UNIT I

Psychiatric Social Work

Psychiatric social work is the application of social work methods and practices in the field of psychiatry. It is the social work practiced in psychiatric settings, de addiction centers etc. It is both a science and art as the social work belongs to discipline of art and psychiatry belongs to discipline of science. Psychiatric patients cannot be treated by medicines alone. He needs both psychological and social treatment. Social treatment is necessary because a person’s social conditions get disturbed due to psychiatric illness. Psychiatric social worker needs knowledge in both the fields of psychiatry and social work.

HISTORICAL DEVELOPMENT OF PSW

In the beginning the psychiatrists were interested to understand the personality of the patients in relation to their social environment. They appointed some agents for collecting the family back ground of the patients. These agents collected case histories from the patients and acted as an intermediate between the patient and the family members. They were the pioneer social workers in the field of psychiatry. In **1905**, Massachusetts General Hospital established social service department. Dr. Putam who was in charge of the neurological clinic appointed a full time social worker in his clinic under his personal supervision.

In 1906, psychiatric social work was initiated at the Manhattan State Hospital in New York City, by the New York State Charities Aid Association. Here, the psychiatric social worker visited patients' families to obtain collateral information needed by psychiatrists, relative to family background and past life experiences. They just acted as after care agents and clinics in United States began to employ social workers. The

pioneer social workers and the aftercare agents inspired many people to act as social workers in the field of psychiatry.

In 1913, Boston psychopathic hospital established as social service department under the leadership of Dr. Ernest Sutherland and Dr. Mary C Jarret, who was appointed as the head of the social service department. The social service department aim to assist in the study and treatment of mental disorders and aid patients in regaining their normal living. In addition, the social workers took the responsibility of educating the public in promoting the understanding of mental illness, as well as in research to understand the causes for mental disorders. The term 'psychiatric social work' was first used in the book "The kingdom of evils" by Dr. Ernest Sutherland and Dr. Mary C Jarret. The book reveals the scope and importance of psychiatric social work.

In 1917 Mary Richmond in her book "Social Diagnosis" emphasized on the role of personality and society in influencing mental health of the people.

When the United States entered World War I, leaders of the psychiatric social work profession foresaw the need for providing care for the mentally ill in Army and Navy hospitals and, in 1918, initiated a training course for psychiatric social work at Smith College, Northampton, Mass. As the flow of neuropsychiatric casualties increased, the Army Medical Department requested the American Red Cross to supply psychiatric social work personnel to military hospitals.

The first trained worker was assigned on 1 September 1918, to the U.S. Army General Hospital This worker's duties were to assist the medical officers by obtaining information regarding the personal, family, and community background of the soldiers under treatment, as an aid in diagnosis, treatment, and plans for aftercare.

After the war, in March 1919, the Surgeon General of the U.S. Public Health Service requested the American Red Cross to organize a social service program within Federal hospitals. The Red Cross assumed full responsibility for outlining the social

service program, formulating policies, recruiting personnel, and assisting in the organization of the work. Because Federal hospitals served large areas, it was essential that the worker be equipped not only to give aid to the psychiatric staff but also to assist local Red Cross chapters in assembling social data, interpreting recommendations for treatment, and helping the discharged patient accomplish the necessary social and other rehabilitative measures for his recovery. Because there was a serious dearth of trained personnel, the Red Cross offered special scholarships and cooperated with existing schools of social work in a program of training. By January 1920, there were social service departments in 42 Federal hospitals.

Another major vehicle that helped push psychiatric social work into a prominent position was the development of child guidance clinics. Early child guidance clinics were initially created out of a concern about juvenile delinquents. Through this work early clinic professions became concerned over the lack of social and psychological services for all children. As a consequence, child guidance clinics rapidly broadened their mission to include children with mental and emotional problems. In 1920, William Haley started a child guidance clinic and he emphasized in the scope of psychiatric social workers. In child guidance settings, social workers begin to enjoy greater freedom of working. They gained more preference in child guidance.

In 1922, the American Association of social workers was formed. Initially they were part of American Association of hospital workers. In 1926 they separated from the association and considered as an independent body. From 1930 a new emphasis appeared within the family welfare agencies in account of families presenting with problems of emotional mal adjustments, in addition to financial needs. Thus a large number of workers in the field of family welfare began to utilize knowledge form field of psychiatry, to work as therapists to client with psychiatric problems. Most family welfare agencies started to employee psychiatric social workers and they started to give training to their staffs in mental hygiene and social psychiatry.

Around 1936, progress in the shared responsibilities for treatment in relation to psychiatry was obscured by the independent role of the social worker as a therapist, thereby making the activities of the social workers wide spread. In fact the boundary lines between fields that deal with human relationship started steadily breaking down. Thus psychiatric social work became alive with most of the disciplines such as psychology and psychiatry, psychology and sociology, mental hygiene and public health education.

In September 1942, the Association requested a grant from the Rockefeller Foundation in order to accomplish two major objectives: (1) To centralize data on personnel and vacancies in psychiatric social work and (2) to establish a more vital and immediate relationship with professional education for psychiatric social work. This involved plans for recruiting students for psychiatric social work, for developing scholarship plans to finance students, and for channeling new materials and areas of practice to the schools of social work.

As early as mid-1942, in at least two centers, unofficial but active outpatient neuropsychiatric clinics were functioning with social workers. The first formal and completely staffed mental health clinic was developed at Fort Monmouth, where the usual team of psychiatrist, clinical psychologist, and psychiatric social workers functioned in a most effective way and set a pattern for the development of consultation services throughout the Army. This unit was established on 4 March 1942.

The role of psychiatric social workers extended beyond case work. These include creating general public awareness about mental health, and the cause and need to prevent it. They also helped in the development of psychiatric social work. Gradually the psychiatric social workers were employed in psychiatric hospitals and clinics and they were considered as an important part of psychiatric team.

HISTORY OF PSYCHIATRIC SOCIAL WORK IN INDIA

The history of psychiatric social work in India began with the establishment of child guidance clinics by sir Dorabji Tata Graduate School, Bombay in 1937. The clinic was established to provide training facilities for postgraduate social work students. In 1938 a trained social worker was employed on a full time basis. In 1948 the BHORE committee recommended for the appointment of medical and psychiatric social workers. In 1948 YERVADA medical hospital appointed a psychiatric social worker named Malathy Renade under the guidance of DR. G.R Banarjee. After that JJ hospital in Bombay employed a psychiatric social worker in 1950. In 1952 a specialized course in psychiatric social work was established. This was combined with medical social work and it was called medical and social work. DR. Sharadha Menon who was the superindent of Madras Mental Hospital helped the growth of psychiatric social work in South India. The Delhi School of social Work introduces specialization in psychiatric social work in the post graduate training in social work in the year 1962.

CASE WORK GROUP WORK AND COMMUNITY ORGANIZATION IN THE PSYCHIATRIC SERVICES

In the psychiatric setting the social work methods such as case work, group work and community organization are important because through this practice the psychiatric patients and the family members can be helped to a greater extent.

Case work

Social case work, a primary method of social work, is concerned with the adjustment and development of individuals towards more satisfying human relations. It is a social treatment of maladjusted individual, involving an attempt to understand his personality, behaviour, and social relationships, and to assist him in working out a better social and personal adjustment. It seeks to help individual to solve their problems in a systematic way based on knowledge of human behaviour and various tested approaches. Thus social case work is a one to one relationship which works in helping the individual for his adjustment and development.

Mary Richmond (1915) defines social work "as the art of doing different things for and with different people by cooperating with them to achieve at one and the same time their own and society's betterment".

Case history collection in psychiatry is now termed as case work. Case history is the collection of detailed information about the patient. Case work is the process of collecting detailed history about the patient and making a social diagnosis of the problem faced by the patient. So case work in psychiatry includes

Case history + psycho social diagnosis + intervention = psychiatric case work

The case history is analyzed for any psychosocial problem on the basis of which psycho social diagnosis is made and treatment is provided.

The main advantages of practicing case work in psychiatric settings are:

1. It deals with single individual
2. It is better practiced and it is result oriented.
3. The personal and social disorientation of the mentally ill people can be easily understood by this method.
4. It helps the patient to cooperate and adjust with the problems through some interventions, referrals and resource mobilization.
5. It is considered as a part of treatment in psychiatric social work.

Group work

It is the methods of social work that develops the ability of establishing constructive relationship in the individual through group activities. It enhances the social functioning of the people by purposeful sharing of their experiences. According to Konopka, "Social group work is a method of social work which he helps the individuals to enhance their social functioning through purposeful group experiences and to cope more effectively with their personal, group or community problem". The group work can be educational or recreational.

The main advantages of practicing group work in psychiatric settings are:

1. It fulfills human needs such as need of love, affection, feeling security, to have enjoyment etc.
2. It is a unique mean of solving isolation problem among people.
3. Self reliance is developed through group activity.
4. The feeling of being accepted is satisfied with the help of group work activities.
5. The group worker by practicing social group work in psychiatric setting is enhancing the confidence of the patient.
6. Psycho social problems are solved and manage through group experience.
7. It is the best method for the proper development of personality.
8. The main aim of the group is to enhance the problem solving capacity of the patient.
9. A problem which was considered unique is generalized by meeting people who are facing the same problem and by sharing their experiences the patient can model them to find solutions to their problem.
10. People in one group motivate and helps others to overcome their problems.

Community organization

It is an indirect form of social work process distinct from case work and group work. It is directed to provide service for people with special needs. It is process in which efforts are directed towards meeting the community needs and developing integration within the community. According to Ross "Community organization is a process by which a community identifies its needs or objectives, orders (or ranks) these needs or objectives, develops the confidence and will to work at those needs or objectives, finds the resources (internal, and / external) to deal with these needs or objectives, takes action in respect of them, and in so doing extends and develops cooperative and collaborative attitudes and practices in the community'.

The main aims of practicing community organization in psychiatric settings are:

1. Through community organization, the common needs of the people are identified, and the people made to understand about their basic needs.
2. After identification of the need, the community is helped by a community organizer to establish some order of priority among these needs so that efforts may be taken accordingly to fulfill these needs.
3. Community organizer helps the community to locate the resources in the society through which the needs may be fulfilled. There are certain agencies in the community which works for the betterment of the life of the people, but people are generally ignorant about these agencies. Community workers make the community to use these resources.
4. The community worker motivates the community to take actions to solve their problems.
5. It is the application of theoretical social work practices into practice.

Eg: The community organization in psychiatric setting may be used for creating awareness about various psychiatric illness, alleviating stigmas about mental illness among people, educating the people about the importance of family, educating on various symptoms of various illness etc.

LIMITATIONS AND DIFFICULTIES FACED IN PSYCHIATRIC SOCIAL WORK PRACTICE

The importance of medical and psychiatric social work can be well understood from the WHO definition of health which states that “Health is a complete state of

physical, psychological and social well being and not merely the absence of any disease or infirmity". The social wellbeing of an individual can be well handled by medical and psychiatric social workers. The objective of any hospitals is the restoration of health which includes all the dimensions and a complete treatment can be provided only if we look into the social dimension also.

But the main limitation of Psychiatric social work in India is that it is brought from west and slowly entering India. The curriculum of psychiatric social work is based on western pattern. In certain situations it does not suit for Indian situations. The scope for psychiatric social work is poor in India. Most of the psychiatrists and general doctors are not aware about the importance and need of social workers. In a psychiatric setting the duties of doctors, nurses and other professionals are identified. But in case of psychiatric social work, no functions are identified yet. Even after 70 years of functioning of social workers in psychiatric settings, the doctors, nursed, patients or the social workers are not able to identify the role of psychiatric social workers in the team and his contribution to the care of patients. There is a problem of role ambiguity.

