, while clients who are less able in these areas may struggle to make use of therapy.

In this respect, what the research seems to indicate is that therapy tends to help clients capitalise on their strengths, as opposed to compensating for their deficiencies. And, indeed, this does not seem to just take place at the level of overall effectiveness, but also with respect to specific domains of functioning. For instance, there is evidence that clients who have higher levels of cognitive functioning tend to do better in cognitive therapies, while those with higher levels of social functioning tend to do better in more interpersonal therapies( n42).

**Discussion**

What the research seems to indicate is that at the heart of most successful therapeutic journeys is a client who is willing and able to become involved in making changes to her life. If that client then encounters a therapist who she trusts, likes and feels able to collaborate with, she can make use of a wide range of techniques and practices to move closer towards her goals.

For different clients, different kinds of therapist input may be more or less helpful and there may be certain kinds of input that are particularly helpful for clients with specific psychological difficulties. But the evidence suggests that the key predictor of outcomes remains the extent to which the client is willing and able to make use of whatever the therapist provides. The old joke, then, would seem to have got it right: how many therapists does it take to change a light bulb? One, but the light bulb has really got to want to change.

**References**


Cooper M. Essential research findings in counselling and psychotherapy: the facts are friendly. London: Sage; 2008.


By Mick Cooper

Mick Cooper is Professor of Counselling at the University of Strathclyde and a registered psychotherapist who has worked with clients in a range of voluntary, NHS and private settings. His new book, Essential Research Findings in Counselling and Psychotherapy: The Facts are Friendly, is published by Sage in association with BACP in September 2008. He will give a keynote speech on the challenge of counselling and psychotherapy research at the BACP Annual Conference, 17-18 October 2008.

Copyright of Therapy Today is the property of British Association for Counselling & Psychotherapy and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.
Chapter 4

Person-Centered Counseling

Voices from the Field: Counselor and Client Reactions

Yes, it works for me

Client: I really felt my counselor understood what I was saying. The second I sat down with her, I could tell she really cared about me and understood how I was feeling. I admit at first I felt a little frustrated that she wouldn’t give me answers to my problems, but she really hung in there and helped me figure things out for myself. I found myself thinking a lot about our sessions, and I really feel like I learned to trust myself.

Counselor: Finally, I have found an approach that seems to work for me. I thought I would go nuts trying to reflect everything my clients told me, but I realized that if you can understand how they are feeling, and let them know that, you can do a lot of good. It takes a lot of energy to listen that closely, and it’s a bit risky to be that open to your own feelings, but I think that’s the only way you can really reach others.

No, it doesn’t work for me

Client: My counselor was a nice person, and I really feel like she understood what I was going through. But she spent most our time saying “You feel this” or “You feel that.” I mean, where does that get us? It seems like all she did was repeat things back to me. Now don’t get me wrong—I really felt like she cared about me and wanted to help me. But counseling wasn’t at all what I expected. I thought I would have a chance to figure out how my past has gotten me into this situation and to talk about changing my philosophy of life so that I can be a happier person. I think I needed a different kind of therapist.

Counselor: I really don’t feel comfortable with person-centered counseling. It seems to me that you don’t really offer clients any real help. They expect a counselor to have answers! I thought you want to a counselor to help solve your problems. I admit that I really like helping people get down to the basic feelings underlying their problems, but then what do you do?

Maria is a Latina college student in her early twenties. She is feeling conflicted about her romantic feelings toward members of the same sex. While this feels right to her, she fears disapproval from her family because it is not in accord with their values and religious beliefs. She has decided to visit her college counseling center.

Maria: I feel like I’ve been leading a double life—when I’m away at college, I am pretty open about being a lesbian, but when I’m home, I have to lie and pretend I’m straight.

Counselor: You’re feeling conflicted because, on the one hand, you don’t want to lie about who you are, but on the other hand, you don’t want to upset your family.

Maria: Yes, I’m tired of the deception, and I feel it’s time to talk to my parents, but how can I know what their reaction will be? What if they disown me? Can you help me?
Historical Background

Counselor: I'll sure do everything I can to help you figure out the right course of action. It sounds like you are very torn right now, wanting to find some way of being honest with your family but also being true to yourself.

Person-centered counseling was developed by Carl Rogers in the middle to latter decades of the twentieth century. This approach is based on a humanistic philosophy that assumes people are inherently growth seeking and naturally capable of leading fulfilling, productive lives. Person-centered counselors seek mainly to help clients resolve difficulties for themselves through the experience of a warm and validating relationship with the counselor.

In the example above, you can see how the counselor focuses on understanding Maria's concerns and reflecting back to her what she seems to be experiencing and feeling. From the last exchange, we can see that Maria is understandably seeking concrete suggestions or advice about her concerns from the counselor. But following person-centered principles, the counselor seeks to establish a relationship and help her explore this situation as fully as possible rather than offering advice or suggestions. The guiding assumption here is that Maria will eventually come to trust her own judgment in making important decisions in her life after experiencing an accepting and warm counseling relationship.

HISTORICAL BACKGROUND

Historical Context

Carl Rogers received his degree in clinical psychology in 1931, and his initial ideas about the nature of counseling emerged from his clinical work with troubled children and their families. Rogers found that with empathy and understanding his clients were capable of making decisions and resolving difficulties in their lives. His approach to counseling was part of a movement by humanistic and existential theorists that came to be known as a "third force" in counseling. These theorists rejected the deterministic view of human nature, expressed by both psychoanalytic and behaviorist theorists, that people are either driven by internal, unconscious forces or shaped by external events. Instead, proponents of this third force viewed people as being innately free, spontaneous, growth seeking, and altruistic (Monte, 1987). Carl Rogers went on to establish a counseling model based on this philosophy. Dysfunctional behaviors, feelings, and thoughts are the result of external forces that interfere with the natural tendency of humans to grow and reach their potential.

Not only was Rogers a pioneer in developing an approach to counseling based on humanistic and existential principles, but also he was extremely influential in shaping counseling as a profession. He was a leader in applying effective principles and techniques for interpersonal communication in order to resolve conflicts among individuals and groups, and he conducted decades of systematic empirical research with colleagues on the therapeutic process. Perhaps most important was the key role he played in spreading the practice of counseling and psychotherapy beyond psychiatry and psychoanalysis to all the helping professions—including psychology, social work, nursing, education, the ministry, and even the public at large (Kirschenbaum & Henderson, 1989). He was the first to use the term client in describing the people he worked with, rather than the term patient, as is used in medical settings, thus
deemphasizing the notion that such persons were sick or ill. Rogers's systematic efforts to understand the counseling process also led to widely (almost universally) accepted methods for training beginning counselors in listening skills, rapport building, and the use of empathy. In the decade prior to his death in 1987, Rogers also sought to apply his person-centered approach on a global level, seeking to reduce conflict and promote understanding among persons from different nationalities, cultures, and religions. He traveled extensively in Europe, Latin America, Russia, and Japan to promote such ideas, and in January 1987, Rogers was nominated for the Nobel Peace Prize by then-Congressman Jim Bates.

Development of the Theory

Carl Rogers was born in a suburb of Chicago in 1902, the fourth of six children. In his book *On Becoming a Person* (Rogers, 1961), Rogers described his upbringing as "marked by close family ties, a very strict and uncompromising religious and ethical atmosphere, and what amounted to a worship of the virtue of hard work" (p. 5). Carl Rogers's father was a successful engineer, and when Rogers was 12 years old, the family moved to a farm west of Chicago. Not surprisingly, Rogers began his undergraduate studies at the University of Wisconsin studying agriculture. However, while a sophomore in college, Rogers attended a conference of student volunteers for evangelical Christian work and decided to revise his career plans to pursue the study of religion and the ministry. The following year, in 1922, he was among 10 students chosen by the World Student Christian Federation to go to China. Rogers described this experience as extremely important in his personal development. During his journey to China, he spent considerable time with fellow students from far more liberal backgrounds than his own, and in meeting citizens of other countries, he came to "realize that sincere and honest people could believe in very divergent religious doctrines" (p. 7). This realization broadened his thinking and led him to revise some of the religious teachings imparted to him by his parents.

In 1924, Rogers married Helen Elliott and began 2 years of graduate study at Union Theological Seminary in New York City. During his time there, he was attracted by courses and lectures on psychology and began to take courses at Teachers College, Columbia University. Eventually, he transferred to Columbia University to study psychology full-time. His ideas about counseling and change are generally viewed as progressing in four stages (Zimring & Raskin, 1992).

**Stage 1: Nondirective Counseling (1939–1950)** In his first job following graduation, Rogers worked as a child psychologist in the Child Study Department of the Society for Prevention of Cruelty to Children in Rochester, New York, and was deeply immersed in clinical work with children and their families for 12 years. It was here that Rogers formed his beliefs about the proper method for conducting psychotherapy with children and their parents. He was guided by one criterion: "Did it work?" (Rogers, 1961).

Rogers increasingly felt a lack of identification with the field of psychology, which seemed to him fixed at that time on experimental studies with animals that had little to do with human problems. Instead, he felt a closer professional connection to psychiatric social workers, who involved themselves deeply in helping their clients using practical means (Rogers, 1961).
During this time of full-time clinical work, Rogers also managed to publish a book based on his experience: *The Clinical Treatment of the Problem Child* (1939). Its publication soon led to the offer of a full professorship at Ohio State University. In interacting with his students at Ohio State, Rogers came to realize the uniqueness of his approach to counseling, which led him to publish another book, titled *Counseling and Psychotherapy* (1942). In that book, Rogers described a "non-directive" approach, which meant that counselors were urged to avoid giving clients specific suggestions or advice about their concerns.

Rogers (1942) noted several ways in which this nondirective approach differed from the way that counseling was being practiced at that time: (1) It relied on the individual's natural drive toward growth—counseling was more a matter of helping clients realize their potential; (2) great emphasis was placed on clients' feelings rather than on their thoughts; (3) current experiences were valued over past history; and (4) the therapeutic relationship itself was seen as a vehicle for change.

**Stage 2: Client-Centered Counseling (1951–1960)** The second stage in the progression of Rogers's approach can be marked with the publication of *Client-Centered Therapy* (1951). While Rogers's initial formulation of nondirective counseling emphasized a warm, accepting relationship between the counselor and the client, in *Client-Centered Therapy* he discussed several problems that could emerge when the nondirective approach was misapplied. First, Rogers noted that some counselors, particularly those with little training, took the nondirective approach to mean "anything goes." In other words, the counselor would simply try to listen, stay out of the client's way, and allow the client to figure out his own solutions. Rogers argued that counselors who take such a hands-off approach risk communicating to their clients that they do not care.

A second problem stemmed from Rogers's belief that the therapist's role was to help clients recognize and clarify their feelings. He feared that many practitioners sought to do this using an analytic and sterile approach. Rogers believed that client feelings occur in the context of their life successes, struggles, and hopes for the future, and he deemed it essential that the counselor enter their world as fully as possible, not just to "categorize" their feelings. While nondirective counseling had established the importance of a warm and accepting relationship between the counselor and the client, the publication of *Client-Centered Counseling* emphasized the importance of the counselor understanding the client's internal frame of reference and communicating that understanding to the client.

**Stage 3: Emphasis on Experiencing (1961–late 1960s)** Carl Rogers's thinking about his approach entered a third phase with the publication of *On Becoming a Person* (1961), in which he emphasized the "experiencing" part of the counseling process. Experiencing refers to awareness of the subjective, internal emotional responses that are triggered when two or more people establish a relationship with each other. Instead of just talking about feelings during the counseling relationship, Rogers believed that feelings should actually be experienced in the moment. For example, if a client describes a particularly painful experience that provokes sadness in the counselor, she/should not hesitate to experience such feelings and talk about them with the client. Rogers acknowledged that talking about such private feelings in the moment is often awkward.
and difficult and entails trust in one's internal experiences (Monte, 1987). Rogers believed that clients in a relationship with an “experiencing” counselor would gradually learn to trust and share their own feelings.

On Becoming a Person represented a significant advance in Rogers's thinking, but its publication coincided with his departure from academic life. While at the University of Wisconsin from 1957 to 1963, Rogers was appointed as a professor in both psychology and psychiatry, and he attempted to integrate training and research in psychology, psychiatry, and social work. He became disillusioned with life in academia, however, and described this time as one of the most painful in his professional career. At the age of 62, Rogers and his wife moved to California, and he joined the staff of the Western Behavioral Studies Institute (WBSI) in La Jolla, California, which had been founded by Richard Farson, a former student of his at the University of Wisconsin. Later, in 1968, Rogers left the WBSI with several colleagues to start the Center for the Studies of the Person.

Stage 4: The Person-Centered Approach (1970s and 1980s) This fourth stage was marked by Rogers changing the name client-centered counseling to the person-centered approach. This change reflects the extension of his approach from individual counseling to group work, education, industry, and efforts at promoting world peace. In 1977, Rogers published Carl Rogers on Personal Power to describe how his methods could be applied to a broad range of settings and applications.

ASSUMPTIONS AND CORE CONCEPTS

View of Human Nature

Rogers's view of human nature was shaped by his clinical experience and by humanistic and existential theory. Psychoanalytic and behavioral counseling approaches were dominant when he began as a clinician in the 1930s, and Rogers rejected the core assumption of both: that humans do not control their own destinies. Particularly in his clinical work, Rogers saw clients who overcame significant life obstacles such as neglectful families, poverty, and lack of education to make great strides in counseling, and he came to closely identify with the humanists' belief that humans are social, rational, and fully capable of taking charge of their own destiny.

Another important aspect of Rogers's view of human nature comes from the existential theorists' emphasis on phenomenological experience. As you will read in Chapter 5, existentialists such as R. D. Lang (1959) and Rollo May (1961) focused on the importance of individuals making sense of their own existence as they perceive it rather than accepting what an outside observer might conclude. Accordingly, assigning labels to the behavior of another—e.g., using diagnostic terms like depression and anxiety—could potentially be both harmful and useless. Rogers believed that these terms could not only be inaccurate but also contribute to the myth that highly complex behaviors can be reduced to simple terms. Thus, Rogers rejected the notion of labeling the behaviors of others and instead focused on entering the world of the client as fully as possible.
Rogers's view of human nature departed significantly from that of some existential theorists who believed that human misery is caused by awareness of the fundamental concerns of existence—i.e., by the knowledge that life is uncertain and that one day we will die (Lang, 1959). Instead, Rogers believed that the degree of misery a person experiences is related to the discrepancy between what she is and what she is capable of becoming. One of the major goals of person-centered counseling therefore is to lessen this discrepancy by creating a safe and permissive atmosphere where the client is able to get back in touch with her "true" self.

**Core Concepts**

**Self-Actualizing Tendency** An important component of Rogers's view of human nature is that we are naturally equipped with what Kurt Goldstein (1939) and Abraham Maslow (1970) labeled a self-actualizing tendency, something referred to in the famous Army recruiting slogan "Be all you can be." Rogers embraced the notion that individuals are fundamentally motivated to fulfill their potential to meet basic needs (to eat and drink, to seek shelter and relationships with others), develop greater independence from outside forces, and contribute to a healthy way to the world around them (Meador & Rogers, 1984). He maintained that the evolutionary process has equipped each of us to naturally strive toward the things we want and value, including basic needs for survival, such as air, water, and food, as well as for "higher-order" needs, such as knowledge, beauty, and art. In other words, he believed that the natural order of nature was for living things, including human beings, to continue to develop and grow unless impeded by other living things or the environment.

**Organismic Valuing Process** Rogers (1942) believed that evolution equipped all humans for self-actualization through the *organismic valuing process*. We are born with the ability to determine what is good for us and what is not: Senses such as taste and smell help us decide what to eat and drink, auditory and visual senses evaluate threats in the environment, and a range of physiological systems keep the body functioning at an optimal level. The important survival mechanisms at work here are obvious very early in life. Anyone who has spent time around infants knows that when it comes to their survival, they are not concerned with other people's opinions, priorities, or attitudes. If they are hungry, they cry until fed, for example. Infants evaluate experiences that maintain their own growth and development and are not swayed by other people's ideas about how they should feel.

**Limits to the Self-Actualizing Tendency** Rogers (1977) wrote that infants intrinsically know to value that which is growth enhancing, but as we grow and develop, acceptance by and approval of other people gradually gain in importance. The social and cultural context in which we live can both enrich life and block growth. On the one hand, society is critically important to our well-being: We are social creatures, and our very survival, as well as much of the fulfillment and meaning that we derive from life, comes from interactions with other people. However, Rogers also acknowledged the complexity and potential insularity of such systems. Well-functioning families can be a source of nurture and support, while dysfunctional families can inflict serious psychological wounds on children. Healthy cultural institutions can inspire, maintain order,
and provide for the well-being of citizens in a society, while ineffective ones can serve to degrade and repress them.

**Self and Ideal Self** The *self*, as theorized by Rogers, refers to an organized, consistent set of perceptions and feelings through which we relate to the outside world (Rogers, 1961). Similar to some psychodynamic authors such as Mahler (1968), Rogers believed that early in life infants do not actually have a notion of "self"—in other words, they are not able to distinguish between themselves and the outside world, and they focus only on their own needs. Gradually, as the child matures psychologically, she is able to distinguish her feelings and experiences from those of other people, which has a profound impact on her ability to manage day-to-day interactions with the outside world.

Persons with a healthy sense of self are able not only to recognize and value their feelings as their own (through the organismic valuing process) but also to work with others toward goals that are mutually beneficial. This is an important aspect of development, according to Rogers, because regard for the self (i.e., self-esteem) develops over time as we experience positive regard from others. Rogers (1951) saw this as a rather unique characteristic of human beings, and obviously, parents and other caregivers are an important potential source of positive regard. If such important figures demonstrate positive regard toward the infant unconditionally, the young child experiences self-regard and values her experiences and feelings. If not, she may assign increasing importance to constructing an *ideal self*, which refers to the self-concept the individual would like to possess but does not. The more discrepant the ideal self is from the real self, the more the person is at risk for psychological distress—a state Rogers defined as *incongruence*. In other words, an individual may want to be friendly, likable, and outgoing (ideal self) but may not experience herself that way (perceived self). This discrepancy may develop from interactions with the outside world, as when one is not popular at school or work.

A colleague of Rogers at the University of Chicago, William Stephenson (1953) developed a way to measure a person's experience of the self using what he called a Q-sort. Essentially, a person was provided with as many as 100 cards with written statements describing various aspects of a person's self and was asked to sort them into, for example, nine piles, ranging from "least like me" to "most like me." A sorting task such as this might be conducted to determine how a person experiences herself (perceived self) and what she would most like to become (ideal self). A basic aim of person-centered counseling is to reduce the discrepancy between the ideal self and the "real" self, and the Q-sort method was used by Rogers and his colleagues to research its effectiveness. For example, in a research study, clients could be asked to do a Q-sort prior to beginning counseling and after counseling was over in order to determine if it worked to lower their incongruence.

**Conditions of Worth** Rogers saw conditional worth as a key reason that clients were stuck in a state of incongruence—a state of discordance between the person they would like to be and their everyday experience. Incongruence results from the belief that one is worthy only when she meets the expectations of others. Conditions of worth develop when others approve of a person based on what she does rather than on her worth as a person. A discrepancy between the real self and the ideal self develops when one experiences conditions of worth. Her ideal
self, based on the approval of others, becomes different from her real self, what she values in herself. Conditions of worth seem inevitable in a modern society, where so much emphasis is placed on achievement.

Rogers (1961) believed that parents would inevitably place conditions of worth on their children as part of the normal socialization process but that this could be balanced by communicating clearly to the children that they are highly valued regardless of what they do. For example, if a child struggles academically in school because she spends most of her time and energy hanging out with friends, the parent might become irritated or upset with the child and scold her. If this happens frequently, the child may experience inner conflict because she wants to please her parent but also to act according to her own wishes and feelings. Conditions of worth put in place a conflict between the self-concept (I want to be a good child) and inner experience (I'm sure it's fun to hang out with my friends rather than study).