The psychiatric social workers are not able to get the professional supervision and guidance at the needed time. It lacks a professional body and there is absence of regulatory board which leads to absence of quality of the profession. The salary scale of psychiatric social work is very low and they are facing very low recognition from the society. In most of the psychiatric hospital, social workers are facing very heavy work load and there is no proper work boundary for their field.

PROBLEMS IN MENTAL HEALTH FIELD

The problems still faced in mental health field are

1. There is a problem of stigma. The mentally ill people are not treated at par with the so called normal people.

2. Still a greater part of the population believes in faith healing and traditional treatment. In some area of the country the clergymen is considered as the physician.
3. The no of institutions specialized in psychiatry is less.
4. Absence of multidisciplinary team in big hospital poses another problem.
5. No of professionals specialized in dealing with mental illness is less.

The low priority to mental health is evidence from the fact that there were only 42 mental hospitals with the total of 20,000 beds in 1981. There were only 1,100 physiatrist of whom 200 were in private practice, approximately 400 to 500 clinical psychologists and 200 to 300 psychiatric social workers.

Man power requirement

In India for psychiatric social workers are required to go through a post graduate course in social work with specialization in psychiatric social work. During the two years they should have practical training in psychiatric setting for at least one year. They should have been exposed to all type of mental illness, and should know how to diagnose their psycho social problems under the guidance of psychiatric social workers. The man power requirements may be worked out in the following manner.

1. 6 psychiatric social workers for mental health hospitals with 500 beds (2 inpatients, 2 out patients, and 2 for community health services)
2. A minimum of 2 social workers will be required for not only taking down detail case history but also to take up at least 3 – 4 patients for counseling and psychotherapy.

UNIT II

Therapeutic intervention for psychiatric illness

Social work mainly deals with adjustmental problems. The therapies are intervention or treatment process given to people facing adjustmental problem. The therapies gain importance in treatment process because:

- It helps in the treatment of mental and emotional disorders through the use of psychological techniques.
- Designed to encourage communication of conflicts.
- It provides insight into the problem.

The main goal of therapy is to bring about a change in behavior, improved social & occupational functioning and personality growth. It is defined as the relief of distress or disability in one person by another, using an approach based on a particular theory, and the person performing the therapy has had some form of training in delivering this.

COGNITIVE THERAPY

In the 1950s, American psychologist Albert Ellis introduced Rational Therapy in which people were taught the A-B-C approach for dealing with uncomfortable situations. The A-B-C approach states that when a person is confronted with an adversity A, their beliefs B, will influence the way they respond to that adversity and lead to emotional and behavioral consequences C. If the beliefs B, are rigid, absolute, and unrealistic, the consequences C, will likely be self-defeating and destructive. If the beliefs B, are flexible and constructive, the consequences C, will likely be self-helping and constructive. People can change their lives and their consequences by D, disputing and challenging their beliefs. Rational therapy was partly developed as a reaction to psychoanalysis, in which it was assumed that understanding your negative beliefs was the most important part of self-change.

In the 1964, American psychiatrist Aaron T. Beck introduced Cognitive Therapy partly based on the ideas of Albert Ellis. It is a form of short term psychotherapy that focuses on current problems instead of on the past. The way we think about events influences how we feel and behave. We can change our thinking, and that will change

the way we feel and behave. Cognitive therapy helps us to identify our negative thinking and replace it with healthier thinking.

Steps in cognitive behavioral therapy

Although there are different ways to do cognitive behavioral therapy, it typically includes these steps:

Identify troubling situations or conditions in your life

These may include such issues as a medical condition, divorce, grief, anger or symptoms of a specific mental illness. The client and the therapist may have to spend some time deciding what problems and goals the client has to focus on.

Become aware of your thoughts, emotions and beliefs about these situations or conditions.

Once the client has identified the problems, the therapist will encourage the client to share their thoughts about them. This may include observing what the client tell to himself about an experience (your "self-talk"), his interpretation of the meaning of a situation, and his beliefs about himself, other people and events. The therapist may suggest the client to keep a journal of his thoughts.

Identify negative or inaccurate thinking.

To help the client recognizes patterns of thinking and behavior that may be contributing to the problem, the therapist may ask the client to pay attention to the physical, emotional and behavioral responses in different situations.

Challenge negative or inaccurate thinking.

As the client continues to examine the thought patterns, the therapist may encourage the client to test the validity of the thoughts and beliefs. This may include asking to himself whether the view of a situation is based on fact or based on an inaccurate perception of what's going on. This step can be difficult. Many thought patterns are first developed in childhood. Thoughts and beliefs that we held for a long time feel normal and correct, so it can be a challenge to recognize inaccuracies or negative tendencies in the thinking. With practice, helpful thinking and behavior patterns will become a habit, and won't take as much effort.

The process of identifying our negative thinking and replacing it with healthier thinking is called as cognitive restructuring. It involves changing misconceptions, unrealistic expectations and to identify and alter the client's typical way of belief and thoughts. Some of the cognitive techniques are:

Activity scheduling: It is tracking the activities throughout the day and rating them for pleasure, mastery, anxiety, sadness, fear, or other feelings or sensations. Example: The patient uses an hourly schedule to track his moods and activities.

Graded task assignments: It is planning and enacting behaviors that are expected to produce pleasure or mastery. Often these behaviors are chosen from a reward menu that the patient and therapist construct. Example: The patient lists behaviors that he used to engage in before he was depressed and agrees to assign these activities to himself beginning with the least difficult and progressing to more difficult behaviors.

Behavioral rehearsal: The patient enacts and practices the behavior which he plans to follow in any social situation. Example: The patient demonstrates in session how he would assert himself with his boss.

Homework: Regardless of what technique is used, independent homework to understand the behavior will be required. This can be done in a variety of ways such as journaling or collecting data of when the behaviors occur. This forces the client to be responsible for understanding the behavior and the thoughts that cause it.

Cognitive therapy is used for the treatment of depression, anxiety disorders, panic disorders, phobias and eating disorders.

GROUP PSYCHOTHERAPY

Group psychotherapy or group therapy was introduced by Joseph H. Pratt, Trigant Burrow and Paul Schilder for parents of tuberculosis patients. Pratt believed that these patients could provide mutual support and assistance. Some early psychoanalysts, especially Alfred Adler, a student of Sigmund Freud, believed that many individual problems were social in origin. In the 1930s Adler encouraged his patients to meet in groups to provide mutual support. It is a form of psychotherapy in which one or more therapists treat a small group of clients together as a group. The purpose of group psychotherapy is to promote the personal growth and psychological health of its members. Although the composition, theme and length may vary, all group psychotherapy has in common: (i) A group psychotherapist: He is specially trained in the theory and technique of group psychotherapy. (ii) A regular meeting time and place: group therapy generally meets once weekly, but this can vary. Some groups are time limited (meet for a fixed number of sessions), others are open ended with members joining and leaving from time to time. (iii) A focus on self-examination and exploration of interpersonal relationships: This is the ultimate focus of most types of psychotherapy, although the particular methods and style varies depending on the therapist's orientation. The people in the group share similar problems.

The duration of the group therapy may be 1- 2 hours. Group therapy may utilize psychoanalytic, supportive, and transactional or behavioral approaches. The aim of group psychotherapy is to help with solving the emotional difficulties and to encourage the personal development of the participants in the group. The noted psychiatrist Dr. Irvin D. Yalom in his book The Theory and Practice of Group Therapy identified 11 curative factors that are the primary agents of change in group therapy.

Instillation of hope

All patients come into therapy hoping to decrease their suffering and improve their lives. Because each member in a therapy group has different coping ability and when they watch others cope with and overcome similar problems successfully, it instills hope and inspiration. New members or those in despair may be particularly encouraged by others' positive outcomes.

Universality

A common feeling among group therapy members, especially when a group is just starting, is that of being isolated, unique, and apart from others. Many who enter group therapy have great difficulty sustaining interpersonal relationships, and feel unlikable and unlovable. Group therapy provides a powerful antidote to these feelings. For many, it may be the first time they feel understood and similar to others. Enormous relief often accompanies the recognition that they are not alone; this is a special benefit of group therapy.

Information giving

An essential component of many therapy groups is increasing members' knowledge and understanding of a common problem. Explicit instruction about the nature of their shared illness, such as bipolar disorders, depression, panic disorders, or bulimia, is often a key part of the therapy. Most patients leave the group far more knowledgeable about their specific condition than when they entered. This makes them increasingly able to help others with the same or similar problems.

Altruism

Group therapy offers its members a unique opportunity: the chance to help others. Often patients with psychiatric problems believe they have very little to offer others because they have needed so much help themselves; this can make them feel inadequate. The process of helping others is a powerful therapeutic tool that greatly enhances members' self-esteem and feeling of self-worth.

Corrective recapitulation of the primary family

Many people who enter group therapy had troubled family lives during their formative years. The group becomes a substitute family that resembles—and improves upon—the family of origin in significant ways. Like a family, a therapy group consists of a leader (or coleaders), an authority figure that evokes feelings similar to those felt toward parents. Other group members substitute for siblings, seeking for attention and affection from the leader/parent, and forming subgroups and coalitions with other members. This recasting of the family of origin gives members a chance to correct dysfunctional interpersonal relationships in a way that can have a powerful therapeutic impact.

Improved social skills

According to Yalom, social learning, or the development of basic social skills, is a therapeutic factor that occurs in all therapy groups. Some groups place considerable emphasis on improving social skills, for example, with adolescents preparing to leave a psychiatric hospital, or among bereaved or divorced members seeking to date again. Group members offer feedback to one another about the appropriateness of the others' behavior. While this may be painful, the directness and honesty with which it is offered can provide much-needed behavioral correction and thus improve relationships both within and outside the group.

Imitative behavior

Research shows that therapists exert a powerful influence on the communication patterns of group members by modeling certain behaviors. For example, therapists model active listening, giving nonjudgmental feedback, and offering support. Over time, members pick up these behaviors and incorporate them. This earns them increasingly positive feedback from others, enhancing their self-esteem and emotional growth.

Interpersonal learning

Human beings are social animals, born ready to connect. Our lives are characterized by intense and persistent relationships, and much of our self-esteem is

developed via feedback and reflection from important others. Yet we all develop distortions in the way we see others, and these distortions can damage even our most important relationships. Therapy groups provide an opportunity for members to improve their ability to relate to others and live far more satisfying lives because of it.

Group Cohesiveness

Belonging, acceptance, and approval are among the most important and universal of human needs. Being a part of a group fulfill these basic human needs. Many people with emotional problems, however, have not experienced success as group members. For them, group therapy may make them feel truly accepted and valued for the first time. This can be a powerful healing factor as individuals replace their feelings of isolation and separateness with a sense of belonging.

Catharsis

Catharsis is a powerful emotional experience—the release of conscious or unconscious feelings—followed by a feeling of great relief. Catharsis is a factor in most therapies, including group therapy. It is a type of emotional learning, as opposed to intellectual understanding, that can lead to immediate and long-lasting change. While catharsis cannot be forced, a group environment provides ample opportunity for members to have these powerful experiences.

Existential factors

Existential factors are certain realities of life including death, isolation, freedom, and meaninglessness. Becoming aware of these realities can lead to anxiety. The trust and openness that develops among members of a therapy group, however, permits exploration of these fundamental issues, and can help members develop an acceptance of difficult realities.

TYPES OF GROUP

Homogeneous and heterogeneous groups

Most of the therapists believe that for a group to be effective it must be heterogeneous including people from all races, social levels, all educational levels, of varying ages and both sexes. Patients between ages of 20 to 60 can be a part of same group. Homogeneous groups consist of people of the same gender and the same category.

Open and Closed Groups

Closed groups have fixed number of members. If one member leaves the group no new members are accepted. In open groups members are more fluid, and new members are taken in whenever the old members leave.

Small groups and large groups

A group may be small consisting of minimum of 8 members or a large group consisting of more than 8 members.

FAMILY THERAPY

Family therapy is based on the belief that the family is a unique social system with its own structure and patterns of communication. These patterns are determined by many factors, including the parents' beliefs and values, the personalities of all family members, and the influence of the extended family (grandparents, aunts, and uncles). As a result of these variables, each family develops its own unique personality, which is powerful and affects all of its members. Family therapy is based on the following concepts as well. (I) Illness in one family member may be a symptom of a larger family problem. To treat only the member who is identified as ill is like treating the symptom of a disease but not the disease itself. It is possible that if the person with the illness is treated but the family is not, another member of the family will become ill. This cycle will continue until the problems are examined and treated. (ii) Any change in one member of the family affects both the family structure and each member individually. The main purpose of a family therapy is

1. To treat the family as a unit.

2. To change the way the family members interact.
3. To help the family members clarify and express their feelings.
4. To develop mutual understanding.
5. Workout effective ways to relate to one another.

The main goals of family therapy are

1. To change the maladaptive roles which governs a family.
2. To give individual approach to family members.
3. To increase communication between family members and
4. To make family members accept responsibility for their actions.

TYPE OF FAMILY THERAPY

Family group therapy

It combines the principles of family therapy and group therapy. A group of families come together with a treatment approach that is born of necessity. Family Group Therapy have been developed to treat inpatient and outpatients struggling with different forms of addiction, mental health problems and perhaps, most significantly, in the management of schizophrenia. Family Group Therapy is usually conducted in residential treatment centers, community clinics and psychiatric hospitals. The goal of treatment is to help the information flow freely within the family system to and from the outside world.

The goals of Family group therapy are: (i) to help each family member deal with his/here reality; (ii) to improve communication between family members; (iii) to change how the family works; (iv) to help the therapist as a change agent by sharing the group leadership experience with peers (co-therapists), nursing staff, trainees and families.

Social network therapy

In social network therapy the social community or network of the disturbed patient meets in a group session with the patient. The network includes those with whom

the patients come into contact in daily life, not only the immediate family, but also relatives, friends, teachers, staffs etc.

Paradoxical therapy

Paradoxical therapy consists of suggesting that the patient intentionally engages in the unwanted behaviour, such as performing compulsive ritual or bringing on a conversion attack. It can be defined as those interventions in which the therapist apparently promotes the worsening of problems rather than their removal. The paradoxical approach has been reported to be successful with symptoms such as obsessive behaviour and thinking, insomnia, migraine headaches, anorexia nervosa, phobic neurosis and psychotic state. The patients are encouraged to have severe panic attacks or conversion attacks. When patients experience these attacks frequently, twice a day they become insensitive to their anxiety-related problems and satisfaction its symptom and this may bring about a change of attitude towards the symptom which enables the patients to place themselves at a distance from the symptom. When this is conducted in group, the patient sees his symptom in other people and this leads in development of insight about the illness.

MARITAL THERAPY

Couple or marital therapy is a form of psychotherapy designed to modify the interaction of two people who are in conflict with each other over one parameter or a variety of parameter - social, economic, sexual or economic. A trained person establishes a therapeutic contract with a patient - couple and, through definite types of communication attempts to alleviate the disturbances, to reverse or change mal adaptive patterns of behaviour and to encourage personality growth and development.

Typical marital problems that couples seek treatment for include:

1. Inability to compromise
2. Sexual difficulties
3. Financial disputes
4. Child-rearing conflicts
5. Extended family issues (e.g., dealing with in-laws)

MARITAL THERAPY APPROACHES

Emotionally Focused Marital Therapy

Emotionally focused marital therapy enables couples to identify and break free of their destructive emotional cycles such as when one person criticizes and the other withdraws. The therapy helps couples build trust in each other.

Insight-Oriented Marital Therapy

Insight-oriented marital therapy is a combination of behavioral therapy and teaching couples how to understand their power struggles, defense mechanisms, and other negative behaviors.

TYPES OF MARITAL THERAPY

Individual therapy

In individual therapy the partners may consult different therapists who do not necessarily communicate with each other and indeed may not know each other. The goal of treatment is to strengthen each partner's adaptive capacities. At times only one of the patient is in treatment and in such cases the person who is not in treatment visit the therapist to give information about the patient which may be overlooked.

Individual couple therapy

In individual couple therapy, both the partner is in therapy, which is either concurrent with the same therapists or collaborative with each partner seeing different therapists.

Conjoint therapist

Either one or two therapists treat the partners in joint session. Co therapy with therapists of both sexes prevents a particular patient from feeling ganged up on when confronted by two members of the opposite sex.

Four way session

Here both the patients are seen by different therapists with regular joint sessions in which all four persons participate.

Group psychotherapy

Group usually contains 3 to 4 couples and one or two therapists. The couple identifies with one another and recognizes that others have similar problem. Each gains support and empathy from fellow group members of the same or opposite sex. They gain new information from their peer group and each receive specific feedback about their about his or her behaviour.

Combined therapy

It includes all or any of the above said techniques used concurrently or in combination. It may start with an individual therapy and may continue as conjoint therapy and end in group therapy.

BEHAVIOUR THERAPY

The term behavior in behavior therapy refers to a person's observable actions and responses. Behaviour therapy is used to help "clients acquire new coping skills, improve communication, or learn to break maladaptive habits and overcome self-defeating emotional conflicts". The behavioural therapist focuses on interpreting the client's behaviour, emphasizing a collaborative and positive relationship with the client and values the use of objectivity to assess and understand the client. Behavior therapy involves changing the behavior of patients to reduce dysfunction and to improve quality

of life. It is a type of psychotherapy which is based on theories of learning particularly the Skinner's operant conditioning and Pavlov's classical conditioning.

THE PROBLEM

It views problem as essentially the result of a failure to learn necessary adaptive behaviors or competencies or the learning of ineffective and maladaptive behaviors. It may happen due to conflicting situations that require the individual to make discriminations or decisions of which he feels incapable.

BEHAVIORAL TECHNIQUES

1. Systematic desensitization

This anxiety reducing technique is based on the learning principle and it is developed by Joseph Wolpe. It is a technique to deal with a wide variety of maladaptive emotional behaviour, particularly involving anxiety, irrational fears and phobias and other forms of dysfunctions. It employs counter conditioning, substituting one type of response for another, to lower the client's level of fear. In a relatively relaxed state the client is exposed, step by step to increasingly stronger stimuli until what used to bring about fear can now be experienced in a state of relaxation. The procedure involves three basic steps: (i) training in deep muscle relaxation (ii) constructing a hierarchy of emotionally provoking situations (iii) pairing the items in the hierarchy with a state of relaxation.

Relaxation training

The most common form of relaxation used by the behavior therapists is called progressive relaxation or muscle relaxation. The basic premise of relaxation therapy is muscle tension worsens the anxiety and as a result the individuals experience a reduction in felt anxiety by learning to discriminate between tense and relaxed muscle group and relax them upon cue. It involves training the clients to tense and relax various muscle groups in their bodies while the counselor directs their attention to pleasant sensations.

Constructing hierarchy

It involves identifying various situations that evoke fear or anxiety. It also involves situations the client has already experienced or anticipates that situation in future and consists of 10 to 20 different items arranged by the client in order from lowest or least anxiety provoking to the highest.

Eg: See the word ‘snake’ in book

See a picture of a snake in a book

See a live snake in zoo

See a dead snake

Touch a dead snake

Touch a live snake held by some one

Hold a live snake

Pairing

Once the hierarchy has been constructed and the client has been trained in muscle relaxation, the counselor and the client begins the pairing process. This starts with the counselor and client agreeing on a signal the client can use to let the counselor know if and when the client is experiencing any anxiety during the pairing. A state of relaxation is then induced for the client and the counselor asks the client to imagine the first item on the hierarchy. The scene is presented for 10 seconds and if the client does not produce any anxiety, the counselor presents the next item on the hierarchy.

2. Token economy

A token economy is a form of behavior modification designed to increase desirable behavior and decrease undesirable behavior with the use of tokens. Individuals receive tokens immediately after displaying desirable behavior. The tokens are collected and later exchanged for a meaningful object or privilege. The goal of token

economies is to teach appropriate behavior and social skills that can be used in one's natural environment.

Elements to be covered in token economy

Tokens

Anything that is visible and countable can be used as a token. Tokens should preferably be attractive, easy to carry and dispense, and difficult to counterfeit..

A clearly defined target behavior

Individuals participating in a token economy need to know exactly what they must do in order to receive tokens. Desirable and undesirable behavior is explained ahead of time in simple, specific terms. The number of tokens awarded or lost for each particular behavior is also specified.

Back-up reinforcers

Back-up reinforcers are the meaningful objects, privileges, or activities that individuals receive in exchange for their tokens. Examples include food items, toys, extra free time, or outings. The success of a token economy depends on the appeal of the back-up reinforcers.

A system for exchanging tokens

A time and place for purchasing back-up reinforcers is necessary. The token value of each back-up reinforcer is pre-determined based on monetary value, demand, or therapeutic value. For example, if the reinforcer is expensive or highly attractive, the token value should be higher. If possession of or participation in the reinforcer would aid in the individual's acquisition of skills, the token value should be lower. If the token value is set too low, individuals will be less motivated to earn tokens. Conversely, if the value is set too high, individuals may become easily discouraged. It is important that each individual can earn at least some tokens.

A system for recording data

Before treatment begins, information (baseline data) is gathered about each individual's current behavior. Changes in behavior are then recorded on daily data sheets. This information is used to measure individual progress, as well as the effectiveness of the token economy. Information regarding the exchange of tokens also needs to be recorded.

Consistent implementation of the token economy by staff

In order for a token economy to succeed, all involved staff members must reward the same behaviors, use the appropriate amount of tokens, avoid dispensing back-up reinforcers for free, and prevent tokens from being counterfeited, stolen, or otherwise unjustly obtained.

Advantages of token economies are that behaviors can be rewarded immediately, rewards are the same for all members of a group, use of punishment (response cost) is less restrictive than other forms of punishment, and individuals can learn skills related to planning for the future. Disadvantages include considerable cost, effort, and extensive staff training and management. Some professionals find token economies to be time-consuming and impractical.

3. Aversive therapy

Aversion therapy is a form of behavior therapy in which an aversive (causing a strong feeling of dislike or disgust) stimulus is paired with an undesirable behavior in order to reduce or eliminate that behavior. The therapist begins by assessing the problem, most likely measuring its frequency, severity, and the environment in which the undesirable behavior occurs. The most important choice the therapist makes is the type of aversive stimulus to employ. The aversive stimulus may be any electric shocks or removal of any positive reinforcements. The first formal use of aversion therapy was made use by Kantorovich in 1930 who administered electric shock to alcoholics in

association with sight, smell, and taste of alcohol. Since then it is used in the treatment of wide range of maladaptive behavior.

4. Flooding

Flooding was invented by psychologist Thomas Stampfl in 1967. It is sometimes referred to as exposure therapy or prolonged exposure therapy. As a psychotherapeutic technique, it is used to treat phobia and anxiety disorders including post traumatic stress disorder. It works by exposing the patient to their painful memories, with the goal of reintegrating their repressed emotions with their current awareness. In doing so they realize that they have encountered their most dreaded object or situation, and come to know that it causes no actual harm, can be a powerful form of therapy. The exposure may occur in the actual presence of the feared object (eg a spider), in which case this is said to bein vivo exposure. Alternatively the procedure may involve looking at pictures of the feared stimulus, or producing internal imagery (so called imagianal approach). Flooding maximizes the anxiety state of the client.