The above discussion does not suggest that parents need to indulge their children's every wish or fantasy or risk harming them for life. Even the most dedicated of parents will disappoint their children every now and then, and it is essential that children be socialized to delay gratification and learn to live and work in harmony with other people. The key, however, is the manner in which the parent interacts with the child. If a parent can empathize with the child's feelings ("I know you want to have fun with your friends at school!") while still providing direction about appropriate behavior ("but we expect you to play with your friends at recess and not when you are supposed to be listening to the teacher"), the child's inner psychological conflict will be minimized.

**THERAPEUTIC RELATIONSHIP**

**Counselor's Role**

The counselor's role in person-centered counseling is nondirective and is distinguished by a number of characteristics unique to this approach. First, nondirective refers to the idea that it is the client who should make decisions about her life, and the counselor should not attempt to influence that outcome by imposing her own preferences and attitudes. Second, as we have noted, it is the person of the counselor, rather than specific techniques, that is thought to be critical to a successful counseling relationship.

The counselor should keep in mind that it is the client's subjective experience that is the focus for counseling—it is not necessary, and in fact could be counterproductive, for the counselor to interpret, diagnose, or direct the counseling process. The therapist's main role therefore is to remove the conditions that restrict the client's awareness and to have an authentic "encounter" with the client; they should meet as fellow human beings, spontaneously, and in the moment. The healing ingredient is the relationship.

In order for a counseling relationship to be therapeutic, Rogers believed the counselor needed the following core conditions.

**Unconditional Positive Regard** This is the opposite of conditional worth, described in the previous section, and is a central component of the counselor's role in the counseling relationship. It refers to the counselor's ability to see the client as having inherent worth as a
human being. The client must feel that whatever she says to the counselor will not cause her to be rejected as a person. This does not mean, however, that the counselor has to endorse every behavior or course of action the client pursues, such as suicide, aggression toward others, or illegal drug use. What it does mean is that the client is seen, at her core, as good and worthy of acceptance as a fellow human being. The counselor must be able to communicate this regard to the client, especially when the client is describing negative emotions or problematic behaviors.

**Congruence** In the “Core Concepts” section of this chapter, incongruence was defined as the discrepancy between one’s ideal self and one’s real self. Its opposite, congruence, refers to how authentic and genuine the counselor is in the counseling relationship. Rogers believed that for the client to achieve congruence in his own life, the counselor needed to display congruence in the therapeutic relationship, to be real and open to her own feelings and reactions.

In the following example, the counselor is attempting to be genuine while working with an adolescent boy, Hector, who was physically abused:

**Hector:** I don’t see why I should trust you. This is just your job; you don’t really care about me. And how can you pretend to know me, anyway? Did your parents ever hit you? You don’t know what it feels like!

**Counselor:** Hector, I hear that you’re very upset and that your parents treated you terribly. I don’t expect you to trust me right away—I wouldn’t trust someone the first time I met her either. And you’re right, this is my job—but that doesn’t mean I can’t also care about you. But we’ve just met each other, and I suspect it will take some time for us to really get to know each other.

**Hector:** So you think if you talk to me for a few weeks, then you’ll really know what it’s like to be me?

**Counselor:** All I can say is that I really want to understand your experiences, and I hope you will help me to understand what you’ve been going through.

This brief example illustrates that a person-centered counselor would attempt to be as honest as possible in expressing her feelings toward a client. The client in this case, Hector, is extremely mistrustful of adults because of his history of abuse, and the counselor is attempting to be congruent by expressing a willingness to work with Hector but also acknowledging that it is far too early in their relationship for him to trust her.

**Empathy** Rogers (1959) defined empathy as the ability to perceive the internal frame of reference of another person; it is captured by such expressions as “walking in another’s shoes” or “crawling into the other person’s skin.” Rogers was very aware that accurately perceiving another person’s world and communicating this empathy were difficult tasks for counselors to do well.

For example, consider the case of Margeurite, a Mexican immigrant to the United States who is experiencing a significant amount of depression because of her isolation from friends and family who still live in her home country. Margeurite is working with a European-American
female counselor who was raised in Arizona and currently works there as a counselor. Margeurite describes her concerns this way:

I moved here to take a job with a big retail company, and I never thought I would feel so isolated. I thought I'd find people here in Arizona who share my culture, and I have, but they're not like my friends and family back in Mexico. I just feel so sad. I can't eat, I can't sleep, and I don't have the energy to do anything.

Can a counselor who may not share Margeurite's experiences or cultural background really have empathy for the hardship she is experiencing while living in a different country from friends and family? According to Meader and Rogers (1984), in order to experience empathy for this client, the counselor will have to do more than intellectually understand what the client is saying. They believe that the counselor must "get into the shoes" of the client (p. 163) and not only listen to the client's words but also immerse herself in the client's world. Not only will this counselor need a knowledge of Margeurite and her cultural background, but also she will need to reflect on times in her own life when she felt alone and isolated, which might help her in understanding Margeurite's experience.

In working with Margeurite, an initial attempt to respond with empathy might be "You're feeling lonely and upset because this place is so different and you are cut off from those who mean the most to you." This response includes an attempt to identify some of the feelings that Margeurite is likely experiencing, as well as the context for why she feels that way. Obviously, whether or not the counselor has lived through a similar experience, formulating such a response involves understanding how a person in Margeurite's situation would feel.

**Counselor-Client Relationship**

Rogers (1961) posed a number of questions for counselors to consider when establishing a relationship with clients, including:

- Can I be some way which will be perceived by the other person as trustworthy, as dependable or consistent in some deep sense? (p. 50)
- Can I be expressive enough as a person that what I am will be communicated unambiguously? (p. 51)
- Can I let myself enter fully into the world of his feelings and personal meanings and see these as he does? (p. 53)
- Can I meet this other individual as person who is in the process of becoming, or will I be bound by his past and by my past? (p. 55)

Rogers (1957) articulated six conditions for effective helping, which build on the core conditions for effective helpers identified in the preceding "Counselor's Role" section.

1. The counselor and client must be in psychological contact. Rogers believed that the basis for all forms of helping is a warm, therapeutic relationship between the client and the counselor. On one level, this may seem obvious: Of course, helping cannot occur
without a relationship between the counselor and the client. However, Rogers believed that psychological contact entailed much more than simply showing up at the appointed time and listening carefully to a client. According to Rogers, the counselor must be fully present in the relationship. In other words, she must be free of distractions and ready to immerse herself in the client’s world for as long as the contact is to occur.

2. The client must be in a state of incongruence. Incongruence refers to the discrepancy between the real and ideal selves, which were described in the preceding discussion of “core concepts” of Rogers’s theory. As was noted there, Rogers believed that each of us is born with an organismic, or innate, valuing process that allows us to determine what kinds of experiences and behaviors will lead us to further growth and development. Unconditional positive regard from others (in this case, the counselor) allows us to continue valuing our own feelings and lessens feelings of incongruence between the real and ideal selves. When we are subjected to terms of conditional worth by others based on what we do rather than who we are, it forces us to substitute their judgments and feelings for our own. This leads to incongruence between our real self and the ideal self we construct mainly to please others.

3. The counselor must be congruent in the relationship. Rogers believed that clients reached a state of incongruence when subjected to terms of conditional worth by other people. The counselor’s first job in person-centered counseling is to avoid being incongruent herself. This means that the counselor should be honest and open about sharing her own thoughts and feelings with clients. This does not, however, mean that the counselor is a perfectly congruent person, with her ideal self always in line with her real self. Rogers would be the first to say the counselors are imperfect beings, striving for growth and development just as their clients are.

4. The counselor must demonstrate unconditional positive regard for the client. As was described in the “Counselor’s Role” section, unconditional positive regard refers to the counselor’s ability to see the client (and all people, for that matter) as basically good and worthy. Again, because the client’s incongruence is thought to be the result of the conditional regard of others, the counselor must create an environment where the client does not feel judged or devalued. The client needs to feel acceptance from the counselor for his basic personhood and for his feelings. This does not imply that the counselor endorses all of a client’s behaviors.

5. The counselor must experience empathy for the client. The counselor must be able to enter the client’s world and understand, on an emotional level, the feelings and reactions that the client experiences. This does not mean that the therapist must have gone through the exact same experience—only that as a human being she must be able to relate to the client’s experiences and feelings.

6. The client must experience the counselor’s unconditional positive regard, congruence, and empathy. It is not enough for counselors to simply possess these characteristics; they must be experienced by the client. A helping relationship does not exist unless the client actually experiences these conditions from the counselor.
ASSESSMENT, GOALS, AND PROCESS OF THEORY

Assessment

Carl Rogers used formal assessment early in his work with clients but then shifted his focus to developing the therapeutic relationship with the client. According to Rogers, the counselor should be actively engaged in understanding the client's experiences and must constantly be concerned that she is comprehending what the client is saying and demonstrating this awareness back to the client. As we will see in the "Primary Applications" and "Research" sections of this chapter, while Rogers saw a very limited role for assessment in the counseling process, he and his colleagues used such systems extensively for research purposes.

Patterson and Watkins (1982) noted, however, that most counselors use assessment of some type. Patterson (1958) described two components of the person-centered approach that are important when using assessment: (1) Each person has inherent worth that must be respected, and (2) each individual has the right to self-direction in choosing values and goals. If assessment is used in person-centered counseling, it is used for the client's benefit, with the counselor attempting to collect information that will serve the client's goal of self-actualization.

Patterson and Watkins (1982) stated that clients should be given as much information as possible about potential tests to be given and as much freedom as possible in deciding which tests are to be used. When test results are given to the client, the focus of the evaluation should remain with the client as much as possible. In other words, an assessment instrument should be avoided if its results can be understood only by the counselor. In person-centered assessment, the client must not be put into the role of being a passive recipient of information. Assessment information provided to the client must therefore be understandable, and all results should be fully disclosed—the counselor should not attempt to withhold unpleasant results. Instead, the counselor and client should both be in agreement about the nature of the information being gathered and the fact that it will be fully disclosed to the client.

Goals

Barrett-Lennard (1998) noted that a wide range of human concerns, including education, the healing of psychic trauma, and personal growth, can be addressed through the person-centered approach. Each topic is addressed through the establishment of an authentic, spontaneous relationship between the counselor/teacher and the client. The goals are established by the client, and while it is presumed that the client will behave differently if counseling is successful, changing behavior is not the focus of the work between the counselor and client. A person who is able to accept her own feelings and develop a healthy sense of self has the potential to develop into what Rogers (1969) called the "fully-functioning person." A fully functioning person will naturally gravitate toward maximizing her own potential and that of the people around her. This creativity may be expressed in any number of different ways, including work, personal relationships, and artistic endeavors such as music or painting.

Rogers did not believe that every person would necessarily reach the goal of becoming a fully functioning person while in counseling. Rather, he spelled out a number of indicators of the degree to which the person was making progress in this direction as a result of her work with a counselor. One important indicator is an increasing openness to one's own experiences, which
Rogers described as the opposite of defensiveness. This entails being able to accept reality, understand one’s own feelings and perceptions, and distinguish real feelings and anxieties from those brought on by conditions of worth. In other words, if a person is concerned about some future event, is it because it truly signifies a threat to her well-being, or are feelings of concern caused by the pressure to live up to others’ expectations?

Another such indicator is the ability to live in the “here and now.” As we noted at the beginning of this chapter, Rogers was influenced by existential theory, particularly the notion that we should live in the present and not the past or future. He did believe that we should learn from our past and prepare for the future, but also that we should be present and experience the here and now and take responsibility for the choices we make in life. Another indicator of progress toward becoming a fully functioning person is an increasing level of organismic valuing, which refers to our ability to trust our own feelings about what works well as a guide toward self-actualization.

**Process of Theory**

Rogers believed that the establishment of an effective therapeutic relationship at the beginning of counseling would lead the client to reorganize her self-perceptions and be more open to her own feelings and experiences (i.e., her real self). He did not spell out distinct stages of the process and instead wrote about counseling mainly in terms of relationship development with the client. If the counselor displayed the necessary core conditions and was available and open to the client, a relationship would ensue that would have therapeutic benefits for the client.

Other person-centered theorists have attempted to formalize the person-centered approach, at least to a degree. For example, Barrett-Lennard (1998) described several stages of the process of person-centered counseling, which are “each distinct in principle but shading into the next in practice” (p. 106).

In the entry phase, the establishment of a safe, trusting, and warm relationship between the counselor and the client is essential. The counselor’s openness to the client’s experiences, her facilitation of the client’s exploration, and her congruence with the client’s own perceptions and experiences are vital. According to Barrett-Lennard, advancement through this initial stage of counseling is marked by a number of factors, including the client’s acknowledgment of the personal impact of the experiences that have brought her to counseling. In other words, the client will begin to explore not just what has happened to cause her distress but also how it has affected her and what she would like to change in her life. She will begin to express her feelings or at least acknowledge that they exist and need to be a focus of counseling. As the client moves beyond simply telling stories about her life, she will begin to treat the counselor as a “real person,” as opposed to a remote authority, and acknowledge that being in counseling “matters” (Barrett-Lennard, 1998).

The second stage, forging a personal working alliance, involves movement beyond the exploration stage of counseling (Barrett-Lennard, 1998). There are at least two components, continued development of the client-counselor relationship and movement from “woundedness” to hope. The “client leads the alliance in terms of content issues” (p. 110) and gradually lets go of the notion that the counselor should direct the sessions. Barrett-Lennard saw this as a make-or-break phase of counseling. The “therapist ally needs to come into view for the client in his/her own distinctive likeness as helper-person; and the client likewise needs to become not just a string of feelings and perceptions responded to . . . but an increasingly known whole configured person” (p. 110).
With respect to movement from woundedness to hope, Barrett-Lennard believed that most of us experience psychosocial wounds at one point or another in our lives and that these can flare up again during times of stress. For example, in her past, the client may have experienced diminished self-esteem, feelings of anxiety, or a loss of meaning, and more recent negative events could trigger these feelings again, leaving her without the confidence that something good can come from the counseling effort (Barrett-Lennard, 1998). As therapy progresses, the client hopefully experiences a sense of her burden being lifted and a return to optimism about the future.

After these two initial stages, Barrett-Lennard (1998) noted that the counseling relationship progresses as the client increasingly gains understanding of the discrepancy between her real self and her ideal self. Because of the therapists' unconditional positive regard, the client need not feel defensive about this discrepancy—instead, she can reorganize her experiences, reclaim previous experiences that were once distorted or denied in an attempt to garner acceptance from others (conditional worth), and increasingly reduce the discrepancy between her self as perceived and her ideal self. In so doing, the client will take increasing responsibility for her own life and its direction. She will become more fully aware of her own experiences and feelings and tend to trust her internal experiences more and more in making decisions about her life. As was suggested in the “Goals” section of this chapter, concrete changes in client behaviors are not heavily emphasized, and counseling may be terminated at the point where the client feels capable of continued progress without the assistance of the counseling relationship, even if she has not necessarily reached all of her goals.

Rogers believed that the counselor and client move through these stages primarily because the counselor is able to empathize with, and develop an understanding of, the client through reflection. This involves the counselor paraphrasing what she has heard from the client in her own words, paying particular attention to the feelings the client is expressing. The value of reflection is twofold: First, it allows the counselor to demonstrate to the client that she is listening and understanding what the client has said. Second, the process of reflection allows the client to explore her own thoughts and feelings as they are repeated back to her—in other words, the counselor acts as a sounding board for the client.

Many beginning counselors have reservations about relying on the use of reflections and being nondirective. Counseling students enter the profession to help other people, and many wonder if their clients will really find their reflections to be helpful. They also worry about sounding like they are just parroting back what the client is saying, when what their client really wants is solutions and advice.

To further examine this issue, consider the case of Kevin, a 17-year-old African-American junior in high school, who needs advice about courses to take in his senior year. His parents believe strongly in the value of a "practical education" that will allow him to be financially successful, and they want him to take courses in his last year of high school that will prepare him for college, including honors courses in English and history. Neither of his parents attended college, and both worked very hard to develop their own food services company. After years of long, grueling work building their company, they saved enough money to send Kevin to college. Understandably, they want Kevin to benefit from their own hard work and to be able to earn a good living without having to endure the long hours they did.

Kevin, however, loves electronics and wants to focus on courses that will prepare him to go to technical school or possibly into the military so he can start a career repairing electrical equipment. Kevin is now at a decision point—he needs to register for classes for next year and
desperately wants to take classes that will allow him to pursue his passion for electronics. But he knows this will upset his parents because they equate a college degree with financial security. So Kevin has come to see his school counselor to get help making decisions about his classes and communicating with his parents.

A counselor attempting to be directive and "solve" Kevin's problem:

Counselor: So, Kevin, it sounds like you are struggling with a difficult choice here, whether to please yourself or please your parents. Which is more important to you?

Kevin: Well, I want to be happy, you know? I like everything about electronics—it involves math and science, which I like, but it's also about a sense of really doing something important, you know, by fixing things.

Counselor: So it's pretty clear that you should go the trade school route with your classes rather than college preparation. How can you tell your parents about your choice?

Kevin: Well, I think they'll freak out. Look, their lives have not been easy—I can't believe how hard they worked when I was growing up. But they had a dream for me: that I could make it without killing myself like they did. That I could be a college grad and have status. I don't think they ever really felt important.

Counselor: OK, I hear you, but let's talk about the best way to break it to them.

Kevin: Well, in my family, you just don't do that sort of thing—you don't openly question what your parents have in mind for you.

Counselor: But let's say you did, what would they say?

Kevin: Well, I don't know....

While many of the questions asked by the counselor in this example may seem reasonable, it is important to note the effect that this form of interviewing has on the counseling relationship. First, the counselor in this example is more or less in control of the direction that the session takes—she asks the questions and leads the client to specific areas of exploration. Second, the counselor is not establishing a relationship between herself and the client—she seems to be more of an advisor than a counselor. Third, there is the question of whether this counselor is demonstrating respect for Kevin's values and goals. The counselor seems to be pushing Kevin to make a career choice.

Also, urging Kevin to talk to his parents right away may be inappropriate for any number of reasons. For example, Kevin's family may react negatively if Kevin simply announces his career choice—they may expect to be consulted first. Thus, the counselor's suggestion that Kevin make a choice and immediately announce it to his parents could cause conflict in Kevin's family. This could damage the relationship between Kevin and the counselor as well and cause Kevin to question whether the counselor really had the potential for understanding his concerns. Contrast this example with the more nondirective approach a person-centered counselor would use.

A nondirective counselor using reflection with Kevin:

Counselor: Kevin, it sounds like you feel conflicted—on the one hand, you want to pursue classes and a career that you really enjoy, but on the other hand, you don't want to disappoint your parents.
Kevin: Yeah. . . I really want to get training in electrical repair, and that seems to be what all my friends are doing—they are choosing the courses they want.

Counselor: It sounds like a real struggle: Do I go with my own interests, like many of my friends, or go with my parents' wishes?

Kevin: Yeah, and they said they would pay for college, so I feel like I owe them that.

Counselor: You really want to honor their expectations and the hopes they have for you.

Kevin: Yes, but I don't want to be miserable, either.

Counselor: So it seems like uncharted territory in a way—you can't do both things, and it's not clear how you can reconcile what your parents want and what you want for yourself.

Kevin: Yeah, I guess I need to find a way to talk with them. . .

In the second example, the counselor is letting the client take the lead by reflecting back the client's feelings and thoughts. Eventually, the issue of Kevin talking with his parents still comes up, but in this case, it was his idea, not the counselor's. Rogers believed that an important strength of the nondirective approach is that it gives clients the ability to find their own solutions, and the counselor's role is to assist clients in this exploration without guiding them toward any particular outcome.

THERAPEUTIC TECHNIQUES

Person-centered counseling does not lend itself to the use of specific therapeutic techniques. Rogers thought that a reliance on such prescriptions would detract from the authenticity of the counseling relationship, and he criticized some counseling theories textbooks as inaccurately portraying his approach as a series of techniques (Rogers, 1980).