5. Modeling

It is used to help a client acquire desired responses or to extinguish fears through observing the behavior of another person. This observation can be presented in a live modeling demonstration, in symbolic form through written and media taped models or via the client's own imagination. Through live modeling the counselor can demonstrate a behavior by role playing, taking the part of client and showing him or her a different way to behave or respond or behave. The counselors also make use of symbolic models through audiotapes or videotapes in which a desired behavior is introduced and presented. Yet another way of using modeling technique is to have the client imagine a model performing a desired behavior or activity.

6. Time out

Time out is an effective disciplinary technique in which no physical punishment is used. It involves removing the person from the environment and activities in which the inappropriate and undesirable behavior occurred and placing him or her in

a specific place for a specific amount of time to be quiet and reflect on the behavior. It provides an opportunity for the person to try to regain control of emotions.

7. Positive reinforcement

Reinforcement is a term in operant conditioning and behavior analysis for the process of increasing the rate or probability of a behavior by the delivery or emergence of a stimulus (e.g. a candy) immediately or shortly after the behavior, called a response, is performed. Reinforcement can be either positive or negative. Positive reinforcement is the process whereby desirable behavior is encouraged by presenting a reward at the time of occurrence of such behavior.

8. Negative reinforcement

Negative reinforcement occurs when a behavior is reinforced by removal of a stimulus. The word negative does not mean unpleasant. It means a stimulus is removed or subtracted from the situation as a form of reinforcement. It is different from punishment. Punishment is presenting an aversive stimulus contingent on a response, with a goal to reduce the response.

ELECTRO CONVULSIVE THERAPY

It is introduced in the year 1938 by Cerletti and Bini. ECT is a procedure in which electric currents are passed through the brain, deliberately triggering a brief seizure. Electroconvulsive therapy seems to cause changes in brain chemistry that can immediately reverse symptoms of certain mental illnesses. The usual dose of electricity is 70–150 volts for 0.1–0.5 seconds. This therapy is given under anesthesia using muscular relaxation.

WHEN IS ECT ADMINISTERED

ECT is administered if any one of the following criteria is met

1. Patient is unresponsive to effective medications, given for adequate dose and duration, that are indicated for the member's condition (e.g., antidepressants, antipsychotics, etc., as appropriate); *or*
2. Patient is unable to tolerate effective medications or has a medical condition for which medication is contraindicated; *or*
3. Patient has had favorable responses to ECT in the past, *or*
4. Patient is unable to safely wait until medication is effective (e.g., due to life-threatening inanition, psychosis, stupor, extreme agitation, high suicide or homicide risk, etc.); *or*
5. Patient is experiencing severe mania or depression during pregnancy; *or*
6. Patient prefers ECT as a treatment option in consultation with the psychiatrist.

TREATMENT OF MENTAL ILLNESS

Electroconvulsive therapy (ECT) can provide rapid, significant improvements in severe symptoms of a number of mental health conditions. It may be an effective treatment in someone who is suicidal, for instance, or end an episode of severe mania. ECT is used to treat:

Severe depression, particularly when accompanied by detachment from reality (psychosis), a desire to commit suicide or refusal to eat.

Treatment-resistant depression, long-term depression that doesn't improve with medications or other treatments.

Schizophrenia, particularly when accompanied by psychosis, a desire to commit suicide or hurt someone else, or refusal to eat.

Severe mania, a state of intense euphoria, agitation or hyperactivity that occurs as part of bipolar disorder. Other signs of mania include impaired decision making, impulsive or risky behavior, substance abuse and psychosis.

Catatonia, characterized by lack of movement, fast or strange movements, lack of speech, and other symptoms. It's associated with schizophrenia and some other psychiatric disorders. In some cases, catatonia is caused by a medical illness.

Electroconvulsive therapy is sometimes used as a last-resort treatment for:

Treatment-resistant obsessive compulsive disorder, severe obsessive compulsive disorder that doesn't improve with medications or other treatments

Parkinson's disease, epilepsy, and certain other conditions that cause movement problems or seizures

Tourette syndrome that doesn't improve with medications or other treatments

RISKS IN ADMINISTERING ECT

Confusion

Immediately after an ECT treatment, the client may experience a period of confusion. This confusion may last from a few minutes to several hours. The client may be able to return to work and normal activities right away; or, may need to rest for several hours after treatment. Rarely, confusion may last several days or longer. Confusion is generally more noticeable in older adults.

Memory loss

ECT can affect memory in several ways. The client may have trouble remembering events that occurred before treatment began, a condition known as retrograde amnesia. It may be hard to remember things in the weeks or months leading up to treatment, although some people do have problems with memories from years previous, as well. And some people have trouble with memory of events that occur even after ECT has stopped. These memory problems usually improve within a couple of months.

Physical side effects

On the days the client have an ECT treatment, he or she may experience nausea, vomiting, headache, jaw pain, fracture of the bones, muscle ache or muscle spasms. These are common and generally can be treated with medications.

Medical complications

As with any type of medical procedure, especially one in which anesthesia is used; there are risks of medical complications. During ECT, heart rate and blood pressure increase, and in rare cases, that can lead to serious heart problems.

TYPES OF ECT

Direct ECT

The ECT is given without any anesthesia or any muscle relaxation.

Modified ECT

It is generally administered under the supervision of an anesthetist.

Bilateral ECT

In bilateral ECT, the electrical current is passed across the whole brain. It can be further subdivided into bitemporal and bifrontal ECT. In bitemporal ECT, the current is passed across the temporal lobes, with an electrode being placed on either side of the head. Bifrontal ECT is a modified form of bitemporal ECT in which the electrodes are placed on the fore head. Bilateral ECT seems to work more quickly and effectively and it's probably the most widely used in Britain; however, it may cause more side effects.

Unilateral ECT

In unilateral ECT, the electrodes are only placed on the right side of the head, to pass the current primarily through the right temporal lobe. Unilateral ECT has fewer side effects, but may not be as effective; it is also more difficult to do properly.

BENEFITS OF USING ECT

Many people begin to notice an improvement in their symptoms after two or three treatments with electroconvulsive therapy. Full improvement may take longer, though. Response to antidepressant medications, in comparison, can take several weeks or more. No one knows for certain how ECT helps treat severe depression and other mental illnesses. What is known, though, is that many chemical aspects of brain function are changed during and after seizure activity. These chemical changes may build upon one another, somehow reducing symptoms of severe depression or other mental illnesses.

CHEMOTHERAPY

Chemotherapy is a drug treatment that uses powerful chemicals o kill bacteria, viruses, fungi, and cancer cells. The term comes from two words that mean "chemical" and "treatment." Chemotherapy, often shortened to just "chemo," is a systemic therapy, which means it affects the whole body by going through the bloodstream. Chemotherapy is the only scientifically proven method that can reach virtually every part of the body to seek and destroy cancer cells that surgery and radiation cannot reach and sensitive instruments cannot see. It is able to do this because it circulates throughout the body. It is given orally or by injection.

Drug treatment for mental illness can be classified into

1. **Anti depressants drugs**

   They are used to treat symptoms of depression, but are also used for treating agro phobia and eating disorder. They have a general effect of increasing the availability of neuro transmitters norepinephrine and serotonin.

2. Anti psychotic drugs

   They are mainly used to treat schizophrenia and in some cases mania. They reduce the symptoms of schizophrenia.

3. Anti maniac drugs

    They control symptoms of mania and they made of lithium salts.

4. Anti anxiety drugs

    They reduce the level of anxiety.

SIDE EFFECTS THAT OCCUR DURING CHEMOTHERAPY TREATMENT

More common side effects of chemotherapy drugs that can occur during treatment include:

5. Nausea
6. Vomiting
7. Diarrhea
8. Hair loss
9. Loss of appetite
10. Fatigue
11. Fever
12. Mouth sores
13. Pain
14. Constipation
15. Easy bruising

Many of these side effects can be prevented or treated. Most side effects subside after treatment ends.

LONG-LASTING AND LATE-DEVELOPING SIDE EFFECTS

Chemotherapy drugs can also cause side effects that don't become evident until months or years after treatment. Late side effects vary depending on the chemotherapy drug, but can include:

1. Damage to lung tissue

2. Heart problems
3. Infertility
4. Kidney problems
5. Nerve damage (peripheral neuropathy)
6. Risk of a second cancer

PSYCHO SURGERY

Psychosurgery, also called neurosurgery for mental disorder (NMD), is the neurosurgical treatment of mental disorder. Psychosurgery is a collaboration between psychiatrists and neurosurgeons. During the operation, which is carried out under a general anesthetic, a small piece of brain especially the frontal and pre-frontal is destroyed or removed. Modern psychosurgical techniques target the pathways between the limbic system (the portion of the brain on the inner edge of the cerebral cortex) that is believed to regulate emotions, and the frontal cortex, where thought processes are seated. Psychosurgery should be considered only after all other non-surgical psychiatric therapies have been fully explored. India had an extensive psychosurgery programme until the 1980s, using it to treat addiction, and aggressive behaviour in adults and children, as well as for depression and OCD.

TYPES OF PSYCHO SURGERY

Lobotomy

It is a surgical procedure in which an incision is made between the frontal cortex and the lower part of the brain.

Pre frontal lobotomy

A lobotomy in which the white fibers that connect the thalamus to the prefrontal and frontal lobes of the brain are severed performed as a treatment for intense anxiety or violent behavior.

Cingulotomy

It is a form of brain surgery in which an electric current is used to destroy the cortex of the cingulate gyrus and part of the corpus callosum. Cingulate gyrus is used to Coordinates Sensory Input with Emotions, regulates aggressive behavior and helps in emotional response to brain. Corpus callosum is used to connect the left and right side of brain (hemisphere). The two hemispheres are physically separate and their only connection is through the corpus callosum, a thick white band of nerves deep within the brain. It allows the two hemispheres to communicate and coordinate their activities.

Some of the conditions for which various types of neuro surgery are performed

Parkinson's disease
Epilepsy
Obsessive Compulsive Disorder (OCD)
Obsessive Neurosis

MEGA VITAMIN THERAPY

Megavitamin therapy, also known as mega dose vitamin therapy or orthomolecular therapy, involves taking vitamins in doses that exceed the recommended dietary allowance (RDA) in an effort to cure or prevent physical or mental disorders. Megavitamin therapy dates back to the early 1930s when psychiatrists began prescribing excessive doses of supplemental nutrients to treat severe mental problems. "Megavitamin therapy" was first coined in 1952 by psychiatrists Humphry Osmond and Abram Hoffer to describe the large dosages of niacin used in the treatment of schizophrenia. Years later other vitamins, minerals, and hormones were added to treatments. In the 1950s, Biochemist Linus Pauling coined the term, "orthomolecular," which he defined as: "the preservation of good health and the treatment of disease by varying the concentration in the human body of substances that are normally present in the body." Orthomolecular psychiatrists make up approximately one percent of 30,000 of the nation's practicing psychiatrists. The scope of treatable disorders has broadened

since the initial treatment of schizophrenia to include epilepsy, autism, senility, childhood hyperactivity, arthritis, colds, herpes simplex virus, allergic and digestive problems. Many more diseases and chronic problems such as back ache, poor memory, psoriasis, etc. are being treated successfully by orthomolecular therapy. Orthomolecular medicine restores clear thinking in many thought disorders and when necessary may work in a complementary fashion with psychotherapy. It is greatly used in psychiatry on the notion that there is a reciprocal interaction between the behavioral and the biochemical. Psychological stress alters individual biochemistry and biochemical stress alters an individual's psychological state. This is because the behavioral is the sum of thousands of biochemical reactions; the biochemical is behavioral because cells and cell organelles of all kinds are communicating, moving, reacting, working, etc.