Although many person-centered counselors downplay the role of the counselor in directing change, Miller and Rollnick (2002) developed an approach called motivational interviewing (MI), which is a brief, directive method for adapting Rogers's principles with clients who are ambivalent about change. They defined MI as a "client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (p. 25). According to these authors, "Counsel in a directive, confrontational manner and client resistance goes up. Counsel in a reflective, supportive manner, and resistance goes down while change talk increases" (p. 9). They see this approach as an evolution of the person-centered approach in that the focus is on the person's interests and concerns. However, MI differs from the person-centered approach in focusing on ambivalence about change as a natural human condition.

Recall that Rogers viewed self-actualization as a natural tendency, which could be facilitated by removing obstacles to an individual's growth. Miller and Rollnick built on research by Prochaska, DiClemente, and Norcross (1992) suggesting that clients enter counseling with varying levels of motivation for change and that client-centered techniques alone might not be sufficient to resolve the ambivalence that clients may have toward effecting change in their lives. An important tenet of MI is that it is incorrect to label almost anyone as "unmotivated." Everyone
has motivations, but these motivations may not be aligned with the preferences of important people in her life (such as teachers, parents, partners, etc.). A student with lagging performance in school is not necessarily unmotivated, but she may be more motivated to play a musical instrument, participate in a sport, or hang out with friends than to study for tests.

Miller and Rollnick pointed out that common wisdom suggests that the best way to motivate people is to punish them: in other words, to threaten them, take away privileges, or invoke consequences. However, they suggested that many clients who come to counseling ambivalent about change are, in fact, already suffering, and further negative consequences may serve only to paralyze them or invoke psychological defenses such as minimizing the impact of their struggles. According to Miller and Rollnick, “People often get stuck, not because they fail to appreciate the down side of their situation, but they feel at least two ways about it. The way out of the forest has to do with exploring and following what the person is experiencing and what, from his or her perspective, truly matters” (2002, p. 12).

Miller and Rollnick noted that MI builds on Rogers’s person-centered methods to help clients develop the motivation to change. This approach is grounded in Rogers’s belief that counselors need to establish a therapeutic relationship by demonstrating accurate empathy. Since MI is specifically designed to help clients reduce ambivalence about problematic aspects of their lives, it is critical that MI counselors seek to understand their clients’ feelings and experiences without judging them.

It is also essential that the MI counselor not “take sides” when a client express conflicting feelings about change. For example, a client who is having trouble with alcohol may express ambivalence about giving it up forever. On the one hand, the client may talk about how much she enjoys having drinks with friends and how alcohol helps her relax when she is tense. On the other hand, she may also feel ashamed of losing control when drinking and regret how much alcohol interferes with her life and overall health. Miller and Rollnick pointed out that many people, including counselors, are tempted to argue for the “stop drinking” side of the client’s ambivalence. However, this can have the unintended consequence of forcing the client to defend her feelings and actions when drinking. The more people confront her about drinking, the more she may feel a need to defend her current behavior. Therefore, counselors using MI have to be careful about accepting all aspects of the client’s ambivalence.

Another important feature of MI counseling is that while a counselor using MI needs to express empathy, she is not expected to accept people as they are or simply use reflective listening to follow clients down an avenue they happen to discuss. Instead, Miller and Rollnick suggested the counselor should help the client “develop a discrepancy between present behavior and his or her broader goals and values” (2002, p. 38). In other words, the counselor should look for any opportunity to help the client realize how a problematic behavior is getting in the way of what she wants to accomplish in life. Miller and Rollnick pointed out that many people who seek counseling already perceive significant discrepancies between what is happening in their lives and what they want to happen. However, it is important that the counselor wait until the client states her own reasons for change rather than having them come from the counselor.

Finally, MI counselors need to focus on supporting the self-efficacy of their clients—essentially, this means helping the client maintain a sense of hope and optimism about her potential to effect meaningful change. One of the greatest obstacles the client faces in making changes is a loss of faith in her own abilities or capacities. The counselor’s role is therefore to not only give the client the responsibility for making decisions about change but also affirm her ability to do so.
Therapeutic Techniques

Let's consider two different approaches to working with Frank, who was arrested for driving under the influence of alcohol (DUI) and is attending substance abuse counseling as a condition of probation.

Counselor: Would you like to tell me something about how you got the DUI?

Frank: Well, I was at a wedding and I admit I had too much to drink. But I was driving just fine, and then I had a tire blow out. A cop sees me on the side of the road, and when he came up to help me, he noticed the beer on my breath. So he takes me to the station, gives me a blood alcohol test, and now I'm stuck here. This sucks, if you want to know the truth.

Counselor: So the whole thing seems unfair and you're pretty ticked off.

Frank: Wouldn't you be mad? I don't have a problem with alcohol. I'm just unlucky that I happened to get a flat tire.

Counselor: Well, it sounds like alcohol has caused you at least one problem... getting arrested.

Frank: Yeah, but like I said, I was just unlucky. I didn't kill anybody or anything. I hardly even get drunk and I never get into fights or anything.

Counselor: So this is the first time that drinking has caused you trouble. It could be a warning sign of more trouble to come if you don't seriously look at your alcohol use.

Frank: Are you kidding? I just told you I don't have a problem, and after this, I might never drink again!

In the example above, the counselor is being directive by pointing out the possibility, based on the arrest for driving under the influence, that the client is at least in the early stages of abusing alcohol. While the counselor's intention may be to point out the obvious and help the client admit this possibility, it is clear that the client is resisting the suggestion. Rather than rolling with resistance, as Miller and Rollnick suggested, the counselor is meeting it head on and forcing her client to argue the other side—that he doesn't have a problem. It is not hard to imagine that the more the counselor presses this point, the more the client might feel compelled to resist it.

Next let's consider how a counselor might use MI with the same client.

Counselor: Would you like to tell me something about how you got the DUI?

Frank: Well, I was at a wedding and I admit I had too much to drink. But I was driving just fine, and then I had a tire blow out. A cop sees me on the side of the road, and when he came up to help me, he noticed the beer on my breath. So he takes me to the station, gives me a blood alcohol test, and now I'm stuck here. This sucks, if you want to know the truth.

Counselor: So the whole thing seems unfair and you're pretty ticked off.

Frank: Wouldn't you be mad? I don't have a problem with alcohol. I'm just unlucky that I happened to get a flat tire.

Counselor: So drinking usually doesn't get you in trouble, but this time it sure did.

Frank: Yeah, I guess I was just unlucky. I could have just called a cab or something, but I didn't. I thought I was fine.

Counselor: So somehow you missed the warning signs that you were intoxicated, and it's landed you here.

Frank: Yes, and I want to get out of here as soon as possible.
Miller and Rollnick noted that change is facilitated by focusing on the disadvantages of the status quo and the advantages of change. In the previous example, we saw that the client was not open to labeling himself as a substance abuser. However, the counselor in this example is mainly focusing on the undesirable aspects of the client’s current situation and, over time, will engage the client in a discussion of the advantages of change. This will hopefully result in greater motivation for change. In this example, the client might be encouraged to identify situations in which he acts irresponsibly after using alcohol, as when he decides to drive after drinking. However, using MI, the counselor would attempt to elicit more discussion of the client’s dissatisfaction with his current situation rather than labeling the client or offering advice.

MULTICULTURAL AND DIVERSITY EFFECTIVENESS

Helms and Cook (1999) wrote that the global perspective, cross-cultural harmony, and spiritual connections emphasized by Rogers in the latter stages of his career make it possible to communicate with clients on a deeper level than is possible in psychodynamic and behavioral approaches. Rogers and his associates conducted numerous workshops all over the world, including South Africa and Belfast, Ireland, both sites of intense cultural and religious conflict. They had an undeniable global impact, and human services workers in places such as Japan, Australia, and South America have used elements of person-centered approaches.

In many of his international workshops, Rogers worked to bring groups in conflict together using the person-centered approach. By working to bring these groups into contact with each other, Rogers hoped to facilitate mutual understanding where little existed before. In many cases, he reported significant progress in a matter of days as individuals worked through long group sessions with a person-centered facilitator.

When used in multicultural counseling with individuals and small groups, the person-centered approach offers a number of strengths. Ivey, D’Andrea, Ivey, and Simek-Morgan (2002) cited Lerner’s (1992) contention that its positive notion of humans makes the theory appealing to those interested in working with women and persons from diverse cultural backgrounds. Van Kalmthout (1998) pointed out that the person-centered approach can be seen as a system of meaning making—as each person follows the unique path of her life, she is moving away from facades or attempts to please others and toward self-direction, complexity, and openness to experience.

However, person-centered counseling can have significant limitations when working with persons from diverse backgrounds. First, the theory relies heavily on mutual understanding between the client and counselor, which can be difficult to achieve between individuals with significant cultural differences. Second, the emphasis on the innate growth potential of individuals can lead to neglect of the powerful influence of culture. Rogers’s notion that the environment serves mainly to limit the innate growth-seeking potential may underestimate the importance of social institutions, customs, and values to human progress. Hawlin and Moore (1998) also noted that the person-centered approach runs the risk of colluding with the prevailing power structure if it does not explicitly identify how certain segments of a society can be systematically oppressed. Finally, Ivey et al. (2002) pointed out that the term person- or client-centered
can imply a secular focus on the individual that can obscure the value of this approach for non-middle-class and non-European-North American clients who may seek a collectivist and/or spiritual focus.

In order to address concerns such as these, Glauser and Bozarth (2001) suggested balancing fundamental aspects of the multicultural counseling movement with the person-centered approach. Their concern was that the emphasis on multicultural competency might lead to an overreliance on techniques for understanding the client's cultural background at the expense of an authentic human relationship. For example, they noted that even though the client and counselor may come from different cultural frames of reference, it is essential that both work to understand each other as individuals with unique experiences, as well as members of cultural groups with characteristic attitudes, values, and beliefs. Also, they suggested the importance of understanding extratherapeutic variables that are impacting a client, such as systematic discrimination, from the client's perspective, not that of the counselor.

PRIMARY APPLICATIONS

Rogers's core conditions for counseling are so well accepted in counseling practice that it can be difficult to separate what is truly a person-centered intervention from an intervention that incorporates some of its principles but also relies on other counseling theories. Some of the more common applications of person-centered counseling are reviewed next.

Couples and Family Counseling

Rogers did not write directly about marital or couples therapy but did author a book for the general public entitled Becoming Partners: Marriage and Its Alternatives (1972). It included interviews with couples that, while not necessarily therapy, were intended to facilitate communication.

Frye, Guerney, and Stover (1973) described a version of person-centered couples counseling called conjugal therapy. Each member of the couple practices the roles of speaker and listener on certain topics, and a facilitator is present to help them communicate. In a somewhat different approach to couples work, Esser and Schneider (1990) distinguished between work with couples and partnership therapy, focusing on the relationship itself using person-centered principles. Commonly, the couple's therapist is fully present when working with them to facilitate their effective communication. Programs for families include psychoeducation, in which parents are trained in interpersonal communication skills (Levani, 1983).

Working with Children and Adolescents

Given that Carl Rogers's early clinical work was with children and their families, it is not surprising that his approach is well represented in approaches to working with children and adolescents. The field of child therapy drew heavily from Rogers's work, and Axline directly referenced Rogers's ideas about the counseling process in Play Therapy (1947). This approach involves children playing with various objects, such as puppets, dolls, fingerpaint, clay, and sand, as a
medium for communication. Axline presented a number of principles for play therapy based on person-centered ideas, including (1) establishment of a warm, friendly relationship between the child and the counselor; (2) acceptance of the child exactly as she or he is; (3) establishment of a permissive atmosphere in which the child is able to freely express feelings; and (4) reflection of the child’s feelings so she gains insight.

Erdman et al. (1996) noted that many of Rogers’s basic ideas about counseling skills, such as reflecting client feelings, need to be adapted when working with children. They point out that many counselors become frustrated in working with children when they attempt to use basic counseling skills for adults. “It is not uncommon to hear surprise and concern in statements such as ‘When I restated what the child said, he asked me why I was repeating what he just said’ and questions such as ‘What do you do with kids when they just won’t talk to you?’” (p. 374).

Erdman, Lampe, and Lampe further pointed out that children often lack abstract reasoning abilities and may not question their thoughts or reasons for doing things. They therefore recommended a number of modifications to person-centered techniques when working with children. First, counselors need to establish an appropriate physical environment. While adults may be capable of sitting in an empty room with two chairs, children need an environment that puts them at ease and offers the opportunity to interact with their environment. Books, toys, and furnishings appropriate for children from various backgrounds (e.g., gender, ethnicity) are therefore essential.

A second important consideration when using a person-centered perspective with children is the need to use listening skills that are appropriate for younger individuals. Reflective listening skills can be far more important than questioning skills early in the relationship with a child, since it is important to understand the child’s experiences from her own perspective. When questions are asked, they should be simple and easily understood, such as “Which of your friends do you spend the most time with?” The open-ended questions that person-centered counselors use to promote self-exploration with adults may confuse children. Third, it is also important that the counselor attend to nonverbal cues and be able to understand these cues in terms of the child’s cultural background. Asking the child for help when appropriate (e.g., “Please help me understand what you meant when you said . . .”) helps reverse the typical adult-child authoritative positions. Finally, it is also important that the counselor refrain from criticizing, blaming, or challenging the child about a problem while she talks about it.

Geertjens and Waaldijk (1998) suggested specific requirements when person-centered counseling is used with adolescents. They noted that to be genuine, therapists should draw on their own experiences as adolescents. For example, the counselor should use her own experiences with her parents, or parental figures, to understand the adolescent’s frame of reference and communicate this in language that the adolescent can understand. They also noted that without the demonstration of unconditional positive regard, a therapist working with children and adolescents cannot get far. “Unconditional positive regard will therefore above all aim at the recognition of the uniqueness, the particularity of the single adolescent at this moment of their life” (p. 165). Finally, they noted that empathy is an “ongoing process of checking hypotheses, in which the therapist becomes acquainted with the inner world of the client in cognitive as well as emotional respects” (p. 166).
Educational Settings

Rogers (1989) believed his person-centered approach had many applications to educational settings and detailed a number of qualities that facilitated learning. He saw many teachers as taking on an inauthentic role of “educator” rather than being a real person with specific likes and dislikes. Just as he encouraged counselors to be authentic and real in their interactions with clients, he thought that teachers should do the same with students. He even encouraged teachers to communicate their feelings toward student projects in an authentic manner: “[T]hus, she is a person to her students, not a faceless embodiment of a curriculum requirement nor a sterile tube through which knowledge is passed from one generation to the next” (p. 306, as cited in Kirschenbaum & Henderson, 1989).

Rogers believed that effective teachers demonstrate a caring for and an acceptance of the learner as a separate person with worth in her own right. This type of teacher is able to tolerate the personal feelings that both disturb and promote learning—e.g., the student may be enthusiastic one day, distracted the next. Finally, just as Rogers stressed the importance of using empathy in counseling situations, he also thought that this was an important skill for educators to use with their students.

Group Work

Rogers was a pioneer in group work, and immediately following World War II, he and his associates at the University of Chicago Counseling Center used groups to train counselors intending to work with patients in Veterans Administration hospitals (Rogers, 1970). Rogers believed that the same core conditions important in individual counseling—empathy, acceptance, warmth, congruence, and unconditional positive regard—need to exist in the group, modeled first by the group facilitator (a term Rogers preferred to group leader) and then among the group members as the group developed.

Rogers (1970) described some of the basic stages that typically emerge in encounter groups over time. Groups usually start with an initial awkward “milling around” stage, in which members engage mostly in small talk and discussions are halting and awkward. Inevitably, Rogers believed that some members would begin disclosing personal information, which could lead to ambivalence among other members who are uncertain about whether they want to trust the group. Hopefully, over time, the members’ trust in the group will increase, and they will begin to share their feelings in the group and relate more intimate details about their own lives. According to Rogers, an important component of development in the group’s life is the extent to which members begin to share information with each other in the group—in other words, the extent to which they begin to take the risk of communicating honestly and openly with each other.

As the group continues to develop, Rogers believed it was important that each member receive feedback from others and in doing so “rapidly acquire[s] a great deal of data as to how he appears to others” (1970, p. 29). Rogers believed that by giving feedback about how they experience each other, the members come closer and closer to what he described as “the basic encounter,” in which persons come to know each other and reveal parts of themselves in ways that do not happen in everyday life. He saw this experience as one of
the central and change-producing aspects of participation in groups. Rogers believed that eventually such experiences would lead to concrete behavior changes in the group and in the outside world.

Rogers described encounter groups, another approach that he pioneered, in his book *Carl Rogers on Encounter Groups* (1970). The encounter group movement closely paralleled some of the cultural shifts that occurred in the United States in the 1960s and 1970s, including freedom of expression, self-discovery, and the need to get in touch with one's feelings. Encounter groups were somewhat different from the groups described previously in that the emphasis was on personal growth and freedom of expression. According to Rogers, encounter groups lead to "more personal independence, few hidden feelings, more willingness to innovate, more opposition to institutional rigidities" (p. 13). The leaders of such groups might not even be professional counselors. Some of these groups took place in wilderness settings and could consist of continuous, marathon meetings lasting several days.

Lieberman, Yalom, and Miles (1973) conducted one of the most famous studies of the encounter group movement and found that while many members benefited from such experiences, 8% of the participants in the study experienced psychological injury that was still present 6 months after the group ended. Lieberman et al. found that in large measure the effectiveness of the group leaders made the difference in how much members benefited. Specifically, they found that leaders who demonstrated high levels of meaning attribution and empathy had the best outcomes. Meaning attribution was defined in the study as providing explanations, clarification, and a cognitive framework for change in the members, while empathy referred to one of the core conditions of the therapist identified by Rogers. As Yalom put it, "The Rogerian factors of empathy, genuineness, and unconditional positive regard thus seem incomplete; we must add the cognitive function of the leader" (1995, p. 498).

**Counselor Training**

Elements of the person-centered approach have become an essential component of training in basic counseling skills, sometimes labeled *micro-skills* training because of the emphasis on specific, fundamental skills important to counselor effectiveness. Carkhuff (2000) developed one specific model based on person-centered principles and described two specific components of counselor skills: attending and verbal response. Attending skills refer to the nonverbal behaviors of the counselor. According to Carkhuff, more than half of the communication between counselors and clients takes place nonverbally through posture, eye contact, and tone of voice, for example. Therefore, when we refer to the attending skills of the counselor, we are referring to the nonverbal behaviors that communicate the extent to which the counselor is "attending" to the concerns of the client. Among the nonverbal behaviors that facilitate communication is squaring, in which the counselor is positioned directly in front of the client, adopts an open posture (i.e., she is not crossing her arms or otherwise indicating that she is not receptive to the client), leans in toward the client to communicate interest, and maintains eye contact. In addition to these nonverbal behaviors, Carkhuff described a number of fundamental verbal responses that are essential components of counseling. These include accurately paraphrasing what the client has said and demonstrating empathy by responding to the client's feelings.
Counselor training models like Carkuff's, which emphasize non-verbal and verbal skills, go a step beyond person-centered counseling by concretizing specific skills that counselors need to have when interacting with clients. Rogers was quite concerned that such approaches would turn his authentic model of counseling into a technical endeavor. However, such approaches do maintain his nondirective stance toward counseling by exploring client concerns while avoiding specific suggestions for advice, and they do provide more specific direction for counselors who are attempting to be person centered.

**BRIEF THERAPY/MANAGED CARE EFFECTIVENESS**

Person-centered principles are widely used in a range of counseling interventions in health care and medical settings. Rogers's methods are not typically classified as a brief form of therapy, but neither did Rogers emphasize a protracted series of meetings between the counselor and the client before the core conditions of therapy could be realized. In other words, person-centered counseling can be described as somewhere in the middle of the continuum of theories presented in this book with respect to its suitability for brief therapy: The emphasis on the counselor-client relationship necessitates that enough sessions occur for a therapeutic bond to be developed, but once that is established, its benefits can be immediately realized.