SOME EFFECTS OF MEGA VITAMIN THERAPY

1. High doses of vitamin A have been known to cause a range of effects from mild headaches to seizures. Recent findings suggest that too much of this vitamin can promote osteoporosis.
2. Too much vitamin D has been shown to cause muscle weakness, vomiting and cardiac arrhythmias.
3. Large amounts of B vitamins can slow blood flow, causing hypotension and numbness.
4. Vitamin C in high doses may cause vomiting and diarrhea, as well as increased levels of estrogen.

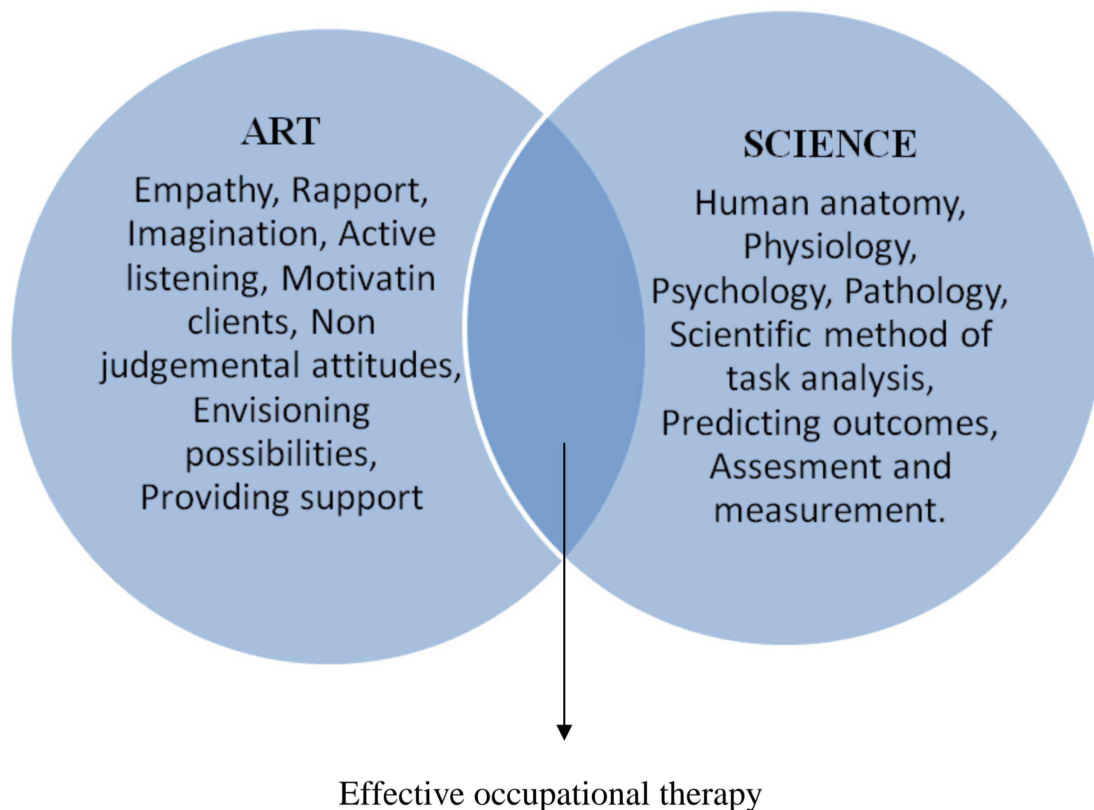
OCCUPATIONAL THERAPY

It is the use of purposeful activity or intervention designed to achieve functional outcomes which promote health, prevent injury or disability and which develop, improve sustain or restore the highest possible level of independency of any individual who has an injury, illness or cognitive impairment, psycho social dysfunctions, mental illness, developmental or learning disability or others disorders or conditions. It includes assessment by means of skilled observation or evaluation through the

administration and interpretation of standardized or non standardized tests and measurements.

It includes

1. The assessment and provision of treatment in consultation with the individual, family or other appropriate person.
2. Interventions directed towards developing, improving, sustaining or restoring daily living skills, including self care skills and activities that involve interaction with others and the environment, work readiness or work performance, play skills or leisure capacities, or enhancing educational performance skills.
3. Developing, improving, sustaining or restoring sensory motor, perceptual, or neuromuscular functioning, or range of motion or emotional, motivational, cognitive or psycho social components of performance.
4. Education of the individual, family or other appropriate person in carrying out appropriate interventions.



Effective occupational therapy

For an occupational therapy to be effective it should be a blend of both arts and science. The most important principle of Occupational Therapy is that of purposeful activity. It is through purposeful activity that OT is distinguished from other health care professions, and also the means of treatment used by an occupational therapist, the activity being physical or psychological. Hand-in-hand with purposeful activity is active participation. The therapist selects certain activities which will be beneficial to the client's condition, and reduce functional problems - this is known as the remedial purpose. In addition, activities in which the client shows an interest and feels comfortable performing is selected, being the second purpose.

The various stages of occupational therapy are;

1. Referral
2. Information gathering
3. Initial assessment
4. Needs identification/problem formation
5. Goal setting
6. Action planning
7. Action
8. Ongoing assessment and revision of action
9. Outcome and outcome measurement
10. End of intervention or discharge
11. Review

There are many advantages of this type of treatment: firstly, the client is involved in the process of doing something, and is therefore playing an active part in his/her therapy; the activities often involve repetition which is so crucial in neuro physiological integration; occupational therapy involves learning through doing which encourages and motivates the client, hence facilitating the healing process.

Unit III

Therapeutic Interventions in Psychiatric Illness

Psychotherapy is a form of treatment for behavioral, emotional, or cognitive disorders that usually involves counseling, the disclosure of personal information, and an attempt to change maladaptive psychological habits. It is an effort to understand the personality structure of patients, the mental mechanisms which are at work, and the specific relationship of psychological situation in the precipitation of the illness. It may be defined as a process which utilizes psychodynamic principles to bring about economical growth, thus permitting greater development of the individual's capacities and better social adjustment. It is two person relationships which has the purpose of modifying attitudes and behavior largely, though not exclusively through psychological process. In general it aims towards the personality growth in the direction of maturity, competence and self actualization. This involves the achievement if one or more of the following goals:

1. Increased insight into one's problem and behavior
2. A better delineation of one's self identity.
3. Resolution of handicapping or disability or disabling conflict
4. Changing of undesirable habits or reaction pattern
5. Improved interpersonal and other competencies
6. Modification of inaccurate assumption about oneself and one's world
7. The opening of a pathway to a more meaningful existence.

There are several main broad systems of psychotherapy:

INDIVIDUAL PSYCHOTHERAPY

Individual psychotherapy is usually performed by a psychiatrist, psychoanalyst, clinical psychologist, or licensed mental health professional. The goals of therapy may include simple emotional support; insight into sources of thoughts, feelings, perceptions, or behaviors; relief of symptoms such as anxiety or depression; stress management; behavioral changes; or crisis intervention. Psychotherapy sessions can be

short-term
(4 to 6 sessions), intermediate (up to 6 months), or long-term (6 months to several years); and can occur several times a week, weekly, bi-weekly, or on an as-needed basis. Each session lasts about 50 minutes and is conducted by the therapist with a single individual.

An authentic, open, and trusting relationship between a client and a therapist is crucial for psychotherapy to be successful. While often the process of psychotherapy involves a conversation between a client and a therapist, it is fundamentally different from a conversation between two friends. The main differences are as follows:

1. Individual psychotherapy is not a mutual support, typical for friends, but a professional relationship, aimed at the change in a client's life and elimination of client's suffering
2. Individual psychotherapy provides a client with a safe, non-judgmental, and confidential atmosphere for exploring truths of his or her life

During the initial period (usually the first session), the therapist attempts to establish rapport, assess the individual's needs, and determine therapeutic goals in cooperation with the individual. In an accepting, non-judgmental atmosphere, the individual is encouraged to talk about feelings, fears and anxieties, relationship issues, problematic behaviors, or disturbing thoughts. The therapist listens and provides comment and feedback based on training and experience. The therapist guides the individual to a deeper insight and understanding of his or her thoughts, feelings, and behaviors, and explores methods of self-acceptance or ways to make needed and desired changes. It is very effective in enhancing the social adjustment and social role performance of discharged patients. The therapeutic elements of individual psychotherapy are

1. Interview
2. Re assurance
3. Explanation
4. Ventilation

5. Guidance

COUNSELLING

It is defined by Patterson as “the process involving interpersonal relationship between a therapist and one or more clients by which the former employs psychological methods based on a systematic knowledge of human personality in attempting to improve the mental health of the latter”. It aims at enabling individual to solve present problems at prepare themselves for future tasks, to attain higher standards of efficiency and well being and to develop personal resources for growth. The committee on Definition of Division 17 of the American Psychological Association describes the objectives of counseling by stating that counseling psychologists contributes to the following

1. The client’s realistic acceptance of his own capacities, motivation and self attitudes.
2. The client’s achievement of a reasonable harmony with his social, economic and vocational environment and
3. Society’s acceptance of individual differences and their implication for community, employment and marriage relations.

Cormier and Hackney described three functions that goals serve in the counseling process: motivational, educational and evaluative. First goals can have a motivational function, especially when clients are involved in establishing the counseling goals. They may also be more motivated when they have specific, concrete goals to work toward. They help clients focus energy on specific issues. The second function of counseling goals is educational. From this perspective clients learn new skills and behaviors that they can use to enhance their functioning. For example the counseling goal might be to become more assertive, and so during the assertiveness training the client learns various skills. The third function of counseling goal is evaluative. Clear goals allow the counselor and client an opportunity to evaluate the process. The other general objectives of counseling are:

1. Facilitation behavior change: some of the behavior changes are usually necessary for the clients to resolve their concerns. The amount of change necessary varies from client to client. One client may need counseling to learn how to deal effectively with a child, while another might require psychotherapy to change an unhealthy, stressful life.
2. Enhancing coping skill: Erikson identified several developmental tasks and associated coping mechanism unique to various stages of development. For example intimacy and commitment are developmental tasks of young adulthood. Coping behavior are necessary to meet these developmental tasks. Some clients may have problems in coping and they require help.
3. Promoting decision making: some clients have difficulty making decision. They may feel no matter what they decide, it will be wrong. Difficulty making decision is often a normal reaction to a stressful life situation. In such cases the counselors may help the client by reassuring them and promote their decision making skills.
4. Improving relationship: Adler once suggested that the barometer of mental health is social interest. He believed that a person who did not have a close relationship with any one was at risk for mental problems. Counselors can use a wide variety of counseling strategies to help clients improve their relationships. The strategies may include social skill training programme, group counseling etc that focus on interpersonal relations.
5. Facilitating client's potential: The goals relate to the concept of self realization and self actualization. Self realization implies helping clients to become all they can, as they maximize their creative potential.

PROCESS OF COUNSELING

The entire process of counseling may take more than one session and it involves nearly five steps.

1. Stage one: relationship building

The counseling relationship is the heart of counseling process. A successful counseling requires core conditions like empathy, unconditional positive regard, congruence, respect for the client, immediacy, self disclosure etc.

Core conditions	Descriptions	purpose
Empathy	Communicating a sense of caring and understanding.	To establish rapport; gain an understanding of the client; and encourage self exploration of the client
Unconditional positive regard	Communicating to the clients that they have value and worth as individuals.	To promote acceptance of client as a person of worth as distinct from accepting the client's behavior.
Congruence	Behaving in a manner consistent with how one thinks and feels.	To be genuine in interaction with the client.
Respect	Focusing on the positive attributes of the client.	To focus on client's strength.
Immediacy	Communicating in the here and now about what is occurring in the counseling session.	To promote direct mutual communication between the counselor and the client.

Confrontation	Pointing out the discrepancies in what the client is saying and doing (between the statements and non verbal behavior)	To help the clients clearly and accurately understand themselves and the world around them.
Concreteness	Helping the client discuss themselves in specific terms.	To help clients focus on pertinent issues.
Self disclosure	Making the self known to others.	To promote increasing counseling relevant to communication from the client; enhancing the client's evaluation of the counselor; and increasing the client's willingness to seek counselling.