Rogers's ideas and principles have impacted the health care system itself through patient-centered medicine, an approach first introduced by Balint, Hunt, Joyce, Marinker, and Woodcock (1970) and centered on the idea that patients need to be intricately involved in the treatment process. According to this approach, the doctor should work to understand not only the patient's illness but also her experience of the illness (Laine & Davidoff, 1996). In addition, the doctor is encouraged to involve the patient in the details of her diagnosis, the treatment opportunities available, and their various costs and benefits.

According to Stewart et al. (1995), disease is a theoretical construct or abstraction, while illness refers to the patient's illness experience. For example, arthritis is a disease that involves inflammation of a joint, characterized by pain, swelling, stiffness, and redness. However, for any given patient, the illness experience can be quite different in terms of where the arthritis affects her, how much discomfort it causes her, and how much it impairs her life. To understand the illness experience, medical personnel must be able to explore with patients their ideas about what is wrong with them; their feelings, especially about being ill; the impact of their problems on their current functioning; and their expectations for what should be done (Stewart et al., 1995). The doctor-patient relationship is the key to this holistic approach to medicine. As doctors get to know their patients better after seeing them time after time for a range of different concerns, they are better able to be helpful in managing subsequent problems.

The patient-centered approach represents something of a departure from Western medicine as it is typically practiced, where the doctor is the authority and primary decision maker (along with third-party payers). However, it has generated considerable support both abroad and in the United States and also provides an increasing opportunity for the involvement of counselors and psychologists in health care settings. Since they have extensive training in the person-centered skills necessary to conduct patient-centered medicine (e.g., rapport building, reflective listening), counselors and psychologists are in a position to play a vital role.
Use of the person-centered approach might be limited in managed care settings due to its avoidance of labels or diagnoses. Rogers believed that such systems were both inadequate for understanding other people and potentially distracting to a counseling relationship. Instead, it is the counselor’s job to understand the client as a unique person with strengths and areas for growth that need to be addressed in counseling sessions.

INTEGRATING THE THEORY WITH OTHER APPROACHES

Carl Rogers’s core conditions of helping—acceptance, warmth, congruence, and unconditional positive regard—have become widely viewed as essential fundamental counselor skills (Carkhuff, 2000), particularly for establishing a therapeutic bond between the counselor and the client at the outset of counseling (Cheston, 2000). Frank and Frank (1991) suggested that all counseling approaches are variations of time-honored procedures for healing, including an emotionally charged relationship in a healing setting. In his writing, teaching, and practice, Rogers conveyed the importance of this type of relationship between the counselor and client. The nondirective component of Rogers’s theory also ensured that it was the client’s goals, not those of the counselor, that would get addressed in counseling. The emphasis on understanding the client’s internal frame of reference can also be an asset in working with clients from diverse backgrounds.

These characteristics of person-centered counseling allow it to be integrated with other counseling approaches that emphasize the establishment of a therapeutic and respectful relationship between the counselor and the client. For example, Alfred Adler rejected the traditional distant psychoanalytic approach in favor of a relationship of equals. Feminist approaches emphasize the egalitarian nature of the counseling relationship, as do existential approaches. Postmodern approaches such as solution-focused therapy and narrative therapy also posit a relationship between client and counselor that does not place the therapist in a more powerful or authoritative position than the client.

While Fritz Perls was known for being confrontational with clients, and thus very much unlike Rogers, more recent Gestalt therapists have emphasized a phenomenological approach to understanding how their clients organize and understand their world. Such efforts require that a counselor be able to enter the world of the client, which is consistent with Rogers’s beliefs about the importance of the counselor demonstrating empathy. William Glasser’s reality therapy also emphasized the bond between client and counselor in understanding how clients are meeting their needs.

Integrating Rogers’s person-centered approach with counseling approaches that do not emphasize the counselor-client relationship or that call for the counselor to fill a prescriptive role in helping clients change is more problematic. However, as we have mentioned before, it is difficult to find a modern counseling theory that does not recognize the need for some type of rapport between client and counselor. Classic psychoanalysis, with the therapist as a distant figure sitting behind a couch, is one that does not seem to fit well with the person-centered approach; however, contemporary analytic approaches require a therapeutic alliance. Cognitive-behavioral and behavioral approaches, while emphasizing the therapist as more of an expert, also rely on the formation of a relationship of some sort. They do not, however, fit well with the nondirective nature of person-centered counseling.
RESEARCH

While Carl Rogers de-emphasized the role of formal assessment in counseling, he believed strongly in the value of empirical research in evaluating the counseling process. Thus, even though he advocated a non-technical, phenomenological approach to working with clients, he also stood for rigorous empirical evaluation of the counseling process—a rather unique combination. Even critics of the person-centered approach credit Rogers and his colleagues for attempting to evaluate the effectiveness not only of the general person-centered approach but also of specific elements of the counseling process. Rogers and his colleagues were among the first to empirically examine what actually happens in the counseling relationship, using transcriptions of session tapes, observations of counseling sessions, and subjective measures based on theoretical components of the person-centered approach.

How does the person-centered approach fare when compared to other systems of counseling? Using the meta-analysis technique reviewed in previous chapters, Smith, Glass, and Miller (1980) were able to quantitatively rank the average “effect” of existing counseling theories based on 475 existing studies. Client-centered therapy was ranked fourteenth among the various theories evaluated, but the overall effectiveness measures of the counseling theories reviewed was so similar that the authors concluded there was little evidence to suggest that one theory of counseling was superior to any other. While other researchers have found that the person-centered approach produces benefits when compared to wait-list or no-treatment groups (Grawe, Donati, & Bernauer, 1998), others have found that it fares less well when compared to behavioral interventions (Weiss, Weiss, Han, Granger, & Morton, 1995).

In addition to the overall effectiveness of the person-centered approach, Rogers’s notions of empathy, genuineness, and acceptance were studied for decades using quantitative measures of the constructs he hypothesized to be essential in effective counseling. The efforts of Truax and Carkhuff, two colleagues associated with Rogers at the University of Wisconsin, are especially noteworthy in this regard. They developed a range of rating scales measuring constructs such as accurate empathy, nonpossessive warmth, and concreteness or specificity of expression in interpersonal processes. While Patterson (1985) compiled an integrated summary supporting the importance of these constructs in effective counseling, others have found the evidence less persuasive (Beutler, Crago, & Aresmenid, 1986). Levant and Shlien (1984) pointed out that until the mid-1970s considerable research supported the core conditions of Rogers’s theory, but this finding was called into question by researchers outside the client-centered tradition who criticized some of these studies for having faulty designs.

Many studies of person-centered counseling involve researchers listening to segments of tapes from counseling sessions and then rating the behaviors of the counselor and the clients according to the objective rating scale of a given construct (such as warmth or empathy). This approach has been criticized for evaluating only segments of counseling sessions, for incorporating methodological flaws, and for insufficiently considering the subjective reactions of clients in sessions. However, Orlinsky and Howard (1986) conducted an extensive analysis of the literature and found that dimensions such as these were related to positive counseling outcomes for clients.

Overall, therefore person-centered counseling has been subjected to considerable empirical investigation, spurred initially by the efforts of Rogers himself and his students. There is considerable support for the proposition that counselors must possess the core conditions of counseling (empathy, congruence, and unconditional positive regard) if counseling is to be
effective. However, it is less clear that these conditions alone will lead to successful counseling. This, in part, explains why many counselors consider the core conditions to be an important foundation with which to approach counseling—but one that needs to be supplemented with interventions from other counseling models.

SAMPLE RESEARCH: Examination of process variables in counseling

Goals of the Research
Martin, Carlthuff, and Berenson (1966) studied whether counselors in training demonstrated higher levels of the core conditions than close friends. They conducted this study because at the time it was acknowledged that in some ways the process of counseling was similar to what happens in a friend relationship. Martin et al. sought to evaluate whether one type of helper (best available friend or professional counselor) would be rated higher in terms of Rogers’s core facilitative conditions for helping.

Participants
Martin et al. conducted this study with six college students who volunteered to be interviewed by both a professional counselor and their “best available friend.”

Methods
Martin et al. gave the following instruction to each of the interviewees: “All of us either in the present or during the past year or so have had a number of experiences which have been very difficult for us. If you feel the person whom you will be seeing is helpful, please feel free to discuss these experiences (pp. 356-357).” Each friend and counselor was given the instruction “Simply relate to the person you will see as you ordinarily do in order to be helpful to them” (p. 357). Following each interview, the interviewee filled out a questionnaire with 50 items, 10 for each of the facilitative conditions of helping: empathy, positive regard, genuineness, concreteness or specificity of expression, and the client dimension of self-exploration. Martin et al. tape-recorded all of the interviews, and three 4-minute excerpts from each interview were rated independently by three trained graduate students, using 5-point scales to assess each of the five process variables according to procedures developed by the second author of the study, Carlthuff.

Results
Even though most of the participants in the study had known their designated friends for 1 year or more, the results of this study showed that according to the self-reports of the volunteer interviewees and the ratings made of the tapes by the graduate counseling students, the professional counselors were rated higher on the five facilitative conditions than the best available friends. The only scale for which counselors were not rated as statistically significantly higher was the interviewee’s ratings for level of self-exploration.
Implications of the Research

According to Martin et al., the differences in ratings between the two groups were important because the average ratings for the counselors hovered around 3 on the 5-point scale used, while the friends generally scored around 2. Using Carthuff’s scale for helper effectiveness, the level 3 represents a minimum level of facilitative functioning—i.e., the person is at least being minimally helpful and is not doing anything unhelpful. At level 2, the person is generally being helpful only infrequently. Both the self-reports of the interviewee and the ratings of graduate students in counseling suggested that trained counselors are able to demonstrate the core conditions of helping more frequently than are friends.

EVALUATION OF PERSON-CENTERED COUNSELING

One of the main contributions of person-centered counseling to the field is a specification of fundamental counseling skills to be used in a wide range of counseling applications. In his writings, Rogers articulated a philosophy of how the counselor should “be”—open to the experiences of their clients and themselves, nonjudgmental, warm, and accepting, even prizing, of the clients as fellow human beings. These ideas about the personhood of the counselor are so well accepted today they have become part of the popular culture. However, at the time of his writing, Rogers’s vision of the role of the counselor was a significant departure from the training of psychoanalytic and behavioral practitioners. Thorne (1992) suggested that “much that was revolutionary in the early years of client-centered therapy is now apparently taken for granted by practitioners of many different therapeutic schools. It is this fact which leads some therapists to believe that person-centered therapy is what everyone does at the outset of a therapeutic relationship before embarking on the real therapy which, of course, bears an entirely different brand label” (p. 44).

One of the major criticisms of person-centered counseling is that it offers few prescriptions for problem solving. Clients might be inclined to seek another counselor who will offer more specific suggestions and not place as much responsibility on them. Beginning counselors who use this approach may see it as an effective means for getting to know their clients better at the outset of counseling but as insufficient for “real” change.

Many students training to be counselors face perhaps one of their biggest struggles with the person-centered approach’s assumption that counselors have to be nondirective; i.e., they should not offer the client specific advice or direction about what choices to make in life but rather should help the client make decisions for herself. This tension between letting the client choose her own goals and exercising one’s judgment about what is best for the client is reflected in professional ethics codes, which mandate that the client’s goals for change should be respected but also provide specific conditions under which the counselor must intervene despite a client’s wishes (for example, if the client’s behavior endangers herself or another person). In any case, many counselors feel like they need to “do something” to help their clients and are uneasy with the notion of providing little or no concrete advice to clients.

The person-centered approach assumes an innate potential for growth in clients. While many counselors might subscribe to this notion generally, those with experience in working with
clients who have been exposed to dysfunctional families, trauma, loss, substance abuse, and the like question whether such individuals will be able to overcome such obstacles unless the counselor resorts to techniques and interventions intended to overcome the consequences of such experiences. For example, a client who comes from a family of substance abusers and has had a lifelong addiction to alcohol might, indeed, have innate potential for growth, but this potential could well be masked as long as the addiction persists.

There are those who criticize Rogers’s emphasis on the “personhood” of the counselor rather than on specific skills that the counselor will need in working with clients. As we noted earlier in this chapter, authors such as Carkhuff (2000) have developed systematic training models that seek to translate Rogers’s general ideas into specific concrete abilities and skills that counselors need to possess—such as attending and responding skills. This criticism of Rogers’s approach also seems to be reflected in professional training standards for counselors that define counselor competence in terms of specific training, experiences, and abilities rather than more general personal qualities. A further criticism of this approach is that even well-defined counselor skills based on Rogers’s approach are useful for building the counselor-client relationship only early on.

Rogers strongly believed that a helping relationship is one that unlocks the innate human capacity for growth and self-improvement, and it was therefore not necessary for the counselor to use a range of techniques or interventions. Instead, Rogers saw these as potential obstacles to a real and authentic human relationship. Rogers’s focus on the therapeutic factors that exist in this relationship spurred considerable research on the process of counseling and could be said to have demystified it considerably. Rogers did not believe that the counselor needed to serve as an expert in this relationship, which is in sharp contrast to other approaches, such as psychodynamic counseling and behavioral therapy, that tend to view the counselor as an expert. This demystification of the role of the counselor helped expand the practice of counseling beyond the exclusive domain of psychiatrists and psychoanalysts to the helping professions, including nursing, social work, counseling, and education. During the latter stages of his career, Rogers came to view his approach as not just a means for counseling but also part of a worldwide movement for peace, justice, and international cooperation.

Questions and Learning Activities

These questions and activities are designed to stimulate your thinking about this theory and to help you apply some of the ideas to your own life and experience. If possible, you should work with another person or with a small group. Getting others’ points of view and sharing your own ideas and perspectives will be invaluable as a way to help you evaluate this theory and its applications.

Personal Application Questions

Consider the following questions when you think about using this approach in your own counseling:

1. Do you believe that people inherently strive toward growth if left to their own devices?
2. Can the experience of unconditional positive regard, congruence, and empathy help clients change negative feelings and attitudes?
3. Rogers believed that it is imperative for counselors to be “authentic” in the counseling relationship. Can you see yourself being this open with clients and with yourself?
4. Will you be able to help clients find their own answers and resist offering solutions or advice?
5. Do you think that Rogers’s “necessary and sufficient” conditions are all that is necessary for clients to change?
6. How does person-centered counseling seem to fit in the setting or population with which you want to work (school, private practice, agency, teenagers, etc.)?

Learning Activities

**Carl Rogers for a Day**

One way to test out the effectiveness of the person-centered approach is to intentionally test it in everyday life. Unlike some of the counseling theories presented in this book, this approach can actually be tested in everyday life. Rogers believed that humans naturally respond to persons who demonstrate genuine interest in and concern for them. In order to test this proposition, try “being Carl Rogers” for an hour or two, perhaps on your next trip to the mall. Whenever you encounter another shopper or salesperson, attempt some form of authentic communication with them (remember, you cannot fake being authentic). If a salesperson seems a bit rude or abrupt with you while checking out, try to communicate your awareness of her feelings in a nonconfrontational way, perhaps with a comment like “You seem a bit overwhelmed. I hope it’s nothing I did.” If she is particularly helpful, acknowledge this as well. The important thing here is to notice the reactions of other people if you take but a moment or two to acknowledge their status as fellow human beings.

**Unconditional Positive Regard**

Rogers thought it essential that counselors be able to demonstrate acceptance, warmth, and the prizing of clients regardless of their actions or attitudes. Are there certain types of clients for whom you could not demonstrate unconditional positive regard (for example, for a client who had molested a child or battered a spouse)? Counselors have an ethical responsibility to avoid counseling clients for whom they could not work effectively, including clients whose behaviors they find objectionable. Make a list for yourself of personal characteristics or behaviors that, if demonstrated by a client, would make it hard for you to work with her. Discuss your list with another person or a small group.

**Identifying Feelings**

A key component of person-centered counseling is identifying a client’s feelings. One way to practice identifying feelings is by listening to different types of music—jazz, rock, folk, country, etc. For each song, attempt to label the predominant feeling being expressed. This activity should be done in a group if possible so that you can compare the different feelings that the group members express.

**Building a Feeling Vocabulary**

Although Rogers cautioned against being “analytical” in labeling feelings, many authors of counseling training texts emphasize the importance of having a rich feeling vocabulary—in other words, having a variety of feeling words so that one can be as accurate as possible when responding to the
feelings of others. Individually or in a group, make as long a list as you can of all the positive and negative feeling words that you can remember.

**The Person-Centered Approach: A Copernican Revolution?**

In his book *Carl Rogers on Personal Power* (1977), Rogers described how a social revolution based on person-centered principles might transform society. To counter skeptics, he pointed out that in the past many "knew" the earth was flat before Copernicus and Galileo proved them wrong and that many people "knew" that invisible micro-organisms could not possibly cause human diseases until they were also proven wrong. In this book, he attempted to debunk the "common sense" view that people are not inherently good and growth seeking with contradictory evidence.

Below are several examples of such beliefs, with contrasting arguments from Rogers. For each example, compare the "common sense" statement with that of Rogers. Which position seems correct to you? Discuss your judgments with another person or a small group. Remember, as you discuss each topic, to try to understand each person’s point of view in a nonjudgmental way.

**Example 1:**

"*Common sense*" says: It is hopelessly idealistic to think that the human organism is basically trustworthy.

*Rogers’s view*: Research tends to confirm the notion that people are trustworthy.

**Example 2:**

"*Common sense*" says: A family or marriage without a recognized strong authority is doomed to failure.

*Rogers’s view*: Where control is shared, where the facilitative conditions are present, it has been demonstrated that vital, sound, enriching relationships occur.

**Example 3:**

"*Common sense*" says: We must assume responsibility for young people, since they are not capable of self-government. It is stupid to think otherwise.

*Rogers’s view*: In a facilitative climate, responsible behavior develops and flowers in young and old alike.

**Example 4:**

"*Common sense*" says: Teachers must be in control of their students.

*Rogers’s view*: It has been established that where teachers share their power and trust their students, self-directed learning takes place at a greater rate than in teacher-controlled classrooms.

**Example 5:**

"*Common sense*" says: Deep religious feuds and cultural and racial bitterness are hopeless. It is a fantasy to think these factions can be reconciled.
Rogers's view: The fact is that small-scale examples exist in abundance to show that improved communication, a reduction in hostility, and steps toward resolving the tensions are entirely possible and rest on intensive group approaches.

Example 6:

"Common sense" says: It is obvious that in any organization there has to be one boss. Any other idea is preposterous.

Rogers's view: It has been substantiated that leaders who trust organization members, who share and diffuse power, and who maintain open personal communication create better morale, have more productive organizations, and facilitate the development of new leaders. (Rogers, 1977, pp. 287–290. Reprinted by permission of SLI/Sterling Lord Literistic, Inc. Copyright by Carl R. Rogers.)

Practicing Listening/Empathy Skills

Work with a triad, with one person as listener, one as speaker, and one as feedback giver. Have the speaker describe an event or experience to the listener. The listener's job is just to be a good listener and express understanding of the event or experience and the person's feelings related to the situation. After a few minutes, stop and have the feedback giver provide feedback to the listener about what she saw. Also have the speaker discuss how she reacted to the listener, and in particular if she felt understood. Let each person play each role.