2. Stage two: assessment and diagnosis

Assessment and diagnosis help a counselor develop and in depth understanding of a client and identify problems that require attention. This understanding can facilitate goal setting and also suggests types of intervention strategies. Assessment strategies can be divided into standardized and non standardized measure. Standardized measures include psychological tests and non standardized measures include strategies like clinical interview and assessment of life history. Diagnosis helps the counselors to incorporate various symptoms of a client into a single diagnosis. It also helps the counselors to narrow down the treatment possibilities.

3. Stage three: Formulation of goals.

The clients are motivated when they have a specific and concrete goal to work over. The goals may be development of assertive skills, communication skills etc.

4. Stage four: Intervention and problem solving

Once the counselor and the client formulate the goal, they can determine what intervention strategy to implement. They can choose from a variety of interventions, including individual counseling, group, couple and family counseling. One way to conceptualize intervention is within the framework of problem solving. This approach would enable client to learn skills that could contribute to their personal autonomy.

5. Stage five: Termination and follow up

The ultimate goal in counseling is for counselors to become obsolete or unnecessary to their clients. This result can occur when clients have worked through their concerns and are able to proceed forward in their lives without the counselor's assistance. It is also advantage to plan the termination several weeks earlier to provide the client an opportunity to prepare psychologically. The counselor should arrange for appropriate follow up to evaluate how things are going without counseling.

TYPES OF COUNSELING

1. Individual counseling
2. Group counseling
3. Family counseling
4. Marital counseling
5. Vocational counseling
6. Industrial counseling
7. Educational counseling

DIFFERENCE BETWEEN COUNSELING AND PYCHOTHERAPY

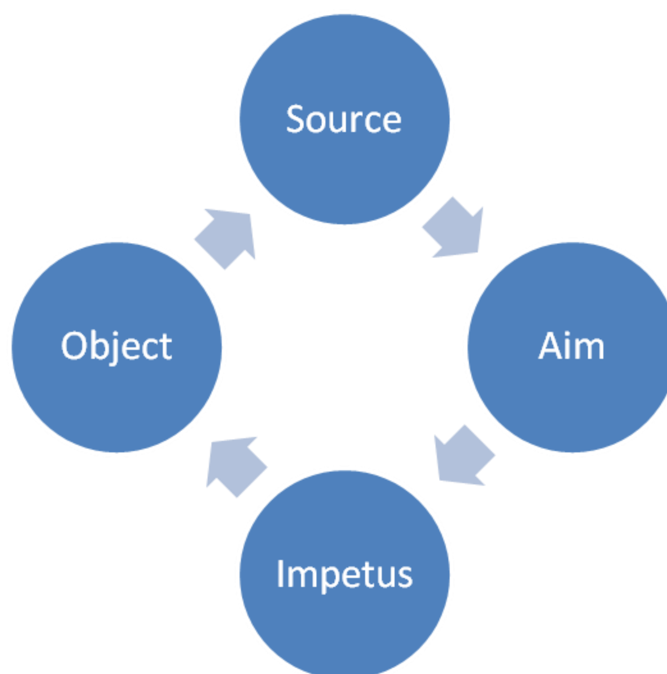
	Counseling	**psychotherapy**
Clients	Clients tend to have problems of living such as relationship difficulties, problems related to career etc.	Client's problems are more complex and may involve formal diagnostic procedures to determine if there is mental illness.
Goals	The focus is more on immediate goals.	The focus is on short term and long term goals. Long term goals can involve process such as helping the clients overcome a particular disorder.
Treatment approaches	The treatment program can include preventive approaches and various counseling strategies to assists with the client's concern.	Psychotherapeutic approaches are complex. They utilize strategies that relate to conscious and unconscious process.
Settings	It can be provided in a variety of settings such as schools, churches and mental health clinics	It is typically offered in settings such as private practice, mental health centers and hospitals.

PSYCHO ANALYTIC THEORY

Psycho analysis was introduced by Sigmund Freud. It attempts to analyze the developmental and functioning of personality and provides explanation of behavior. The psycho analytic approach suggests that human behavior is the result of a complex interplay of psychological process, both conscious and those beyond the limits of our awareness.

VIEW OF HUMAN NATURE

Freud's theory is deterministic; that is he assumes that all behaviour has a specific cause and that cause can be found in the psyche. Freud assumes that the normal, healthy, mental and behavioral pattern aims at reducing the tension created by an impulse to the previously acceptable level. Impulses are the pressure to act without conscious thoughts towards particular end. All impulses have four major components:



Tension reduction model

Source: It accounts for where the need arises. For example dry throats leads to need for water.

Aim: It is the reduction of the need until no more action is necessary. Eg: drinking of water

Impetus: It is the amount of energy, force or pressure that is used to satisfy need or gratify the impulses. Eg: A full bottle of water or just a glass of water.

Object: Anything or action that allows satisfaction of the original aim.

Many thoughts and behavior however do not seem to reduce tension and in fact they create tension, stress or anxiety. Freud believed in two basic impulses. They are the sexual energy and the aggressive energy. The life energy or the sexual energy is called as the libido and it is derived from the Latin word for "I desire." Once characteristic of libido is its mobility, the ease with which it can pass from one area of attention to another. Later Freud understood the importance of death instinct of the aggressive energy. He began to believe that every person has an unconscious wish to die. Death promises release from the struggles of life like poverty, hatred etc and many people viewed life to be more painful. Sometimes the people direct the death instinct in the form of aggressiveness, cruelty, murder, and destructiveness.

CATHEXIS

It is the process by which the available energy in the psyche is attached to or invested in a person, idea or thing. Libido that has been cathected is no longer mobile and can no longer move to any new objects.

Psychoanalytic theory is concerned with understanding where libido has been inappropriately cathected. Once released and redirected this same energy is then available to satisfy other current needs.

Freud’s theory of personality is characterized by several key concepts. They are the structure of personality, endopsychic conflict, defense mechanisms, the conscious unconscious continuum and the psychosexual stages of development.

THE STRUCTURE OF PERSONALITY

In Freud’s view the personality is made up of three autonomous yet interdependent systems: id, ego and super ego. These three parts or three factors are not physical parts of the personality. They cannot be located or seen but nonetheless, they are the real psychological process of the mind. They interact with one another in dynamic ways that change and influence personality.

Id is biological in nature and contains the reservoir of energy for all parts of the personality. Id is not modified as one grows and matures. The id is not changed by experience because it is not in contact with the external world. The main goals of Id are:1) to reduce tension 2) to increase pleasure 3) minimize discomfort. It is driven by pleasure principle, seeking immediate gratification. The contents of id are almost entirely unconscious. They include primitive thoughts that have never been conscious and thoughts that have been denied and found unacceptable to consciousness. Preoccupied with its own needs and desires, the id is selfish and self centered.

The ego is that portion of the psyche which is in contact with the external reality and operates on reality principle. The id is responsive to needs while ego is responsive to oppurtunities. It develops out of id and takes the task of insuring the health, safety and sanitation of the personality. Thus the ego is originally created in an attempt to cope with the need to reduce tension and increase pleasure. This problem-ssolving activity is called the secondary process. The highest function of ego is decision making. Anxiety is caused by the ego’s reaction to threatening or destructive urges from the id. To minimize this unpleasant emotional state, which may run from mild to extreme, the ego recruits a variety of internal defense mechanisms, which protects the person by blocking unacceptable urges or proportions from ever reaching conscious awareness.

The super ego develops not from id but from ego. It serves as the judge or sensor over the activities and thoughts of the ego and acts on morality principle. It is the repository of moral codes, standards of conducts, and those constructs that form the inhibition for the personality. The main functions of super ego are 1) to inhibit impulses from id 2) to alter the ego's orientation from realistic to moralistic 3) and to encourage the personality to strive for perfection. There are two aspects to the superego: One is the conscience, which is an internalization of punishments and warnings. The other is called the ego ideal. It derives from rewards and positive models presented to the child. The conscience and ego ideal communicate their requirements to the ego with feelings like pride, shame, and guilt.

The conflict between the three parts of the personality: the id, ego and the super ego is called as the endopsychic conflict. The conflict arises due to interaction between the three forces. These conflicts create anxiety. The anxiety can be **realistic anxiety** (anxieties arising due to fear) **moral anxiety** (This is what we feel when the threat comes not from the outer, physical world, but from the internalized social world of the superego. It is, in fact, just another word for feelings like shame and guilt and the fear of punishment) **neurotic anxiety** (This is the fear of being overwhelmed by impulses from the id)

DEFENSE MECHANISM

Freud's concept of defense mechanism was one of his most important theoretical achievements. Defense mechanisms develop unconsciously when the ego feels threatened by an endopsychic conflict. When this occurs, defense mechanism can be utilized to deny, falsify, or distort reality so that ego can cope. Some of the defense mechanisms are:

Projection

It is an attempt to attribute to another person, animal or object our own feelings and thoughts. Example instead of saying you hates someone, you say, "she hates me". The projection occurs because the ego is threatened by aggressive id impulses. The

person can therefore deal with actual feelings, but without admitting or being aware of the fact that the feared idea or behavior is his or her own.

Reaction formation

It is a way of coping by creating an extreme emotional response that is opposite of how one actually feels. This results in falsification of reality. For example a man may hate his wife and wants a divorce. At the same time due to guilt feeling, since he believes divorce is morally wrong may tell others how wonderful his wife is and how much he loves her.

Fixation

It can occur if the demands of life become too threatening. In an attempt to avoid new responsibilities, a person can avoid growing up and fixate, or stand still, in terms of development. When this occurs during adolescence, the individual's personality would remains like an adolescent for the remainder of life.

Regression

It is a reversion to an earlier level of development or to a mode of expression that is simpler and more child like. It is a way of alleviating anxiety by withdrawing from realistic thinking into behaviors that have in earlier years reduced anxiety. Where do we retreat when faced with stress? To the last time in life when we felt safe and secure, according to Freudian theory.

Repression

It is an attempt to cope by creating an avoidance response. In repression, the stressful situation is pushed from the consciousness to the unconscious dimensions of the mind.

Denial

It is an attempt to not to accept the reality an event that disturbs the ego. Adults have a tendency to 'day dream' that certain events are not so, that they didn't really

happen. The remarkable capacity to remember events incorrectly is the form of denial found most often in psychotherapy.

Rationalization

It is the process of finding acceptable reasons for unacceptable thoughts or actions. We use it to justify our behavior when in fact the reasons for our action are not commendable or not even understood by us. It is a way of accepting pressure from the superego.