Companion Website

Now go to the Companion Web site at www.prenhall.com/archer to assess your understanding of chapter content with multiple-choice and essay questions, and broaden your knowledge with related Web resources and additional print resources.
Family Systems Therapy

Co-authored by James Robert Bitter and Gerald Corey

1. Introduction
   - The Family Systems Perspective
   - Differences Between Systemic and Individual Approaches

2. The Development of Family Systems Therapy
   - Adlerian Family Therapy
   - Multigenerational Family Therapy
   - Human Validation Process Model
   - Experiential Family Therapy
   - Structural Strategic Family Therapy
   - Recent Innovations

3. A Multilensed Process of Family Therapy
   - Forming a Relationship
   - Conducting an Assessment
   - Hypothesizing and Sharing Meaning
   - Facilitating Change

4. Family Systems Therapy From a Multicultural Perspective
   - Strengths From a Diversity Perspective
   - Shortcomings From a Diversity Perspective

5. Family Systems Therapy Applied to the Case of Stan

6. Summary and Evaluation
   - Contributions of Family Systems Approaches
   - Limitations and Criticisms of Family Systems Approaches

7. Where to Go From Here
   - Recommended Supplementary Readings
   - References and Suggested Readings
Contributors to Family Systems Theory

Family systems theory is represented by a variety of theories and approaches, all of which focus on the relational aspects of human problems. Some of the individuals most closely associated with the origins of these systemic approaches are featured here.

ALFRED ADLER was the first psychologist of the modern era to do family therapy using a systemic approach. He set up more than 30 child guidance clinics in Vienna after World War I, and later Rudolf Dreikurs brought this concept to the United States in the form of family education centers. Adler conducted family counseling sessions in an open public forum to educate parents in greater numbers; he believed the problems of any one family were common to all others in the community (Christensen, 2004).

MURRAY BOWEN (1978) was one of the original developers of mainstream family therapy. Much of his theory and practice grew out of his work with schizophrenic individuals in families. He believed families could best be understood when analyzed from a three-generation perspective because patterns of interpersonal relationships connect family members across generations. His major contributions include the core concepts of differentiation of the self and triangulation.

VIRGINIA SATIR (1983) developed conjoint family therapy, a human-validation process model that emphasizes communication and emotional experiencing. Like Bowen, she used an intergenerational model, but she worked to bring family patterns to life in the present through sculpting and family reconstructions. Claiming that techniques were secondary to relationship, she concentrated on the personal relationship between therapist and family to achieve change.

CARL WHITAKER (1976) is the creator of symbolic-experiential family therapy, a freewheeling, intuitive approach to helping families open channels of interaction. His goal was to facilitate individual autonomy while retaining a sense of belonging in the family. He saw the therapist as an active participant and coach who enters the family process with creativity, putting enough pressure on this process to produce change in the status quo.
SALVADOR MINUCHIN (1974) began to develop structural family therapy in the 1960s through his work with delinquent boys from poor families at the Willwyck School in New York. Working with colleagues at the Philadelphia Child Guidance Clinic in the 1970s, Minuchin refined the theory and practice of structural family therapy. Focusing on the structure, or organization, of the family, the therapist helps the family modify its stereotyped patterns and redefine relationships among family members. He believed structural changes in families must occur before individual members’ symptoms could be reduced or eliminated.

JAY HALEY had a significant impact on the development of strategic family therapy (Haley, 1963). He blended structural family therapy with the concepts of hierarchy, power, and strategic interventions. Strategic family therapy is a pragmatic approach that focuses on solving problems in the present; understanding and insight are neither required nor sought. In his last book, Directive Family Therapy (2007), Haley elaborates even further on the importance of carefully formulating productive creative directives within the social situation for therapeutic change.

CLOE MADANES (1931), with Jay Haley, established the Family Institute in Washington, D.C. in the 1970s. Through their combined therapy practice, writings, and training of family therapists, strategic family therapy became the most popular family therapy approach by the 1980s. This is a brief, problem-solving therapy approach. The problem brought by the family to therapy is treated as “real”—not a symptom of underlying issues—and is solved. Her emphasis is on the caring and emotional aspects of family patterns.

Introduction

Although the seeds of a North American family therapy movement were planted in the 1940s, it was during the 1950s that systemic family therapy began to take root (Becvar & Becvar, 2006). During the early years of its evolution, working with families was considered to be a revolutionary approach to treatment. In the 1960s and 1970s, psychodynamic, behavioral, and humanistic approaches (called the first, second, and third force, respectively) dominated counseling and psychotherapy. Today, the various approaches to family systems represent a paradigm shift that we might even call the “fourth force.”

The Family Systems Perspective

Perhaps the most difficult adjustment for counselors and therapists from Western cultures is the adoption of a “systems” perspective. Our personal experience and
Western culture often tell us that we are autonomous individuals, capable of free and independent choice. And yet we are born into families—and most of us live our entire lives attached to one form of family or another. Within these families, we discover who we are; we develop and change; and we give and receive the support we need for survival. We create, maintain, and live by often unspoken rules and routines that we hope will keep the family (and each of its members) functional.

In this sense, a family systems perspective holds that individuals are best understood through assessing the interactions between and among family members. The development and behavior of one family member is inextricably interconnected with others in the family. Symptoms are often viewed as an expression of a set of habits and patterns within a family. It is revolutionary to conclude that the identified client’s problem might be a symptom of how the system functions, not just a symptom of the individual’s maladjustment, history, and psychosocial development. This perspective is grounded on the assumptions that a client’s problematic behavior may (1) serve a function or purpose for the family, (2) be unintentionally maintained by family processes, (3) be a function of the family’s inability to operate productively, especially during developmental transitions, or (4) be a symptom of dysfunctional patterns handed down across generations. All these assumptions challenge the more traditional intrapsychic frameworks for conceptualizing human problems and their formation.

The one central principle agreed upon by family therapy practitioners, regardless of their particular approach, is that the client is connected to living systems. Attempts at change are best facilitated by working with and considering the family or relationship as a whole. Therefore, a treatment approach that comprehensively addresses the family as well as the “identified patient” is required. Because a family is an interactional unit, it has its own set of unique traits. It is not possible to accurately assess an individual’s concern without observing the interaction of the other family members, as well as the broader contexts in which the person and the family live. Because the focus is on interpersonal relationships, Becvar and Becvar (2006) maintain that family therapy is a misnomer and that relationship therapy is a more appropriate label.

Family therapy perspectives call for a conceptual shift because the family is viewed as a functioning unit that is more than the sum of the roles of its various members. Actions by any individual family member will influence all the others in the family, and their reactions will have a reciprocal effect on the individual. Goldenberg and Goldenberg (2008) point to the need for therapists to view all behavior, including all symptoms expressed by the individual, within the context of the family and society. They add that a systems orientation does not preclude dealing with the dynamics within the individual, but that this approach broadens the traditional emphasis on individual internal dynamics.

**Differences Between Systemic and Individual Approaches**

There are significant differences between individual therapeutic approaches and systemic approaches. A case may help to illustrate these differences. Ann, age 22, sees a counselor because she is suffering from a depression that has
lasted for more than 2 years and has impaired her ability to maintain friendships and work productively. She wants to feel better, but she is pessimistic about her chances. How will a therapist choose to help her?

Both the individual therapist and the systemic therapist are interested in Ann's current living situation and life experiences. Both discover that she is still living at home with her parents, who are in their 60s. They note that she has a very successful older sister, who is a prominent lawyer in the small town in which the two live. The therapists are impressed by Ann's loss of friends who have married and left town over the years while she stayed behind, often lonely and isolated. Finally, both therapists note that Ann's depression affects others as well as herself. It is here, however, that the similarities tend to end:

<table>
<thead>
<tr>
<th><strong>The individual therapist may:</strong></th>
<th><strong>The systemic therapist may:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus on obtaining an accurate diagnosis, perhaps using the DSM-IV-TR (American Psychiatric Association, 2000)</td>
<td>Explore the system for family process and rules, perhaps using a genogram</td>
</tr>
<tr>
<td>Begin therapy with Ann immediately</td>
<td>Invite Ann's mother, father, and sister into therapy with her</td>
</tr>
<tr>
<td>Focus on the causes, purposes, and cognitive, emotional, and behavioral processes involved in Ann's depression and coping</td>
<td>Focus on the family relationships within which the continuation of Ann's depression &quot;makes sense&quot;</td>
</tr>
<tr>
<td>Be concerned with Ann's individual experiences and perspectives</td>
<td>Be concerned with transgenerational meanings, rules, cultural, and gender perspectives within the system, and even the community and larger systems affecting the family</td>
</tr>
</tbody>
</table>

Intervene in ways designed to help Ann cope | Intervene in ways designed to help change Ann's context |

Systemic therapists do not deny the importance of the individual in the family system, but they believe an individual's systemic affiliations and interactions have more power in the person's life than a single therapist could ever hope to have. By working with the whole family—or even community—system, the therapist has a chance to observe how individuals act within the system and participate in maintaining the status quo; how the system influences (and is influenced by) the individual; and what interventions might lead to changes that help the couple, family, or larger system as well as the individual expressing pain.

In Ann's case, her depression may have organic, genetic, or hormonal components. It may also involve cognitive, experiential, or behavioral patterns that interfere with effective coping. Even if her depression can be explained in this manner, however, the systemic therapist is very interested in how her depression affects others in the family and how it influences family process. Her depression
may signal both her own pain and the unexpressed pain of the family. Indeed, many family systems approaches would investigate how the depression serves other family members; distracts from problems in the intimate relationships of others; or reflects her need to adjust to family rules, to cultural injunctions, or to processes influenced by gender or family life-cycle development. Rather than losing sight of the individual, family therapists understand the person as specifically embedded in larger systems.

The Development of Family Systems Therapy

Family systems theory has evolved throughout the past 100 years, and today therapists creatively employ various perspectives when tailoring therapy to a particular family. This section presents a brief historical overview of some of the key figures associated with the development of family systems therapy.

Adlerian Family Therapy

Alfred Adler was the first psychologist of the modern era to do family therapy (Christensen, 2004). His approach was systemic long before systems theory had been applied to psychotherapy. Adler’s original conceptualizations can still be found within the principles and practice of other models.

Adler (1927) was the first to notice that the development of children within the family constellation (his phrase for family system) was heavily influenced by birth order. Adler was a phenomenologist, and even though birth order appeared to have some constancy to each position, he believed it was the interpretations children assigned to their birth positions that counted. Adler also noted that all behavior was purposeful—and that children often acted in patterns motivated by a desire to belong, even when these patterns were useless or mistaken.

It was Rudolf Dreikurs (1950, 1973), however, who refined Adler’s concepts into a typology of mistaken goals and created an organized approach to family therapy. A basic assumption of modern Adlerian family therapy is that both parents and children often become locked in repetitive, negative interactions based on mistaken goals that motivate all parties involved. Although much of Adlerian family therapy is conducted in private sessions, Adlerians also use an educational model to counsel families in open forums in schools, community agencies, and specially designated family education centers.

Multigenerational Family Therapy

Murray Bowen (1978) was one of the developers of mainstream family therapy. His family systems theory, which is a theoretical and clinical model that evolved from psychoanalytic principles and practices, is sometimes referred to as multigenerational family therapy. Bowen and his associates implemented an innovative approach to schizophrenia at the National Institute of Mental Health where Bowen actually hospitalized entire families so that the family system could be the focus of therapy.
Bowen's observations led to his interest in patterns across multiple generations. He contended that problems manifested in one's current family will not significantly change until relationship patterns in one's family of origin are understood and directly challenged. His approach operates on the premise that a predictable pattern of interpersonal relationships connects the functioning of family members across generations. According to Kerr and Bowen (1988), the cause of an individual's problems can be understood only by viewing the role of the family as an emotional unit. Within the family unit, unresolved emotional fusion to one's family must be addressed if one hopes to achieve a mature and unique personality. Emotional problems will be transmitted from generation to generation until unresolved emotional attachments are dealt with effectively. Change must occur with other family members and cannot be done by an individual in a counseling room.

One of Bowen's key concepts is triangulation, a process in which triads result in a two-against-one experience. Bowen assumed that triangulation could easily happen between family members and the therapist, which is why Bowen placed so much emphasis on his trainees becoming aware of their own family-of-origin issues (Kerr & Bowen, 1988).

A major contribution of Bowen's theory is the notion of differentiation of the self. Differentiation of the self involves both the psychological separation of intellect and emotion and independence of the self from others. In the process of individuation, individuals acquire a sense of self-identity. This differentiation from the family of origin enables them to accept personal responsibility for their thoughts, feelings, perceptions, and actions.

**Human Validation Process Model**

At about the same time that Bowen was developing his approach, Virginia Satir (1983) began emphasizing family connection. Her therapeutic work had already led her to believe in the value of a strong, nurturing relationship based on interest and fascination with those in her care. She thought of herself as a detective who sought out and listened for the reflections of self-esteem in the communication of her clients. It was while working with an adolescent girl that it occurred to her to ask about her mother. She was surprised by how her client's communication and behavior changed when the mother was present. As she worked out their relationship, it again occurred to her to ask about a father. When he came in, the communication and behavior of both the mother and daughter changed. It was in working through this process that Satir discovered the power of family therapy, the importance of communication and metacommunication in family interaction, and the value of therapeutic validation in the process of change (Satir & Bitter, 2000).

Over her lifetime as a family therapist, Satir gained international fame and developed many innovative interventions. She was highly intuitive and believed spontaneity, creativity, humor, self-disclosure, risk-taking, and personal touch were central to family therapy. In her view, techniques were secondary to the relationship the therapist develops with the family. Her experiential and humanistic approach came to be called the human validation process model, but her early work with families was best known as conjoint family therapy (Satir, 1983).
Experiential Family Therapy

Carl Whitaker (1976) was a pioneer in experiential family therapy, sometimes known as the experiential-symbolic approach. Clearly an application of existential therapy to family systems, Whitaker stressed choice, freedom, self-determination, growth, and actualization (Whitaker & Bumberry, 1988). Like Satir and other existential approaches, Whitaker stressed the importance of the relationship between the family and the therapist. Whitaker was clearly more confrontive in his “realness” than was Satir, who was more nurturing. Whitaker’s interventions were almost always enacted with co-therapists. Toward the end of his life, he would only see families, and he even tried to get community and work associates of the family to come in.

Whitaker’s freewheeling, intuitive approach sought to unmask pretense and create new meaning while liberating family members to be themselves. Whitaker did not propose a set of methods; rather, it is the personal involvement of the therapist with a family that makes a difference. When techniques are employed, they arise from the therapist’s intuitive and spontaneous reactions to the present situation and are designed to increase clients’ awareness of their inner potential and to open channels of family interaction.

For Whitaker, family therapy was a way for therapists to be actively engaged in their own personal development. Indeed, therapy might actually help the therapist as much as the family. Whitaker saw his role as creating with the family a context in which change can occur through a process of reorganization and reintegration (Becvar & Becvar, 2006).

Structural-Strategic Family Therapy

The origins of structural family therapy can be traced to the early 1960s when Salvador Minuchin was conducting therapy, training, and research with delinquent boys from poor families at the Wiltwyck School in New York. Minuchin’s (1974) central idea was that an individual’s symptoms are best understood from the vantage point of interactional patterns within a family and that structural changes must occur in a family before an individual’s symptoms can be reduced or eliminated. The goals of structural family therapy are twofold: (1) reduce symptoms of dysfunction and (2) bring about structural change within the system by modifying the family’s transactional rules and developing more appropriate boundaries.

In the late 1960s Jay Haley joined Minuchin at the Philadelphia Child Guidance Clinic. The work of Haley and Minuchin shared so many similarities in goals and process that many clinicians in the 1980s and 1990s would question whether the two models were distinct schools of thought. Indeed, by the late 1970s, structural-strategic approaches were the most used models in family systems therapy. Both models seek to reorganize dysfunctional or problematic structures in the families; boundary setting, unbalancing, reframing, ordeals, and enactments all became part of the family therapeutic process. Neither approach deals much with exploration or interpretation of the past. Rather, it is the job of structural-strategic therapists to join with the family, to block stereotyped interactional patterns, to reorganize family hierarchies or subsystems, and to facilitate the development of more flexible or useful transactions.
The structural and strategic models differ somewhat in how each view family problems: Minuchin (1974) tends to see individual and family difficulties as symptomatic whereas Haley (1976) sees them as "real" problems that need real answers. Both models are directive in nature, and both expect therapists to have a certain level of expertise to bring to the family therapy process.

In 1974, Haley and Clöé Madanes started the Family Therapy Institute of Washington, D.C. For more than 15 years they wrote, developed therapeutic practice, and provided intensive training in strategic family therapy. Their strategic approach views presenting problems as both real and as metaphors for system functioning. Considerable emphasis is given to power, control, and hierarchies in families and in the therapy sessions. Haley's more recent work has also emphasized the importance of cultural embeddedness (Haley & Richeport-Haley, 2003).

Haley (1984) and Madanes (1981) have been more interested in the practical applications of strategic interventions to ameliorate a family's problems than in formulating a theory of therapy distinct from the structural model. This is especially evident in Madanes's (1990) model for working with families that include a sex offender. Madanes brought a humanistic perspective to strategic therapy by addressing the need to be loved and by emphasizing the nurturing aspects of therapy.

**Recent Innovations**

In the last decade, feminism, multiculturalism, and postmodern social constructionism have all entered the family therapy field. These models are more collaborative, treating clients—individuals, couples, or families—as experts in their own lives. The therapeutic conversations start with the counselor in a "de-centered" or "not-knowing" position in which the client is approached with curiosity and interest. The therapist is socially active and aids clients in taking a stand against the dominant culture that oppresses them. Therapy often incorporates "reflecting teams" or "definitional ceremonies" to bring multiple perspectives to the work (see West, Bubenzer, & Bitter, 1998).

This brief discussion of the various systemic viewpoints in family therapy provides a context for understanding the development of family therapy. Table 14.1 outlines the differences in these historical perspectives. For an in-depth treatment of the schools of family therapy, see Bitter's (2009) *Theory and Practice of Family Therapy and Counseling*. See also the recommended readings at the end of the chapter.

**Eight Lenses In Family Systems Therapy**

To think and practice within the multiple perspectives that family systems therapy requires is no easy task. In 1992, Breunlin, Schwartz, and MacKune-Karrer (1997) introduced the concept of metaframeworks as a means for transcending the various approaches to family therapy, and they identified six core metaframeworks that function as therapeutic lenses. Taken together, these lenses provide six different perspectives from which a family system might be assessed and a "blueprint for therapy" (p. 281) developed.
<p>| <strong>TABLE 14.1</strong> A Comparison of Six Systemic Viewpoints in Family Therapy |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| <strong>Key figures</strong>             | <strong>Adlerian Family Therapy</strong> | <strong>Multi-Generational Family Therapy</strong> | <strong>Human Validation Process Model</strong> | <strong>Experiential/Symbolic Family Therapy</strong> | <strong>Structural Family Therapy</strong> |
|                             | Alfred Adler                | Murray Bowen                | Virginia Satir               | Carl Whitaker                | Salvador Minuchin            |
|                             | Rudolf Dreikurs             |                             |                             |                             | Jay Haley &amp; Cloé Madanes     |
|                             | Oscar Christensen &amp; Manford Sonstegard |             |                             |                             |                             |
| <strong>Time focus</strong>              | Present with some reference to the past | Present and past: family of origin; three generations | Here and now | Present | Present and past |
|                             |                             |                             |                             |                             | Present and Future |
| <strong>Therapy goals</strong>           | Enable parents as leaders; unlock mistaken goals and interacational patterns in family; promotion of effective parenting | Differentiate the self; change the individual within the context of the system; decrease anxiety | Promote growth, self-esteem, and connection; help family reach congruent communication and interaction | Promote spontaneity, creativity, autonomy, and ability to play | Restructure family organization; change dysfunctional transactional patterns |
|                             |                             |                             |                             |                             | Eliminate presenting problem; change dysfunctional patterns; interrupt sequence |</p>
<table>
<thead>
<tr>
<th>Role and function of the therapist</th>
<th>Educator; motivational investigator; collaborator</th>
<th>Guide, objective researcher, teacher; monitor of own reactivity</th>
<th>Active facilitator; resource detective; model for congruence</th>
<th>Family coach; challenger; model for change through play</th>
<th>&quot;Friendly uncle&quot;; stage manager; promoter of change in family structure</th>
<th>Active director of change; problem solver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process of change</td>
<td>Formation of relationship based on mutual respect; investigation of birth order and mistaken goals, re-education</td>
<td>Questions and cognitive processes lead to differentiation and understanding of family of origin</td>
<td>Family is helped to move from status quo through chaos to new possibilities and new integrations</td>
<td>Awareness and seeds of change are planted in therapy confrontations</td>
<td>Therapist joins the family in a leadership role; changes structure; sets boundaries</td>
<td>Change occurs through action-oriented directives and paradoxical interventions</td>
</tr>
<tr>
<td>Techniques and innovations</td>
<td>Family constellation; typical day; goal disclosure; natural/logical consequences</td>
<td>Genograms; dealing with family-of-origin issues; detriangulating relationships</td>
<td>Empathy; touch, communication; sculpting; role playing; family-life chronology</td>
<td>Co-therapy; self-disclosure; confrontation; use of self as change agent</td>
<td>Joining &amp; accommodating; unbalancing; tracking; boundary making; enactments</td>
<td>Reframing; directives and paradox; amplifying; pretending; enactments</td>
</tr>
</tbody>
</table>
The original six metaframeworks are internal family systems (or individual), sequences (or patterns of interaction), organization (of the system), developmental, multicultural, and gender. Two recent additions are teleological (or goal-orientation) and process lenses. Any or all of these eight lenses may have meaningful applications with a given couple or family. Furthermore, each influence is influenced by the other seven perspectives, a feature common to all systems theories. Using this approach, therapists can draw on multiple perspectives rather than being locked into a single viewpoint. The lenses can be used for assessment as well as to tailor therapeutic interventions to the specific needs of the family (Carlson, Sperry, & Lewis, 2005; Goldenberg & Goldenberg, 2008). These eight lenses provide a foundation for integrating the various models of family systems therapy.

The Individual's Internal Family System

Although Richard Schwartz (1995) is credited with the development of internal family systems, he is not the only therapist to have noticed that there are parts to an individual's personality. Virginia Satir used several avenues to gain access to various parts of the self, including a phenomenological family mapping process, a wheel of influence, and a self-mandala (Satir, Banman, Gerber, & Gamori, 1991). Her most ingenious process was called “the parts party” (p. 175), which involves a psychodramatic integration and transformation of extreme parts. The parts party was especially effective when working with a couple in conflict (Bitter, 1993b). But perhaps the most complete approach to working with parts was developed by Erving Polster (1995), a key figure in Gestalt therapy.

Each of these theorists and practitioners has made contributions to a lens that views the individual as an organismic system, complete with structure, organization, and subsystems. An individual has many parts, or dimensions, to his or her personality. Some of these facets of personality are self-enhancing, and some are self-destructive. Some of these aspects may be physical, cognitive, emotional, social, or spiritual. Some are used more than others. These parts emanate from our social interactions and developmental experiences. They are often evaluative in nature, declaring something about who we are and what has meaning to us: “all parts, in their nonextreme, natural state, want something positive for the person and desire to play a valuable role in the internal system” (Breunlin et al., 1997, p. 66). It is when parts become polarized and extreme—or needed parts seem inaccessible—that individuals experience internal conflict.

Stan’s problems with alcohol are causing him to experience such a conflict, and a therapist might explore with Stan the different parts of himself that draw him toward alcohol and those that help him refrain from drinking. Every therapist-practitioner who works with the concepts of internal parts posits a super-entity that integrates, governs, organizes, and selects essential parts. That entity, known as the self or the person, is the “whole” of the individual system—that which operates the rest of the parts. Stan is currently struggling with such a reorganization of his internal parts.
The Teleological Lens

Teleology refers to the study of final causes, goals, endpoints, and purposes. The teleological lens enables the family therapist to develop an understanding of what motivates individual behavior, the systemic purposes of symptoms, the goals of triangulation, and the uses of patterned interactions and routines.

Purposeful actions promote growth and development when they are characterized by reasonable risk, courage, confidence, self-esteem, energy, optimism, hope, and sequences of experience that open even wider possibilities for experience. Alternatively, actions and interactions characterized by retreat, fear, and protection tend to constrain growth and development. Both individuals and families-as-a-whole act purposively.

The teleological lens is associated with the Adlerian, Bowenian, structural, and strategic approaches to family therapy. Adlerian family therapists make particular use of this lens. Purposive action and life goals are central to an Adlerian understanding of individual, internal family systems, called lifestyle assessments (see Chapter 5). Adlerians also use Kefir’s (1981) personality priorities (significance, pleasing, control, and comfort) to understand impasses and goals during couples counseling. Personality priorities are closely related to Satir’s (1988) communication stances (blaming, placating, super reasonable, and irrelevant, respectively) and can be understood as the goals of dysfunctional communication (Bitter, 1993a).

In Adlerian family therapy, goal orientation and recognition are central for understanding motivations of parents and children—and for unlocking mistaken interactions (Bitter, Roberts, & Sonstegard, 2002; Christensen, 2004). Dreikurs first delineated four goals of children’s misbehavior as a motivational typology for the everyday behaviors of children. These goals are attention getting, power struggle, revenge, and a demonstration of inadequacy (also called an assumed disability). They act as “shorthand [explanations of] consistent patterns of misbehavior in children” (Bitter, 1991, p. 210). Dreikurs (1950; Dreikurs & Soltz, 1964) developed a systematic approach to goal recognition based on (a) descriptions of the child’s misbehavior, (b) the parents’ reactions to the misbehavior, and (c) the child’s reaction to the parents’ attempts at discipline.

The teleological lens is central to Adlerian family therapy, but it can be used in any model that includes assessment and the generation of meaning as well as for interventions such as reframing, or putting what is known into a new, more useful perspective. Family therapists often reframe difficult behaviors by noting the motivation or personal intentions behind the behaviors. Reframing begins by asking these kinds of questions:

- What purpose does this symptom, interaction, or process serve?
- How does the individual’s behavior protect the self and the family system?
- What are the social consequences of an action or interaction?
- Do the goals of family members appear to be at cross-purposes, but still serve to maintain the system?
- Are the goals of the family at odds with the goals of therapy?
Sequences: Tracking Patterns of Interaction

One of the defining aspects of family life is that it is ordered, and family members tend to interact in sequences that, over time, are repeated in multiple forms. Breunlin and his colleagues (1997) refer to these patterns as embedded sequences, and they occur at multiple levels within the sequencing metaframework.

Level 1 sequences occur between two or more family members who are face to face. The face-to-face sequence can be diagramed as follows:

- Father confronts → Daughter enacts hurt → Mother rescues daughter. and helplessness. daughter.

Level 2 sequences support the functioning of the family and become accepted as routines. These sequences support processes that are typical of the family and tend to be enacted almost daily. Adlerians initiated the idea of asking family members to describe a “typical day” (Bitter et al., 2002), and this information has become increasingly important for family therapists working with many different models. Here is an example of the morning routine for one family:

- Father gets up first and wakes oldest daughter.
- Oldest daughter gets up, gets dressed, and feeds dog.
- Mother gets up and wakes 3-year-old daughter.
- Father fixes breakfast for children while mother dresses 3-year-old.
- Children eat. Oldest daughter fixes lunches while mother and father dress.
- Parents grab bagels. Everyone leaves for school and work.

In this sequence, individual roles support a smooth process for the whole system. If any part of this routine stops or breaks down, the whole system must adjust.

Level 3 sequences have to do with the ebbs and flows of life. These much longer sequences often account for family adjustments to outside forces or developmental changes. The classic leaving home sequence is an example for strategic therapists (Haley, 1980):

1. The child, who has distracted the spousal couple from their relational problems for many years, gets ready to leave for college.
2. Anxiety goes up, and when the young person actually leaves, open conflict, threatening divorce, breaks out.
3. The young person becomes symptomatic at school, requiring a return home, and parental conflict seems to disappear.

When Level 1 and 2 sequences effectively resolve difficulties, the ebbs and flows that constitute the processes of family change at Level 3 also tend to find a functional balance.
Level 4 sequences are *transgenerational*. They include sequences that reflect larger system values and rules about culture or gender roles. These sequences are passed from one generation to the next and are intended to provide a sense of continuity to life. In our discussion of the case of Stan later in the chapter, you will see how the use of alcohol has affected the family over at least three generations and has become part of the family culture.

Adaptive sequences require leadership that is balanced, fair, and cooperative. Maladaptive sequences occur when rules are rigid and inflexible, when parts are polarized, and when change is resisted. Family therapy is often about developing more useful sequences at any or all of these four levels.

**The Organization Lens**

Individuals and families have some organizing process that holds everything together and provides a sense of unity. In family systems, organization is manifest in family rules, routines, rituals, and expected roles (that is, the living structure of the family). In the early years of family therapy, emphasis was given to the concept of the hierarchical structure of the family system, and strategic interventions were designed to establish a more functional hierarchy and to redistribute the power in the system toward more productive ends.

Breunlin and his colleagues (1997) take a more collaborative approach with families and have replaced the idea of hierarchy with the idea of *leadership*. Collaboration is found in mutual or egalitarian relationships between couples, and the function of leadership in the family is to organize the system in clear, useful ways. For each of the parts to grow and develop as well as contribute to the family as a whole, there must be room for involving members in the decision-making processes; reasonable access to family resources; and appropriate responsibility for self and the system as a whole. In general, the leadership of families works best in the hands of adults—people with some maturity and life experience who parent out of choice and a desire to raise the next generation.

To this concept of leadership, Breunlin and his colleagues (1997) add the concept of *balance*:

In balanced systems, [the members] cooperate, are willing to sacrifice some of their individual interests for the greater good, care about one another and feel valued by the larger system, and have clear boundaries that allow a balance between belonging and separateness. (p. 136)

Balanced family leadership requires the ability to be firm, but friendly, and to set developmentally appropriate limits while remaining fair, flexible, and encouraging. In balanced families, individuality and connection to the family are both significant: both fit generational, cultural, and developmental needs. As children get older, balanced leadership shifts to more egalitarian, collaborative stances, and family processes tend to be cooperative, consistent, and caring. In effectively led families, children have a sense of safety, room to grow, and the belief that they are valued.
The Developmental Lens

Though the concept of development took hold in psychology in the 1940s, it did not enter the world of family systems therapy until the 1970s. Even then, many family therapists tended to eschew all that they had learned about individual development in favor of a developmental framework that focused on the nuclear family, a model called the family life cycle. Unlike individual development models that map the stages of life from birth onward, the family life cycle focuses on six significant transitions (Carter & McGoldrick, 2005):

1. A single, young adult leaves home to live a more or less independent life.
2. Individuals marry or become a couple to build a life together.
3. The couple has children and starts a family.
4. The children become adolescents.
5. The parents launch their children into the world and prepare to live a life without children.
6. The family reaches its later years where children may have to care for parents as well as their own children, and the parents prepare for the end of their lives.

Consider the case of Stan as an example of these transitional stages. Stan is currently in Stage 1 of the family life cycle. He is a young man struggling with the transition from living at home to an independent life. His parents are at Stage 5, struggling with issues related to launching Stan into the world. A complicating factor may be worries they have about living together without children.

The family life cycle perspective was an innovation in developmental literature that widened the conceptualization of development and gave it a decidedly systemic focus. It also depathologized many of the family life experiences that brought couples and families into therapy. The first presentations of the family life cycle were focused almost entirely on a two-parent, Caucasian, nuclear family, but today there are developmental models for single-parent families; remarried, blended, or stepfamilies; cross-generational, extended families; lesbian, gay, and bisexual families; families from diverse cultures; poverty and the family life cycle; and the effects of gender and roles in the family life cycle (Carter & McGoldrick, 2005).

Breunlin and his associates (1997) propose a developmental lens (metaframework) that reintegrates individual development with developmental perspectives on the family and society. Their model includes “five levels: biological, individual, subsystemic (relational), familial, and societal” (p. 159). Each level affects the other with no requirement of a specific order for growth and development. The focus of therapy is on whether individuals and families are achieving necessary levels of competence to facilitate growth and development.

At the societal level, individuals and families often incorporate the values and beliefs of the dominant culture in which they live (White & Epston, 1990). In the past, values and mores were passed along through contact with the extended family, and to some extent, this may still happen in some communities. We are, however, a global community now, and multiple forms of media have a tremendous influence on individual and familial experience (Gergen, 1991).
The power of the dominant culture on families is similar to the powerful influence parents have on young children. This power cannot be ignored. The value of examining the family life cycle can be both remedial (explain behavior viewed as dysfunction) and preventative (prepare the system for change), but it is important to remember that every family is also in the process of individual, relational, and societal development. Family therapy serves a valuable function in challenging patriarchy and other forms of dominant culture privilege, bias, or discrimination.

Change is inevitable and, indeed, it is life (Satir et al., 1991). In family therapy, growth and development are desired processes. Our belief in development and evolution is optimistic and hopeful. Family therapists address the needs of individuals while simultaneously considering the needs of relationships, the family, and larger systems. In assessing different levels, family therapists look for constraints and seek to remove them so that natural growth and transitions become possible once again (Breunlin et al., 1997).

The Multicultural Lens

Discrimination and oppression shape experiences and symptoms, and these factors are found in all cultures. The dominant culture organizes around two immediate goals, both related to power: (a) it reinforces itself and its values and (b) minimizes the power and influence of alternative positions and the people who hold them (Foucault, 1970, 1980). It is from this power base that all discrimination and oppression flow.

In the United States, the dominant power base is male, heterosexual, Caucasian, English-speaking, Eurocentric, Christian, 35–50 years of age, rich, and educated. Historical narratives are filled with phrases like “the divine right of kings,” “manifest destiny,” or “in the name of progress.” They all have to do with privilege, which includes the assumption that those who have it are both “normal” and “the norm.” Everything else is a deviation from normal. In every culture we can find those with vast amounts of privilege, and those who experience discrimination—who are marginalized, oppressed, or left out.

A multicultural lens challenges the privilege of the dominant culture and introduces diversity and complexity into our understanding of the human condition. By reframing the dominant culture as simply one of many, an appreciation and valuing of diversity is fostered. McGoldrick, Giordano, and Garcia-Preto (2005) describe the multiple cultures that comprise Europe and that have “blended” into the dominant culture we call “American.” This multiplicity challenges the notion that there is a single Western norm to which all people should aspire. As therapists, we do well to consider that our perspective might be biased and only one of many useful perspectives in understanding reality.

Breunlin and his colleagues (1997) describe both intracultural and intercultural experiences. Intracultural experiences and sequences happen within a cultural system. They serve as cultural definitions, give a sense of continuity to community life, and reinforce values and convictions specific to that culture. Intercultural experiences and sequences happen between (or even among) cultural systems. They are based on commonalities of experience that may exist across several cultures.
Ten areas of assessment assist family therapists in bringing a multicultural perspective to their work (Breunlia et al., 1997):

- Membership as an immigrant in a dominant society
- Level of economic privilege or poverty
- Level of education and process of learning
- Ethnicity
- Religion
- Gender
- Age
- Race, discrimination, and oppression
- Minority versus majority status
- Regional background

These assessment areas produce phenomenological meaning that may be different for each member of a family as well as for the therapist. Acknowledging areas of "fit" and areas of difference is foundational for most therapeutic processes. In Stan's family, the multigenerational relationships with alcohol may be based in particular cultural expectations about the use and abuse of this substance. An Irish family's values on this issue may differ significantly from those of an Arab family, for example. Family therapists must view each family through the appropriate multicultural lens in their work.

The Gender Lens

The oldest and most pervasive discrimination and oppression in the world is against women in all cultures, and with few exceptions, across the human life span. Feminists have challenged not only the fundamental precepts of family therapy (Luepnitz, 1988) but also the idea that the family, itself, is good for women (Hare-Mustin, 1978). Women still bear the largest responsibility for and most of the work related to child rearing, kin-keeping, homemaking, and community involvement. Financially, women tend to earn less than men in comparable positions. Even when women earn significant wages, they may not have much say in how the family finances are spent. Between a man and a woman, the woman is more likely to be expected to sacrifice herself for the good of the whole.

As you will recall from Chapter 12 on feminist therapy, the feminist impact on family therapy has led to a reconsideration of many central tenets (Silverstein & Goodrich, 2003). Family therapists have increasingly accepted an advocacy stance as part of their therapy. Therapists can no longer ignore their personal influence and their responsibility to challenge unequal status and treatment of women. Power positions, like hierarchy, enmeshment, and unbalancing—catchwords that have been associated with structural-strategic approaches to families for years—are slowly being replaced with ideas about leadership, connection, conversation, and collaboration.

In Stan's case, a consideration of gender might lead the therapist to examine stereotyped roles that Stan has experienced and still feels he must follow. We might also consider the ways in which masculine expectations regarding power and control, emotional restriction, achievement and success, and general dominance have affected his relationship with women.
The Process Lens

What is happening between people—the process of communication—is essential to experiential models of family therapy. The meaning of any communication is contained within the metacommunication: *How* we communicate contextualizes *what* we have to say. Process is also about our movement through significant events in life. *Clarity of process* tells us where we are and delineates where we are likely to go. It allows the therapist and the family to examine where they are in the flow of life, the process of change, and the experience of therapy.

To function effectively, couples and families create routines that enable them to meet the needs and demands of everyday life (Satir & Bitter, 2000). As long as these routines generally help and enable people within their living systems, they are maintained as the status quo. When essential routines are interfered with, the result is a disruption that throws a system out of balance. In the face of disruption, families may initially seek to retreat, but they generally fall into a state of chaos. Because chaos is experienced as crisis, family members often want to make huge decisions even though everything seems out of balance. Therapists immediately become one of the family’s external resources with a primary responsibility to help individuals reconnect with their internal resources and strengths, which are often not recognized.

Somewhat paradoxically, change is facilitated by staying present and by not trying to change anything at all. Staying with feelings and present experience, finding ways to become grounded and rebalanced, and reconnecting with useful internal parts and external resources help people to develop new possibilities. With support and practice, new possibilities become a new integration—a new routine and, therefore, a new status quo.

When sources of disruption are extreme, such as an affair in a relationship, a divorce, or a death, therapists often are challenged to deal with family members in chaos. For example, when Stan’s wife left him, Stan initially felt devastated and totally blamed himself for another failure. Using a process lens, a family therapist would acknowledge Stan’s hurt and fear but be open to exploring other feelings Stan may have, such as betrayal, disappointment, and hopelessness. The most direct route to get to these additional concerns is to simply stay focused on what Stan is feeling in the present.

The process of therapy is intimately connected to the process of change. Carl Whitaker (1976, 1989) used to play with both family process and the process of therapy. He did so with a co-therapist present during many years of therapy experience. Like most family therapists, he recognized that systems were more powerful than individuals—and that the family counselor can easily become triangulated or incorporated into the systemic processes of the family.

In a sense, Whitaker became a source of disruption that initiated the family into a new change process. In one session, he suggested that if the woman was depressed someone in the family must want her dead (Whitaker & Bumberry, 1988). This systems intervention goes beyond what the family is initially willing to consider and invites them into a shared responsibility for the welfare of the woman. At the heart of Whitaker’s therapy are these very important process questions.
What is the family doing with its time in therapy?
What are the family members experiencing, and what am I experiencing with each family member?
What place does my informed and educated intuition have in this therapeutic process?
What is my best use of self with this family?
What is happening right now?

The eight lenses described here are multidimensional and were developed across several models of family therapy. They serve as a basic structure for assessment. To use them effectively, however, the lenses must be integrated into a coherent therapeutic process. The next section clarifies how this might be done.

A Multilensed Process of Family Therapy

The eight lenses described in the previous section presuppose certain assumptions about families, the therapist, and family therapy. Families are multilayered systems that both affect and are affected by the larger systems in which they are embedded. Families can be described in terms of their individual members and the various roles they play, the relationships between the members, and the sequential patterns of the interactions. In addition, nuclear families in a global community are often part of extended, if distant, families; multiple families make up a community; multiple communities make up both regions and cultures, which in turn constitute nations (or society). The power of these macrosystems to influence family life—especially in the areas of gender and culture—is significant. Given our presuppositions about families and the larger systems in which families are embedded, a multilensed approach to family therapy is essential.