Isolation

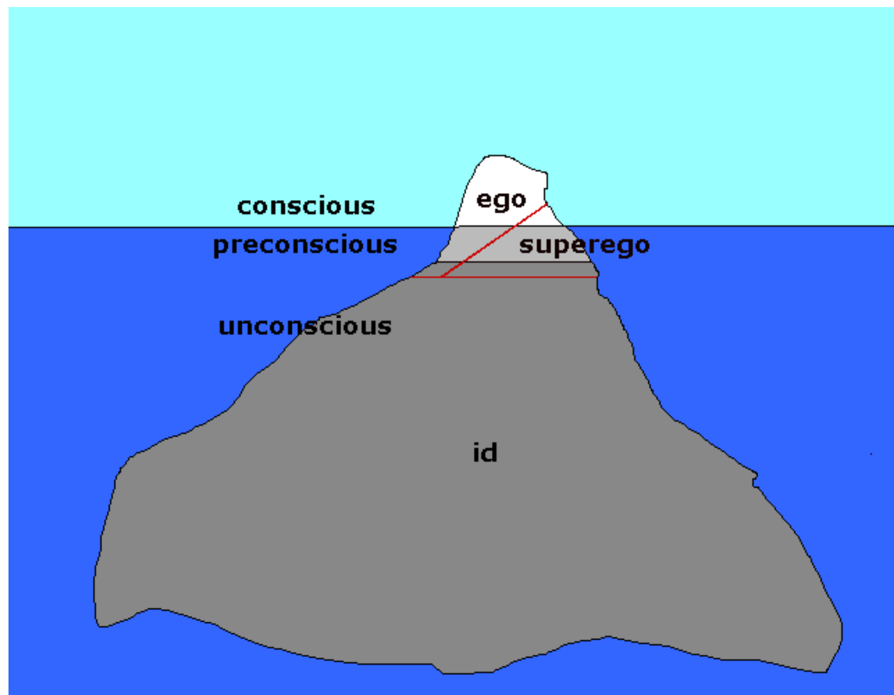
It is a way of separating the anxiety arousing parts of the situation from the rest of the psyche. It is the act of partitioning if off, so that there is little or no emotional reaction connected to the event. The result is that when a person discusses problems that have been isolated from the rest of the personality, the events are recounted with no feeling, as if they had happened to a third party.

Displacement

It is the redirection of an impulse onto a substitute target. If the impulse, the desire, is okay with you, but the person you direct that desire towards is too threatening, you can displace to someone or something that can serve as a symbolic substitute. Someone who is frustrated by his or her superiors may go home and kick the dog or beat up a family member.

THE CONSCIOUS – UNCONSCIOUS CONTINUUM

Freud was one of the first to explore the unconscious dimension of the human psyche. He believed that it held the key to understanding behavior and problem with personality. Freud conceptualized conscious and unconscious in terms of a continuum. The analogy of the iceberg can be used to understand this continuum.



Conscious mind

The conscious mind is what we are aware of at any particular moment, our present perceptions, memories, thoughts, fantasies and feelings.

Unconscious mind

According to Freud, the unconscious is the source of our motivations, whether they are simple desires for food or sex, neurotic compulsions, or the motives of an artist or scientist. And yet, we are often driven to deny or resist becoming conscious of these motives, and they are often available to us only in disguised form. The materials are not lost or forgotten, but it is not allowed to be remembered.

Preconscious mind

We call it as the “available memory:" Anything that can easily be made conscious, the memories we are not, at the moment thinking about but can be readily brought to consciousness. This might include memories of what we did yesterday, name of our school friends etc. It is like a holding area of memories that the consciousness needs in order to perform its functions.

PSYCHOSEXUAL STAGES OF DEVELOPMENT

According to Freud sex drive is the most important motivating force not only for adults but for children and even infants. It is true that the capacity for orgasm is there neurologically from birth. But Freud was not just talking about orgasm. Sexuality meant not only intercourse, but all pleasurable sensation from the skin. It is clear even to the most prudish among us that babies, children, and, of course, adults, enjoy tactile experiences such as caresses, kisses, and so on. As an infant becomes child, a child an adolescents and an adolescent an adult, there are marked changes in what is desired and how those desires are satisfied. The shifting modes of gratification and the physical area of gratification are the basic elements in Freud's description of developmental stages. He called them psychosexual stages emphasizing the role of sexuality in the development process.

THE ORAL STAGE (AGE 0 - 1.5)

Erogenous Zone in Focus: Mouth

Gratifying Activities: Nursing - eating, as well as mouth movement, including sucking, gumming, biting and swallowing.

Interaction with the Environment

During the first year if life, oral functions like sucking, eating, biting, cooing, and crying are the primary means of baby's gratification. The baby's gate way to the world is the mouth through which almost everything that enters the field of consciousness passes. During feeding the child is cuddled, soothed and fondled. The child associates both pleasure and reduction of tension with the feeding process.

At about eight months weaning begins, the breast is withdrawn and other foods are offered. This shift can be traumatic of the withdrawal is abrupt or uncaring. The

more difficult it is for the child to leave the mother's breast, the more the libido is fixed at the oral stage.

Too much or too little gratification can result in fixation. There are two modes of oral expressions: receptive (taking in) and aggressive (spitting out). According to Freud infants who are over indulged will grow up with an oral receptive character and they depend on others for their needs. They are over gullible, swallowing anything they are told. They will be interested in receiving information and acquiring material goods. The oral aggressive character retains a life-long desire to bite on things, such as pencils, gum, and other people. They have a tendency to be verbally aggressive, argumentative, sarcastic, and so on.

THE ANAL STAGE (AGE 1.5 - 3)

Erogenous Zone in Focus: Anus

Gratifying Activities: Bowel movement and the withholding of such movement

Interaction with the Environment

Around the age of two or three the child moves into the anal stage, when libidinal gratifications are met through the regions of anus. Here the child receives sexual gratification in two ways: eliminating feces and retaining them. The major event at this stage is toilet training, a process through which children are taught when, where, and how excretion is deemed appropriate by society. Children at this stage start to notice the pleasure and displeasure associated with bowel movements. Through toilet training, they also discover their own ability to control such movements. Along with it comes the realization that this ability gives them power over their parents. That is, by exercising control over the retention and expulsion of feces, a child can choose to either grand or resist parents' wishes.

Anal Fixation

Anal-Expulsive Personality: If the parents are too lenient and fail to instill the society's rules about bowel movement control, the child will derive pleasure and success from the expulsion. Individuals with a fixation on this mode of gratification are excessively sloppy, disorganized, reckless, careless, and defiant.

Anal-Retentive Personality: If a child receives excessive pressure and punishment from parents during toilet training, he will experience anxiety over bowl movements and take pleasure in being able to withhold such functions. Individuals who fail to progress pass this stage are obsessively clean and orderly, and intolerant of those who aren't. They may also be very careful, stingy, withholding, obstinate, meticulous, conforming and passive-aggressive.

THE PHALLIC STAGE (Age 4 - 5)

Erogenous Zone in Focus: Genital

Gratifying Activities: Masturbation and genital fondling

Interaction with the Environment

Around the age of four or five, the child enters the phallic stage, when satisfaction is gained primarily through stimulation of the penis or clitoris. This is probably the most challenging stage in a person's psychosexual development. The key event at this stage, according to Freud, is the child's feeling of attraction toward the parent of the opposite sex, together with envy and fear of the same-sex parent. In boys, this situation is called the "Oedipus Complex" named after the young man in a Greek myth who killed his father and married his mother, unaware of their true identities. Boys in the midst of their Oedipus complex, often experience intense "castration anxiety", which comes from the fear of punishment from the fathers for their desire for the mothers. Girls' Electra complex involves "penis envy". That is, according to Freud, the girl believes that she once had a penis but that it was removed. In order to compensate for its loss, the girl wants to have a child by her father. Success or failure in the Oedipus conflict is at the core of either normal psychological development or psychological

disorder. If a child is able to successfully resolve the conflict, he or she will have learnt to control their envy and hostility and begin to identify with and model after the parent of their own sex, and are ready to move on to the next developmental stage.

Phallic Fixation

For men: Anxiety and guilt feelings about sex, fear of castration, and narcissistic personality.

For women: It is implied that women never progress past this stage fully and will always maintain a sense of envy and inferiority, although Freud asserted no certainty regarding women's possible fixations resulting from this stage. Similarly, Freud admitted uncertainty on the females' situation when he constructed the "penis envy" theory in the first place.

LATENCY STAGE (AGE 5 - PUBERTY)

Erogenous Zone in Focus: None

Interactions with the Environment

This is a period during which sexual feelings are suppressed to allow children to focus their energy on other aspects of life. This is a time of learning, adjusting to the social environment outside of home, absorbing the culture, forming beliefs and values, developing same-sex friendships, engaging in sports, etc. This period of sexual latency lasts five to six years, until puberty, upon which children become capable of reproduction, and their sexuality is re-awakened. Problems could occur during this period if the parents did not encourage the child’s interest in establishing positive social relationships. As a result the child might not be able to develop the social skills necessary for the successful interpersonal relationship.

GENITAL STAGE (FROM PUBERTY ON)

Erogenous Zone in Focus: Genital

Gratifying Activities: Masturbation and heterosexual relationships

Interaction with the Environment

The focus of this period is an opposite sex relationship leading to experience of intimacy. This stage is marked by a renewed sexual interest and desire, and the pursuit of relationships.

Fixations

This stage does not cause any fixation. According to Freud, if people experience difficulties at this stage, and many people do, the damage was done in earlier oral, anal, and phallic stages. These people come into this last stage of development with fixations from earlier stages. For example, attractions to the opposite sex can be a source of anxiety at this stage if the person has not successfully resolved the Oedipal (or Electra) conflict at the phallic stage.

MAJOR METHODS AND TECHNIQUES

Freud developed many techniques that could be used n psychoanalysis. Their main aim is to make the unconscious conscious. Some of the more commonly used techniques are as follows:

Free association

It encourages the patient to discuss whatever comes to the mind, thereby overcoming the patient's tendencies to suppress or censor information. The theory is that, with relaxation, the unconscious conflicts will inevitably drift to the fore. However, in therapy, there is the therapist, who is trained to recognize certain clues to problems and their solutions that the client would overlook.

Dream analysis

In sleep, we are somewhat less resistant to our unconscious and we will allow a few things, in symbolic form, of course, to come to awareness. Freud found consistent symbol in dreams signified the same thing for everyone. For example, he said steps, stairs, ladders, and staircase represents sexual intercourse.

Parapraxes

A parapraxis is a slip of the tongue, often called a Freudian slip. Freud felt that they were also clues to unconscious conflicts. Freud was also interested in the jokes his clients told. In fact, Freud felt that almost everything meant something almost all the time - dialing a wrong number, making a wrong turn, misspelling a word, were serious objects of study for Freud.

Catharsis

It is the sudden and dramatic outpouring of emotion that occurs when the trauma is resurrected.

Some of the drawbacks of Freud psychoanalytic theory are that the role of environment has been overlooked. There is no scientific proof and the cure rate is very low. Too much of emphasis is given on sexuality and the therapy is time consuming and expensive.