Several forms and structures have been proposed for integrative models of family counseling and therapy (e.g., Carlson, Sperry, & Lewis, 2005; Gladding, 2007; Hanna, 2007; Nichols, 2006, 2007; Worden, 2003). The integrative model we have chosen to present here is similar to the “blueprint for therapy” proposed by Breunlin and colleagues (1997, pp. 281–316), but it allows for an enlarged integration of ideas from multiple models of family therapy. Similar to a piece of classical music, the process of family therapy, it seems to us, has movements. These movements can be described as separate experiences embedded in the larger flow of therapy. In this section we describe four general movements, each with different tasks: forming a relationship, conducting an assessment, hypothesizing and sharing meaning, and facilitating change. In rare instances, these four movements might occur within a single session; in most cases, however, each movement requires multiple sessions.

Forming a Relationship

Over the years, family systems therapists have used a wide range of metaphors to describe the role of the therapist and the therapeutic relationship. As you have seen in the two previous chapters, in the last decade, the emergence of
feminist and postmodern models in therapy has moved the field of family therapy toward more egalitarian, collaborative, cooperative, co-constructing relationships (see Andersen, 1987, 1991; Anderson, 1993; Anderson & Goolishian, 1992; Epstein & White, 1992; Luepnitz, 1988).

The debate Carl Rogers (1980) first introduced to individual therapy in the 1940s has reemerged within family therapy in the form of these questions:

- What expertise does the therapist have in relation to the family, and how should that expertise be used?
- How directive should therapists be in relation to families, and what does that say about uses of power in therapy?

We believe a multilensed approach to family therapy is best supported by a collaborative therapist-client relationship in which mutual respect, caring, empathy, and a genuine interest in others is primary. In addition, we believe directed actions and enactments are most useful when they are a joint venture of both the therapist and the family.

Therapists begin to form a relationship with clients from the moment of first contact. In most cases, we believe therapists should make their own appointments, answer initial questions clients may have, and give clients a sense of what to expect when they come. This is also a time when counselors can let families know their position on whether all members should be present. Some family therapists will work with any of those members of the family who wish to come; others will only see the family if everyone is a part of the therapy session.

From the moment of first face-to-face contact, good therapeutic relationships start with efforts at making contact with each person present (Satir & Bitter, 2000). Whether it is called joining, engagement, or simple care and concern, it is the therapist's responsibility to meet each person with openness and warmth. Generally, a focused interest on each family member helps to reduce the anxiety the family may be feeling.

Therapeutic process and structure are part of the therapist's job description. It is important for family members to introduce themselves and to express their concerns, but the therapist should not focus too tightly on content issues. Understanding family process is almost always facilitated by how questions. Questions that begin with what, why, where, or when tend to overemphasize content details (Gladding, 2007).

Conducting an Assessment

The eight lenses we have proposed provide structure for conducting family assessments, but other assessment procedures, such as genograms (McGoldrick, Gerson, & Shellenberger, 1999), circular questioning, or even formal tests and rating scales (see, for example, Gottman, 1999), may also be useful.

As the therapist listens to family members describe their hopes for the family, it is often difficult to keep all eight perspectives going at once. Focusing on the meta-issues presented in content is one way to begin to select lenses that will provide meaning for the therapist and the family. For example, suppose Tammy is upsetting the family system by ignoring the curfew her parents have set for her. The therapist might ask: "What will happen if Tammy stays out past
curfew and is picked up by the police? Who will be most upset by this?” Here is her father’s reply:

I will probably be the most upset on the outside. I tend to go off before I think, and then I regret it later. On the other hand, her mother may not show it immediately, but her hurt will stay with her longer, and then she will get mad at me for “letting Tammy off the hook.” She will say that Tammy is manipulating me, but I just don’t see why we should keep fighting about things. It doesn’t do any good. We fight, and Tammy disappears. She wants to run with the big kids, some of whom are in college, over 18, and have no curfew.

The therapist might chose to select any one of these lenses for further inquiry:

* Internal Family Systems: Work with anger and guilt parts.
* Sequences: Work related to the sequential patterns for resolving conflict and handling problems.
* Gender Lens: Work related to the roles of men, women, and female children in families.
* Developmental Lens: Work around issues related to Tammy wanting to be older than she is.

In the assessment process, it is helpful to inquire about family perspectives on issues inherent in each of the lenses. We have already noted some questions related to a few of the lenses. Here are some starting questions for each lens that may be useful in a more detailed assessment.

* **Internal Family Systems**
  - What does each family member bring to the session?
  - How does each person describe who he or she is?
  - At times the various parts of an individual are polarized. Which parts cause internal conflicts for each member of the family?
  - Are certain parts of the family members being ignored?

* **The Teleological Lens**
  - What are the feelings and behaviors of various family members revealing about the situation?
  - What purpose is being served when the children interact with their parents in the way they do?
  - What are the goals of each family member? What goals does each family member have for the other people in the family?

* **Sequences**
  - What routines support the daily living of each member of the family?
  - Who makes decisions? How are conflicts resolved or problems handled?
  - What parts are involved in the most common sequences in the family?
  - What is a typical day like?
  - What processes, patterns, or sequences characterize current or past transitions for the family?
The Organization Lens

- Are the parents effective leaders of the family?
- How do the children respond to parental leadership?
- Is the process of leadership balanced or imbalanced?
- Does it lead to harmony or conflict?
- Does the family need further education about effective leadership, or are there internal parts that constrain such leadership?

The Developmental Lens

- Where is each person in the family in relation to personal biological, cognitive, emotional, and social development?
- Where is the family in the family life cycle, and how are they handling transitions?
- What relational processes have developed over time, and how have they changed or developed through transitional periods?
- What developments in larger systems (especially society or the world) are affecting the family?

The Multicultural Lens

- What cultures are in the family backgrounds of each of the family members?
- In what culture or region is the family currently living?
- Is immigration or migration a recent family experience?
- How do economics, education, ethnicity, religion, race, regional background, gender, and age affect family processes?
- How is the fit between the therapist and the family with regard to economics, education, ethnicity, religion, gender, age, race, majority/minority status, and regional background?

The Gender Lens

- What gender role is each member of the family assuming?
- What effects has patriarchy had on this family and its members?
- Where are family members in terms of gender development: traditional, gender-aware, polarized, transitional, or balanced?
- What ideas in relation to gender need to be affirmed or challenged?
- What effect would role reversals have on the personal parts and relational activities of the family members?
- What is the impact of the community's beliefs about men and women on the members of this family?

The Process Lens

- Are there family members who lack a clear sense of purpose, function out of awareness, have poor contact with others, or lack experiences to support a productive life?
- Where is this family in the process of change?
- What resources (internal or external) need to be accessed?
• What am I, as the therapist, experiencing, and what does it tell me about the relationship and process of therapy?
• Which communication patterns do family members use under stress?

**Hypothesizing and Sharing Meaning**

To hypothesize is to form a set of ideas about people, systems, and situations that focus meaning in a useful way. In multilensed family therapy, hypothesizing flows from understandings generated by work through the eight lenses discussed previously. Two questions are germane to the form of hypothesizing one chooses to do: (1) How much faith do the therapist and the family have in the ideas they generate? (2) How much of an influence is the therapist willing to be in the lives of people and families?

Family counselors, like individual therapists, cannot avoid influencing the family and its members. The question is: What kind of influence will the therapist bring to the session? Satir and Bitter (2000) suggest that family therapists cannot be in charge of the people but that they need to be in charge of the process; that is, they own the responsibility for how therapy is conducted. Feminists and social constructionists are, perhaps, the most expressive of their concerns about the misuse of power in therapy. They are joined by multiculturalists, person-centered therapists, Adlerians, and existentialists, to name a few, who have also witnessed the often unconscious imposition of “dominant culture” in therapy. In the early days of family therapy, the mostly male therapists often ignored the effects on family life of patriarchy, poverty, racism, cultural discrimination and marginalization, homo-prejudice, and other societal problems. At the strategic-structural end of the continuum, therapists were more likely to claim a certain expertise in systems work that allowed them to make direct interventions in the enactment of “needed” changes in the family. To counteract therapeutic abuses and what some perceived to be an ongoing misuse of power in therapy, some narrative therapists adopted a decentered position in relation to the family (White, 1997). Like person-centered therapists before them, de-centered therapists seek to keep families and family members at the center of the therapeutic process.

It is important for families to be invited into respectful, essentially collaborative dialogues in therapeutic work. The different perspectives discovered in this work tend to coalesce into working hypotheses, and sharing these ideas provides the family with a window into the heart and mind of the therapist as well as themselves. Sharing hypotheses almost immediately invites and invokes feedback from various family members. And it is this feedback that allows the therapist and the family to develop a good fit with each other, which in turn tends to cement a working relationship.

The tentative hypothesizing and sharing process that Dreikurs (1950, 1997) developed is well designed for the kind of collaborative work envisioned here. Dreikurs would use a passionate interest and curiosity to ask questions and gather together the subjective perspectives of family members. And he would honor ideas that individuals brought to their joint understanding. When he had an idea that he wanted to share, he would often seek permission for his disclosure:
1. I have an idea I would like to share with you. Would you be willing to hear it?
2. Could it be that...

The value of this way of presenting hypotheses is that it invites families and family members to consider and to engage without giving up their right to discard anything that does not fit. When a suggested idea does not fit, the therapist is then clear about letting it go and letting the family redirect the conversation toward more useful conceptualizations.

Facilitating Change

Facilitating change is what happens when family therapy is viewed as a joint or collaborative process. Techniques are more important to models that see the therapist-as-expert and in charge of making change happen. Collaborative approaches require planning. Planning can still include what family therapy has called techniques or interventions, but with the family's participation (Breunlin et al., 1997, p. 292). Two of the most common forms for facilitation of change are enactments and assignment of tasks. Both of these processes work best when the family co-constructs them with the therapist—or at least accepts the rationale for their use.

Even within the change process, the first seven lenses can be used as a guide for preferred or desired outcomes. In general, internal parts function best when they are balanced (not polarized) and when the individual experiences personal parts as resources. Being able to think is usually more useful than emotional reactivity; being able to feel is better than not feeling; good contact with others is more rewarding than isolation or self-absorption; and taking reasonable risks in the service of growth and development is more beneficial than stagnation or a retreat into fear.

Further, knowing the goals and purposes for our behaviors, feelings, and interactions tends to give us choices about their use. Similarly, understanding the patterns we enact in face-to-face relationships, the ebbs and flows of life, or across generations provide multiple avenues for challenging patterns and the enactment of new possibilities.

Family Systems Therapy From a Multicultural Perspective

Strengths From a Diversity Perspective

One of the strengths of the systemic perspective in working from a multicultural framework is that many ethnic and cultural groups place great value on the extended family. If therapists are working with an individual from a cultural background that gives special value to including grandparents, aunts, and uncles in the treatment, it is easy to see that family approaches have a distinct advantage over individual therapy. Family therapists can do some excellent networking with members of the extended family.
In many ways, family therapists are like systems anthropologists. They approach each family as a unique culture whose particular characteristics must be understood. Like larger cultural systems, families have a unique language that governs behavior, communication, and even how to feel about and experience life. Families have celebrations and rituals that mark transitions, protect them against outside interference, and connect them to their past as well as a projected future.

Just as differentiation means coming to understand our family well enough to be a part of it—to belong—and also to be separate and our own person, understanding cultures allow therapists and families to appreciate diversity and to contextualize family experiences in relation to the larger cultures. Today, family therapists explore the individual culture of the family, the larger cultures to which the family members belong, and the host culture that dominates the family’s life. They look for ways in which culture can both inform and modify family work. Interventions are no longer applied universally; regardless of the cultures involved: rather, they are adapted and even designed to join with the cultural systems.

**Shortcomings From a Diversity Perspective**

Given the multicultural lens and collaborative approach of family systems therapy, it is difficult to find shortcomings from a diversity perspective. This model of family therapy embraces attitudes, knowledge, and skills that are essential to a multicultural perspective. Perhaps the major concern for non-Western cultures would be with regard to the balance that this model advocates for the individual versus the collective. The process of differentiation occurs in most cultures, but it takes on a different shape due to cultural norms. For instance, a young person may become separate from her parents yet not move out of the house. When ethnic-minority families immigrate to North America, their children often adapt to a Western concept of differentiation. In such cases, the intergenerational process of therapy is appropriate if the therapist is sensitive to the family’s culture’s roots. Although a multileveled approach addresses the notion of togetherness and individuality from a balanced perspective, many non-Western cultures would not embrace a theory that valued individuality above loyalty to family in any form. Nor would non-Western cultures have the same conceptualizations of time or even emotions. Therapists, regardless of their model of therapy, must find ways to enter the family’s world and honor the traditions that support the family.

A possible shortcoming of the practice of family therapy involves practitioners who assume Western models of family are universal. Indeed, there are many cultural variations to family structure, processes, and communication. Family therapists are challenged to broaden their views of individuation, appropriate gender roles, family life cycles, and extended families. Some family therapists focus primarily on the nuclear family, which is based on Western notions, and this could clearly be a shortcoming in working with clients in extended families.
CHAPTER FOURTEEN  Family Systems Therapy  435

Family Therapy Applied to the Case of Stan

In our work with Stan in this modality, we include examples of forming a relationship and joining, reading Stan's genogram, a multilensed assessment, reframing, boundary setting in therapy, and facilitating change. In the field of family therapy there are many useful models and ways to work with families. The processes described here do not represent the right way to do family systems therapy; rather, they represent some possible ways to work from a multilensed approach.

At an intake interview, a family therapist meets with Stan to explore his issues and concerns and to learn more about him and his life situation. As they talk, the therapist brings an intense interest and curiosity to the interview and wonders out loud about the familial roots of some of Stan's problems. It does not take much of an inquiry to learn that Stan is still very much engaged with his parents and siblings, no matter how difficult these relationships have been for him. This initial conversation involves the development of a genogram of Stan's family of origin (see Figure 14.1). This map will serve both Stan and the therapist as a guide to the people and the processes that influence Stan's life.

Stan's genogram is really a family picture, or map, of his family-of-origin system. In this genogram, we learn that Stan's grandparents tend to have lived fairly long lives. Stan's maternal grandparents are both alive. The shaded lower half of their square and circle indicates that each had some problem with alcohol. In the case of Tom, Stan reports that he was an admitted alcoholic who recommitted himself to Christ and found help through Alcoholics Anonymous. Stan's maternal grandmother always drank a little socially and with her husband, but she never considered herself to have a problem. In her later years, however, she seems to secretly use alcohol more and more, and it is a source of distress in her marriage. Stan also knows that Margie drinks a lot, because he has been drinking with his aunt for years. She is the one who gave him his first drink.

Angie, Stan's mother, married Frank Sr. after he had stopped drinking, also with the help of AA. He still goes to meetings. Angie is suspicious of all men around alcohol. She is especially upset with Stan and with Judy's husband, Matt, who "also drinks too much." The genogram makes it easy to see the pattern of alcohol problems in this family.

The jagged lines \(/--/\) between Frank Sr. and Angie indicate conflict in the relationship. The three solid lines "---" between Frank Sr. and Frank Jr., and between Angie and Karl, indicate a very close or even fused relationship. The double lines "===" between Karl and Stan are used to note a close relationship only. As we will see, Karl actually looks up to Stan in this family. The dotted lines \(\ldots\) between Frank Sr. and Stan and between Frank Jr. and Stan indicate a distant or even disengaged relationship.

Since the family therapist believes that the whole family is involved in Stan's use of alcohol, she spends a good part of the first session exploring with Stan processes for asking his other family members to join him in therapy. Stan may have many difficulties, but at the moment his difficulty with alcohol is the primary focus. Alcohol is a negative part of his life, and as such it has systemic meaning. It may have started out as a symptom of other problems, but now the alcohol is a problem in itself. From a systemic perspective, the questions are "How does this problem affect the family?" and "Is the family using this problem to serve some other purpose?"

In the first therapy session with the family, the therapist's main focus is in forming a relationship with each of the family members, but even here, a variety of approaches present themselves.

THERAPIST [to Frank Sr.]: I know coming here was an inconvenience for you, but I want you to know how appreciative I am that you came. Can you tell me what it's like for you to be here? [forming a relationship through joining]

FRANK SR.: Well, I have to tell you that I don't like it much. [pause] Things are a lot different today than they used to be. We didn't have counseling 20 years ago. I had a problem with drinking at one point, (continues)
FIGURE 14.1 Three Generation Genogram of Stan's Family

Family Therapy Applied to the Case of Stan  (continued)

but I got over it. I just quit—on my own. That's what Stan needs to do. He just needs to stop.

THERAPIST: So I'm hearing that life is better for you without alcohol, and you would like Stan's life to be better too. [reframing]

FRANK SR.: Yeah. I'd like his life to be better in a lot of different ways.

THERAPIST: Angie, what about you? What is it like for you to be here? [forming a relationship with each member]

ANGIE: It's heartbreaking. It's always heartbreaking. He [referring to Frank Sr.] makes it sound as if he just summoned up his own personal power and quit drinking through his own strength of character. That's a
laugh. I threatened to leave him. That's what really happened. I was ready to get a divorce! And we're Catholics. They don't get divorced. [possible face-to-face sequence around family stress and coping]

THERAPIST: So you've been through this before.

ANGIE: Oh my yes. My father and mother drank. Dad still does. My sister won't admit it, but she drinks too much. She goes crazy with it. Judy's husband has a problem. I'm surrounded by alcoholics. I get so angry. I wish they would all just die or go away. [possible transgenerational family sequence; an avenue for exploring values, beliefs, and rules]

THERAPIST: So this is something the whole family has been dealing with for a long time.

ANGIE: Not everyone. I don't drink. Frankie and Judy don't drink. And Karl doesn't seem to have a problem.

THERAPIST: Is that how the family gets divided: into those who drink and those who don't? [possible organization lens application]

JUDY: Drinking isn't the only problem we have. It's probably not even the most important.

THERAPIST: Say more about that.

JUDY: Stan has always had it hard. I feel sorry for him. Frankie is clearly Dad's favorite [Frank Sr. protests, saying he doesn't have favorites], and things have always come easily for me. And Karl, he gets whatever he wants. He's Mom's favorite. Mom and Dad have fought a lot over the years. None of us have been that happy, but Stan seems to have the worst of it. [again, possible sequence and organization lens applications]

FRANK JR.: As I remember it, Stan gave Dad and Mom a lot to fight about. He was always messing up in one way or another.

THERAPIST: Frankie, when your father was talking earlier, I sensed he had some disappointment about Stan too, but he also wanted to see things work out better for him. Is that true for you too? [reframing Frankie's comment, maintaining a focus on new possibilities and new relations that might be developed]

FRANK JR.: Yes. I would like his life to be better.

The initial part of this counseling session has been devoted to meeting family members, listening intently to the multiple perspectives they present, and reframing Stan's problem into a family desire for a positive outcome. Although there is a long way to go, the seeds of change have already been planted. There is evidence in these early interactions that Stan's problem has a multigenerational context. If this context is explored, family sequences that support and maintain alcohol as a problem may be identified. It is possible to track these interactions and to work toward more congruent communications. Evolving relational, organizational, developmental sequences might be explored as a means of freeing family members for new possibilities in their life together. Among other possibilities still to be explored are perspectives related to gender and culture. If the therapist were just listening to Stan, only one point of view would be evident. In this family session, multiple perspectives and the entire interactive process become clear in a very short time.

As the family interview proceeds, a number of possibilities are presented for consideration. The therapist considers and may structure therapy around any or all of the following possibilities:

1. Stan's parents have not been a well-functioning leadership team for a long time, and both their spousal relationship and their parenting have suffered.
2. The adult siblings need a new opportunity to function together without the influence and distractions continually imposed by the parents.
3. Stan has been reduced to a single part (his alcoholic part), and his description and experience of himself needs to be enlarged—both for his own perspective and in the eyes of others.

A new place for Stan in the family, a better way of relating, and an ability to access "lost" parts of his internal system are all critical to winning his battle with alcohol. As therapy continues, it becomes clear that two separate relational—organization hypotheses must be explored. One is that the spousal relationship has been defined by the problem of alcohol too, and it has not evolved or developed in any kind of positive way over the years. Two, the transgenerational sequences have targeted Stan and assigned him to a fixed role that he has been expected to play that has blocked development past his middle to late adolescence, which was the period in which he started drinking.

(continues)
Follow-Up: You Continue as Stan’s Family Therapist (continued)

Use these questions to help you think about how you would counsel Stan from a family systems perspective:

- What unique values do you see in working with Stan from a multilensed, systemic perspective as opposed to an individual therapy approach?
- What internal parts might Stan reaccess as he continues in therapy? What parts of him might be polarized?

- Assuming that Stan was successful in getting at least some of his family members to another session, where would you begin? Would you get everyone involved in the sessions? If so, how would you do that?
- What are some specific ways to explore other lenses with this family?
- What hypotheses are you developing, and how would you share them with the family?
- Are there systemic interventions that you would find hopeful in terms of facilitating change?

Summary and Evaluation

Let’s first review the themes that unite the many approaches to family therapy, with particular emphasis on the multilensed approach.

**BASIC ASSUMPTION** If we hope to work therapeutically with an individual, it is critical to consider him or her within the family system. An individual’s problematic behavior grows out of the interactional unit of the family as well as the larger community and societal systems.

**FOCUS OF FAMILY THERAPY** Most of the family therapies tend to be brief because families who seek professional help typically want resolution of some problematic symptom. Changing the system can stimulate change quickly. In addition to being short-term, solution-focused, and action-oriented, family therapy tends to deal with present interactions. The main focus of family therapy is on here-and-now interactions in the family system. One way in which family therapy differs from many individual therapies is its emphasis on how current family relationships contribute to the development and maintenance of symptoms.

**ROLE OF GOALS AND VALUES** Specific goals are determined by the practitioner’s orientation or by a collaborative process between family and therapist. Global goals include using interventions that enable individuals and the family to change in ways that will reduce their distress. Tied to the question of what goals should guide a therapist’s interventions is the question of the therapist’s values. Family therapy is grounded on a set of values and theoretical assumptions. Ultimately, every intervention a therapist makes is an expression of a value judgment. It is critical for therapists, regardless of their theoretical orientation, to be aware of their values and monitor how these values influence their practice with families.
HOW FAMILIES CHANGE  An integrative approach to the practice of family therapy includes guiding principles that help the therapist organize goals, interactions, observations, and ways to promote change. Some perspectives of family systems therapy focus on perceptual and cognitive change, others deal mainly with changing feelings, and still other theories emphasize behavioral change. Regardless of the lens that a family therapist operates from, change needs to happen in relationships, not just within the individual.

TECHNIQUES OF FAMILY THERAPY  The intervention strategies therapists employ are best considered in conjunction with their personal characteristics. Goldenberg and Goldenberg (2008) and Nichols (2006, 2007) emphasize that techniques are tools for achieving therapeutic goals but that these intervention strategies do not make a family therapist. Personal characteristics such as respect for clients, compassion, empathy, and sensitivity are human qualities that influence the manner in which techniques are delivered. It is also essential to have a rationale for the techniques that are used, with some sense of the expected outcomes. Faced with meeting the demands of clinical practice, practitioners will need to be flexible in selecting intervention strategies. The central consideration is what is in the best interests of the family.

A multilensed approach to family therapy is more complex than models with a singular focus. At least initially, some of the confidence and clarity that might be gained from a single approach may be lost, but in time the flexibility to change directions is an asset. We have presented a structure for therapy that is useful across models. We have integrated a substructure for the use of multiple perspectives (lenses) in assessment, hypothesizing, and facilitating change. And we have described a collaborative process for therapy in which both the family and the therapist share influence according to the needs of the situation. It is our hope that this chapter gives you enough of an introduction to the diverse field of family therapy that you will want to learn more through reading as well as watching the many videotapes currently available.

Contributions of Family Systems Approaches

One of the key contributions of most systemic approaches is that neither the individual nor the family is blamed for a particular dysfunction. The family is empowered through the process of identifying and exploring internal, developmental, and purposeful interactional patterns. At the same time, a systems perspective recognizes that individuals and families are affected by external forces and systems, among them illness, shifting gender patterns, culture, and socioeconomic considerations. If change is to occur in families or with individuals, therapists must be aware of as many systems of influence as possible.

Most of the individual therapies considered in this textbook fail to give a primary focus to the systemic factors influencing the individual. Family therapy redefines the individual as a system embedded within many other systems, which brings an entirely different perspective to assessment and treatment. An advantage to this viewpoint is that an individual is not scapegoated as the "bad person" in the family. Rather than blaming either the "identified patient"
or a family, the entire family has an opportunity (a) to examine the multiple perspectives and interactional patterns that characterize the unit and (b) to participate in finding solutions.

Limitations and Criticisms of Family Systems Approaches

In the early days of family therapy, therapists all too often got lost in their consideration of the “system.” In adopting the language of systems, therapists began to describe and think of families as being made up of “dyads” and “triads”; as being “functional” or “dysfunctional,” “stuck” or “unstuck,” and “enmeshed” or “disengaged”; and as displaying “positive” and “negative” outcomes and “feedback loops.” It was as if the family was a well-oiled machine or perhaps a computer that occasionally broke down. Just as it was easy to fix a machine without an emotional consideration of the parts involved, some therapists approached family systems work with little concern for the individuals as long as the “whole” of the family “functioned” better. Enactments, ordeals, and paradoxical interventions were often “done to” clients—sometimes even without their knowledge (see Haley, 1963, 1976, 1984; Minuchin & Fishman, 1981; Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978).

Feminists were perhaps the first, but not the only, group to lament the loss of a personal perspective within a systemic framework. As the field moves now toward an integration of individual and systemic frameworks, it is important to reinvest the language of therapy with human emotional terminologies that honors the place real people have always held in families.

Where to Go From Here

To learn more about family systems approaches to therapy, join the International Association of Marriage and Family Counselors (IAMFC), a division of the ACA. The Family Journal is the official journal of IAMFC, and it aims to advance the theory, research, and practice of counseling with couples and families from a family systems perspective. In addition to other membership benefits, IAMFC members receive a subscription to The Family Journal. For more information about this association, contact:

*International Association of Marriage and Family Counselors*
Website: www.i amfc.com

Another option is to join the American Association for Marriage and Family Therapy, which has a student membership category. You must obtain an official application, including the names of at least two Clinical Members from whom the association can request official endorsements. You also need a statement signed by the coordinator or director of a graduate program in marital and family therapy in a regionally accredited educational institution, verifying your current enrollment. Student membership may be held until receipt of a qualifying graduate degree or for a maximum of 5 years. Members receive the Journal of Marital and Family Therapy, which is published four times a year, and a subscription to
six issues yearly of The Family Therapy Magazine. For a copy of the AAMFT Code of Ethics, membership applications, and further information, contact:

American Association for Marriage and Family Therapy
112 South Alfred Street
Alexandria, VA 22314-3061
Telephone: (703) 838-9808
Fax: (703) 838-9805
Website: www.aamft.org

RECOMMENDED SUPPLEMENTARY READINGS

Ethnicity and Family Therapy (McGoldrick, Giordano, & Garcia-Preto, 2005) is the seminal work on culture in family therapy. The authors review the importance of cultural considerations in relation to family therapy and provide chapters on the background, research, and therapy issues of more than 15 cultures.

Theory and Practice of Family Therapy and Counseling (Bitter, 2009) is a comprehensive textbook that seeks to develop personal and professional growth in family practitioners as well as orient the reader to the theories that make up the field of family therapy and counseling.

Family Therapy Basics (Worden, 2003) offers practical guidelines for conducting family interviews, emphasizes common clinical problems, and serves as a springboard for clinical and theoretical discussions.

Family Therapy: Concepts and Methods (Nichols, 2006) is an AAMFT-based text that covers seven of the major contemporary family systems models. The final chapter presents an integration of key themes among diverse approaches to family therapy.

Family Therapy: History, Theory, and Practice (Gladding, 2007) is an overview of family therapy models and therapeutic interventions designed for counselors associated with ACA.

Family Therapy: An Overview (Goldenberg & Goldenberg, 2008) provides an excellent basic overview of these contemporary perspectives on family therapy.

Metaframeworks: Transcending the Models of Family Therapy (Breunlin, Schwartz, & MacKune-Karrer, 1997) is the basis for a multilensed approach for understanding families and the larger systems in which they are embedded. A blueprint for integrative family therapy is provided.

The Practice of Family Therapy: Key Elements Across Models (Hanna, 2007) focuses on the diversity of family therapy and integrates common elements of the field. It also deals with family therapy assessment and treatment skills.

Theories and Strategies of Family Therapy (Carlson & Kjos, 2002) is a comprehensive presentation of family therapy models with chapters written by people who practice what they have demonstrated in the video series entitled Family Therapy With the Experts (Carlson & Kjos, 1999).
REFERENCES AND SUGGESTED READINGS


*Books and articles marked with an asterisk are suggested for further study.
READING

Grief and loss counselling

We have noticed that a high proportion of client problems are concerned with relationships. Relationship problems fall into four major categories. These are:

1. dysfunctional relationships
2. failure to form meaningful relationships
3. lost relationships through death and separation
4. negotiating the normal or developmental challenges and changes in relationships.

TYPES OF LOSS

Loss associated with relationships

In each of the categories listed above issues of loss and grief may arise. In dysfunctional relationships there is a loss of expectation that these relationships will be functional and harmonious. People who are unable to form meaningful relationships may have to cope with the loss of their expectations. When couple relationships break up both people need to adjust to the loss of a partner. In the case of married couples there is also the loss of marital status and the loss of the expectation that marriage is for life. If children are involved, then each parent has a loss of support from their spouse in the day-to-day rearing of the children, and often one parent has a significant loss of contact with the children so their parental role is to some extent diminished.

When relationships are functioning normally new situations will arise from time to time and changes will naturally occur due to changes in roles and developmental stages of the relationship. There is therefore a need to confront the challenges incurred by change, and change often involves loss.
Other losses

Counsellors also hear about many other types of loss; for example the loss of a limb, loss of an internal part of the body, loss of mental functioning due to ageing or brain damage, loss of a job, loss of a home or loss of self-respect.

HELPING A PERSON WHO IS GRIEVING

In order to be effective in helping people who are grieving over a loss, counsellors need to understand the process of grieving. There are many books on loss and grief counselling, including those listed at the end of this chapter, for those who wish to do further reading on the subject.

When counselling somebody who has suffered a loss, or who is grieving, it is important to be able to reassure them that the feelings they are experiencing are normal for a person who is grieving, and that it is normal to take time to grieve. In this regard it may be useful to self-disclose if you yourself have in the past taken time to grieve over a similar loss.

Restricting counsellor self-disclosure

Although at times self-disclosure is appropriate, it should be used sparingly, and never solely to satisfy the counsellor’s needs. Before self-disclosing, we suggest that you may wish to examine what you are personally experiencing and to make a decision about whether your motive is to satisfy your own needs or is genuinely to help the client. Where self-disclosure is used more than occasionally, its impact is lost, and the counsellor is certainly putting their needs before those of the client.

Disclosure of information about other counsellors or other people is unethical and should never occur in the counselling process.

Counselling skills to use

When a client is grieving, all the micro-skills previously discussed can be used as explained in Chapter 15 to allow the person to verbalise their thoughts and feelings, to experience rather than suppress their pain, and to generally explore whatever is happening within themselves as they experience their loss. Additionally, it is useful for a counsellor who is helping a client who has suffered a loss to have an understanding of the process of grieving. This understanding will enable the counsellor to recognise and appreciate the client’s experience more fully so that an empathic counselling relationship can be established and maintained.
THE STAGES OF GRIEF

People tend to go through a number of stages in the grieving process. For some people these stages follow a particular sequence, but for other people the stages overlap or occur in a different order. Everyone is unique and grieves in a uniquely personal way, so it is inadvisable to try to fit a predetermined grieving pattern onto a client. However, if as a counsellor you know what the commonly experienced stages in the grieving process are, then you will be better equipped to deal with the grieving person. You will be able to explain to your client that their experiences are not strange or unusual, but are normal for someone who is grieving.

The stages of grief are commonly experienced in the following sequence:

1. shock
2. denial
3. emotional, psychological and physical symptoms
4. depression
5. guilt
6. anger
7. idealisation
8. realism
9. acceptance
10. readjustment
11. personal growth.

If a person is unable to work through the stages of grief, then they are likely to be stuck in a trough of hopelessness and despair. They may become neurotically obsessed by their loss, and become deeply depressed and possibly suicidal. The following paragraphs explain the stages of grief, except depression, in more detail. Depression is discussed in Chapter 28.

Shock

Usually, the first stage of grief is shock. This may be particularly severe in cases of sudden loss, or where a person has not been prepared adequately for an expected loss. In this stage the person almost seems to stop functioning, is numb, in a daze and incapable of doing anything constructive.

Denial

Along with shock, and following on from shock, comes denial. The grieving person can't believe that what has happened is really true.
The denial process can be prolonged for people who separate from a living partner. Very often a rejected partner will deny that the relationship is over, even though the other partner is clearly saying, 'It's finished and I'm not ever going to come back to you'. This is hard for a counsellor to deal with because the grieving person needs to have time to move through the denial stage. Perhaps the most useful approach is to reflect back the client's expectation that their partner may return, and to add to this concrete statements of fact that seem to indicate the opposite. The counsellor might say, for example, 'I get the strong impression from you that you believe that your partner will come back to you. I also notice that she said to you that she would not do that, and that she has rejected all your approaches to her since she left. Do you think that it's possible that she may not come back?' This tentative statement and question enables the client to stay in denial if they need to do that for a while longer, or to move forward. When the client is starting to accept the possibility that the loss may be permanent, it may then be useful to let them know that denial is a normal part of grieving. By doing this they can feel OK about their difficulty in not wanting to accept reality in its entirety.

People who are dying often grieve in anticipation of dying and such people sometimes have real problems with denial. When a person is told that they are dying, they may try to convince themselves that what the medical practitioner is telling them is not true. They may look for and try unorthodox methods to find a cure, and may start to bargain with God in an effort to get an extension to life.

Emotional, psychological and physical symptoms

Grieving people experience feelings of depression, despair, hopelessness and worthlessness. Very often they will exhibit symptoms such as insomnia, inability to concentrate, loss of appetite and physical ill-health. This is normal. There is little that the client can do but accept that such symptoms will pass with time as the pain of grief diminishes. Naturally if such symptoms are severe or persist, the client should consult with a medical practitioner.

Guilt

Guilt often occurs in the grieving person. A counsellor will frequently hear a client say how guilty they feel because they didn't tell the deceased how much they loved them, didn't tell them how much they cared for them, didn't apologise for something they had done wrong, or didn't make peace over an issue where there had been a disagreement. If, as a counsellor, your clients describe such feelings, allow them to fully explore them.
Anger

Often after shock, denial, depression and guilt, anger follows. Remember though, that the stages often overlap, and sometimes a person will move forward from one stage and then go back to an earlier stage.

In the case of a person who is dying, anger may be directed at the medical practitioners involved. The client may feel that they haven’t had satisfactory medical treatment. Maybe they will believe that their illness was diagnosed too late and consequently that it’s the doctor’s fault that death is inevitable. Similarly, a person who has lost a loved one through illness may blame the medical practitioners who treated the deceased before their death. Additionally, a bereaved person may well experience anger towards the person who has died. They may feel that the deceased person ‘had no right to die’ and has hurt them by leaving them alone to cope in the world. This may be especially so in cases where the deceased has committed suicide.

Often it is hard for a client to accept that they are capable of being angry towards somebody they loved who has died. This is especially so for children who have lost a parent through death, and not had adequate counselling. They invariably feel guilty and confused by their anger and resentment towards the deceased parent. Without counselling, these feelings may endure for years.

People whose partners have rejected them often become very angry and, while being angry, desperately want to get back into the relationship. They inevitably make it hard for themselves to do this and probably spoil their chances of reconciliation because while saying, ‘I love you and I want to be back in a relationship with you’, they may also be experiencing anger, and are likely to express it in some way. Thus they give mixed messages to their partner because they are simultaneously giving ‘Please come back’ messages and angry messages. The anger, of course, can easily be understood as part of the process of grieving.

Sometimes a person who has religious beliefs and is grieving will feel angry with God, and will blame God for the loss that has occurred. For deeply religious people this may cause feelings of extreme guilt. When counselling such people a counsellor can explain that it is normal to experience anger in grief. The counsellor might also ask the client whether they think that God is capable of accepting, forgiving and loving someone who is angry with Him. When counselling clients who have faith in other religions similar issues may arise. Here it is important for the counsellor to gain sufficient understanding of the client’s beliefs to be helpful (see Chapter 36 regarding cultural issues).
Idealisation

Idealisation often follows the angry stage of grieving. It is very common for people who have suffered loss through death or separation to idealise the lost partner. The grieving person temporarily forgets any faults or negative characteristics of the deceased and remembers only an ideal person. They remember everything positive that the deceased did and convince themselves that they loved them without reservation, and never had any negative feelings towards them. This is idealisation, and once again it is normal. It takes time for a person to move through idealisation and the counsellor needs to be careful not to try to move the client forward too quickly, but rather to let the grieving process occur naturally. When it is appropriate, a counsellor may ask tentatively whether the lost person had any bad points, any faults, and whether they sometimes made mistakes. Slowly the realisation will dawn that yes, there were polarities in the deceased person. The deceased was a real person, a human being with both strengths and weaknesses.

Acceptance, readjustment and personal growth

The client will hopefully, in time, come to terms with their grief and start to accept the reality of their loss. They will start to be more realistic about the person they have lost, and to accept the loss as a permanent reality. They are then free to move forward and to create a new life as an individual. This may be scary for some clients, particularly for those who were heavily dependent on the relationship which is now lost. In this stage of the grieving process the client needs to be active rather than passive, to try new experiences and thus to experience personal growth. New experiences, by their very nature, involve some degree of risk, and so may understandably cause the client to be apprehensive. Taking risks can be frightening and can also be exciting. Reframing ‘risk taking’ as ‘exciting’ may be helpful.

ALLOWING THE GRIEVING PROCESS TO OCCUR

Finally, as a counsellor, do not try to calm or soothe the grieving person. Do not try to cheer them up or help them to contain their sadness and fears. Instead, help them to express emotions freely, to cry if they wish, and to grieve fully. It is only when grief endures for an excessively long period that it becomes maladaptive. In such cases, clearly professional help from an experienced counsellor, psychologist or psychiatrist is required. Once again, know the limits of your own competence, and refer clients to others more qualified and experienced than yourself when appropriate.
LEARNING SUMMARY

- People grieve for lost expectations, relationships, bodily functions, jobs and losses of all kinds.
- Normal stages of grief include shock, denial, psychological and somatic symptoms, depression, guilt, anger, idealisation, realism, acceptance, readjustment and personal growth.
- It's usually a mistake to try to calm or soothe a grieving person. Encouraging free expression of emotions tends to be more therapeutic.

TRAINING GROUP EXERCISES

1. In the whole group, list as many situations as you can think of where one might experience loss. Rank these in order of severity and share your reasons why with the group. Notice the differences in your group and discuss these differences with regard to how they might impact on your relationship with clients and their perceptions of their loss.

2. Share if you can with the whole group your personal experience of dealing with loss and list those qualities that contributed to your resilience.

FURTHER READING