AGE	STAGE	TASK
0 -18 mos.	Oral	Oral Gratification o behaviors: eating, crying, biting, dependency to primary caregiver o distinguishes between self and mother o develops body image and aggressive drives
18 mo - 3 yrs.	Anal	Voluntary sphincter control o behaviors: independence and control o pleasure through elimination or retention of feces o develops concepts of power, punishment, ambivalence, cleanliness
3 - 6 yrs.	Phallic	Genital focus o behaviors: touching of genitals, erotic attachment to parent of opposite sex (oedipal or electra complex) o pleasure through genitals o develops fear of punishment (parent if same sex), guilt, sexual identity
6 - 12 yrs.	Latency	Repress sexuality; channel sexual drives o behaviors: acquires friends, controls aggressive and destructive impulses o uses energy to gain new skills (in social relationships) and knowledge o develops sense of industry and mastery esp. in school
13 - 20 yrs.	Genital	Puberty with sexual interest in opposite sex o behaviors: responsible for self, clamors for independence from parents o sexual pleasure through genitals o develops sexual identity, and the ability to love and the desire to work

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TRANSACTIONAL ANALYSIS

Transactional Analysis (TA) is both a theory of human personality and a system for the improvement of human relations that was developed during the 1960s by Dr. Eric Berne. It is the new science of man. It explains how man function in three areas: thinking, feeling and behaving. It seeks to change and improve interpersonal and transpersonal relationship. It is based on the assumption that:

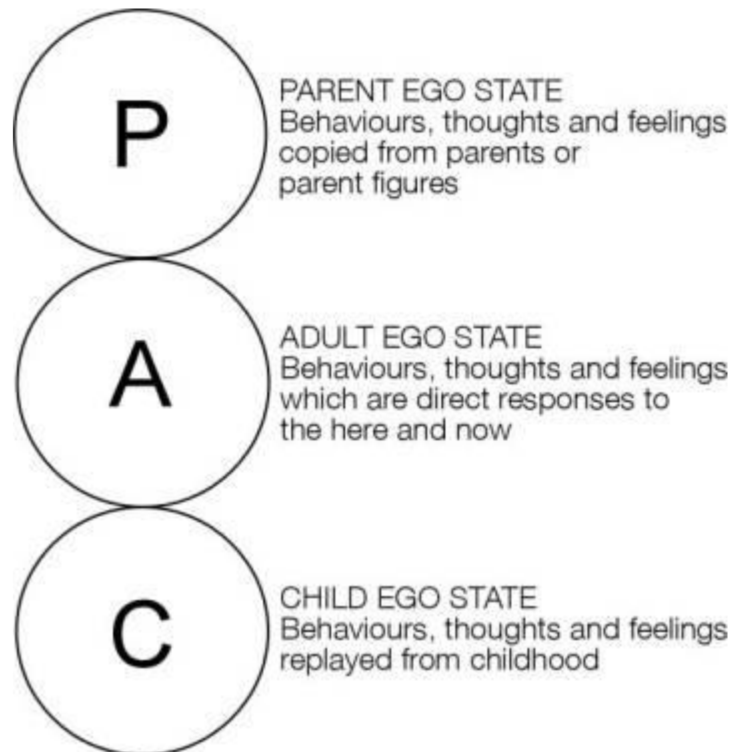
1. All people are born Ok –as prince and princess
2. Everyone is capable of thinking and being responsible of being a winner in life.
3. People become the way they are – losing and struggling because of decisions made in early life. It is possible for them to redecide.

Transactional Analysis is based on the belief that we have three states of communication – Parent, Adult, and Child. It is believed that we use one of these three states when we communicate with others, and when we communicate with ourselves as well, from a mental perspective.

KEY IDEAS IN TRANSACTIONAL ANALYSIS

Ego State

People's interactions are made up of transactions. Any one transaction has two parts: the stimulus and the response. Individual transactions are usually part of a larger set. Some of these transactional sets or sequences can be direct, productive and healthy or they can be devious, wasteful and unhealthy. When people interact they do so in one of three different ego states. An ego state is a specific way of thinking feeling and behaving and each ego state has its origin in specific regions of the brain. Berne defined an ego state as "a consistent pattern of feeling and experience directly related to a corresponding consistent pattern of behavior." The three ego states are:



The parent

The Parent is like a tape recorder. It is a collection of pre-recorded, pre-judged, prejudiced codes for living. When a person is in the Parent ego state she thinks, feels and behaves like one of her parents or someone who took their place. The Parent decides, without reasoning, how to react to situations, what is good or bad, and how people should live. The Parent judges for or against and can be controlling or supportive. When the Parent is critical it is called the Critical Parent. When it is supportive it is called the Nurturing Parent.

The child

When we are in the Child ego state we act like the child we once were. We aren't just putting on an act; we think, feel, see, hear and react as a three or five or eight year old child. When the Child is hateful or loving, impulsive, spontaneous or playful it is called the Natural Child**.** When it is thoughtful, creative or imaginative it is called

the Little Professor. When it is fearful, guilty or ashamed it is called the Adapted Child**.** The Child has all the feelings; fear, love, anger, joy, sadness, shame and so on. The Child is often blamed for being the source of people's troubles because it is self-centered, emotional, powerful and resists the suppression that comes with growing up.

In transactional analysis (TA) the Child is seen as the source of creativity, recreation and procreation; the only source of renewal in life. The Child can be observed in children for extended periods of time, but also in grownups in situations where people have permission to let the Child out, like at sport events or parties. The Child will appear for short periods of time in other situations, such as board meetings, classrooms or serious discussions where it may not be desired at all. In its most undesirable form it completely dominates a person's life, as in the cases of persons who are severely emotionally disturbed whose confused, depressed, crazy or addicted Child will drive them to virtual self-destruction with out-of-control behavior. The Child may also appear for long periods of time in the form of depression or grief, as in the case of people who have incurred a great loss.

The adult

When in the Adult ego state the person functions as a human computer. It operates on data it collects and stores or uses to make decisions according to a logic-based program. When in the Adult ego state the person uses logical thinking to solve problems making sure that Child or Parent emotions do not contaminate the process.

The Adult computes all the facts fed into it. If the facts are up-to-date, then the Adult's answers will be timely and more effective than the Parent's solution. If the facts are incorrect, the Adult computer will produce incorrect answers. A very important function of the Adult is to predict outcomes and to provide a fact-based critique of the effectiveness of people's behavior in the pursuit of their chosen goals. This fact-based, critical function is different from the value-based function of the Critical Parent.

Sometimes the Adult uses information which has its source in the Child or in the Parent and which may be incorrect. This is known as contamination. When a contamination comes from the Parent it is called a prejudice. For instance when someone assumes that women prefer to follow a man's lead instead of making their own decisions this is data which comes to the Adult from the Parent, and is a contamination because it is accepted as a fact without checking it against reality. The same unchecked acceptance of information can occur with information fed by the Child in which case it is called delusion. A delusion is usually based on a Child fear or hope that is accepted as reality by the Adult. For instance when a person is convinced that he is being poisoned by the government this is probably based on his Child's fears which the Adult accepts, rather than on fact. An extremely important process in transactional analysis is decontamination of the Adult.

- Parent is our 'Taught' concept of life
- Adult is our 'Thought' concept of life
- Child is our 'Felt' concept of life

PARENT	Critical Parent	makes rules and sets limits disciplines, judges and criticizes
	Nurturing Parent	advises and guides protects and nurtures
ADULT		concerned with data and facts considers options and estimates probabilities makes unemotional decisions plans and makes things happen

CHILD	Free (Natural) Child	fun-loving and energetic creative and spontaneous
	Adapted Child	compliant and polite rebellious and manipulative

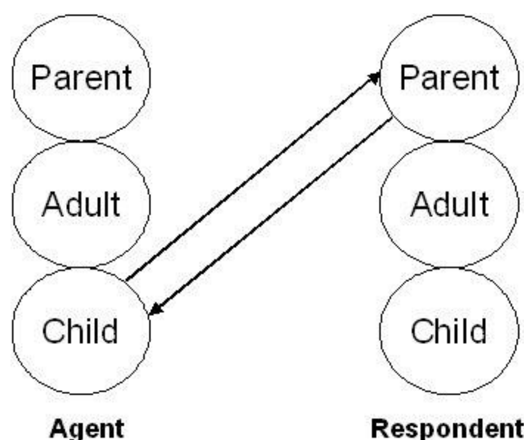
	CONTROLLING PARENT	**NURTURING PARENT**	**ADULT**	**FREE CHILD**	**ADAPTED CHILD**
WORDS	bad should ought must always ridiculous	good nice I love you cute splendid	correct how what why practical	wow fun want won't ouch hi	can't wish try hope please thank you
VOICE	critical condescending disgusted firm	loving comforting concerned	even precise monotone	free loud energetic happy	Whiney defiant demanding
GESTURE	pointing finger frowning shoulders up hands on hips	open arms accepting smiling leaning forward	thoughtful alert open erect	uninhibited loose spontaneous relaxed	Sad innocent closed tight
ATTITUDE	judgemental moralistic Authoritarian	understanding caring giving	interested observant evaluative	curious fun-loving changeable	Demanding compliant ashamed

An egogram can be used to assess the relative strengths and weaknesses of the various ego states. It reflects the type of person one is, one's probable types of problem and the strengths and weaknesses of the personality. Therapists are interested in ego states that are particularly high of low relative to the client's other ego states.

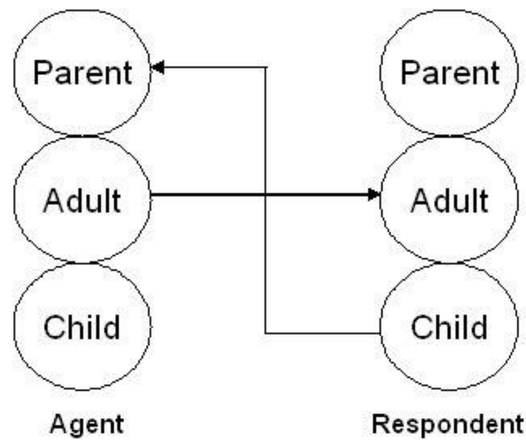
TRANSACTIONS

"The unit of social intercourse is called a transaction. If two or more people encounter each other... sooner or later one of them will speak, or give some other indication of acknowledging the presence of the others. This is called transactional stimulus. Another person will then say or do something which is in some way related to the stimulus, and that is called the transactional response." The concept of transactional analysis involves analyzing the three ego state of parent, adult and child of each person to determine whether the transactions between the people are complementary, crossed or ulterior.

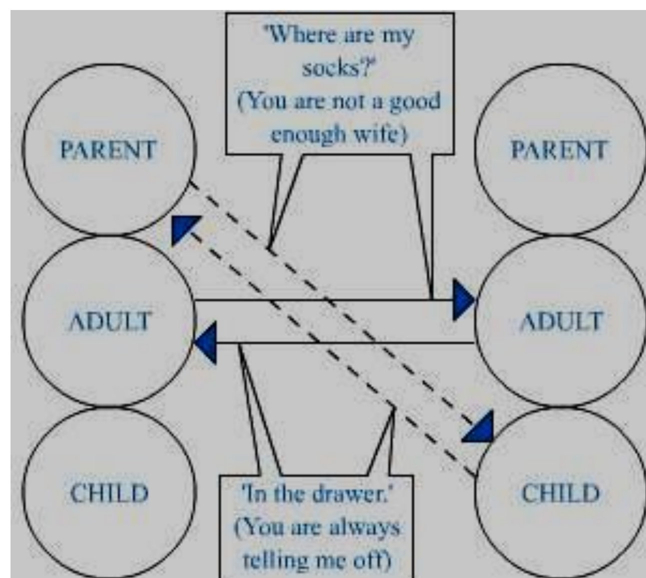
A complementary transaction occurs when each person receives a message from the other person's ego states that seems appropriate and expected. Here both the people are sending and receiving message as expected.



A crossed transaction occurs when one or more of the individuals receive a message from the other person's ego state that does not seem appropriate or expected.



Ulterior transactions occur when a person's communication is complex and confusing. In these transactions, a person sends an overt message from one ego state and a covert ulterior message from another ego state. The ulterior message can be communicated verbally, non verbally via body language or by tone of voice.



GAMES PEOPLE PLAY

Games can be defined as an "ongoing series of complementary ulterior transactions progressing to well defined, predictable outcomes". These games are

played at the unconscious level, with the people not aware they are playing a particular game. Although game playing results in bad feeling for both the players it also offers payoff for the participants. The payoff is a hidden advantage which motivates the players to participate. The roles we assume in games are

Rescuer

We take on the role of rescuer when we perceive another person to be hopeless and helpless, in other words a victim. As part of this role we take full responsibility for that person's well being, making them feel as though they can't help themselves. By adopting this role we keep others dependent on us and make them feel that they can't cope without us.

Victim

There are situations in life where people are victims, for example someone who has been burgled or assaulted, but in transactional analysis the victim contributes to the game. They pass all responsibility for their well being to the rescuer, and don't try to overcome this oppression. Victims eventually persecute their rescuers.

Persecutor

Persecutors start off as rescuers or victims. Because rescuers have assumed total responsibility for a victim's well being, the victim will ask questions of the rescuer. The rescuer tries to solve the questions and give answers, but becomes increasingly frustrated when the victim rejects all of these answers as being unhelpful. Rescuers then begin to persecute the victim.

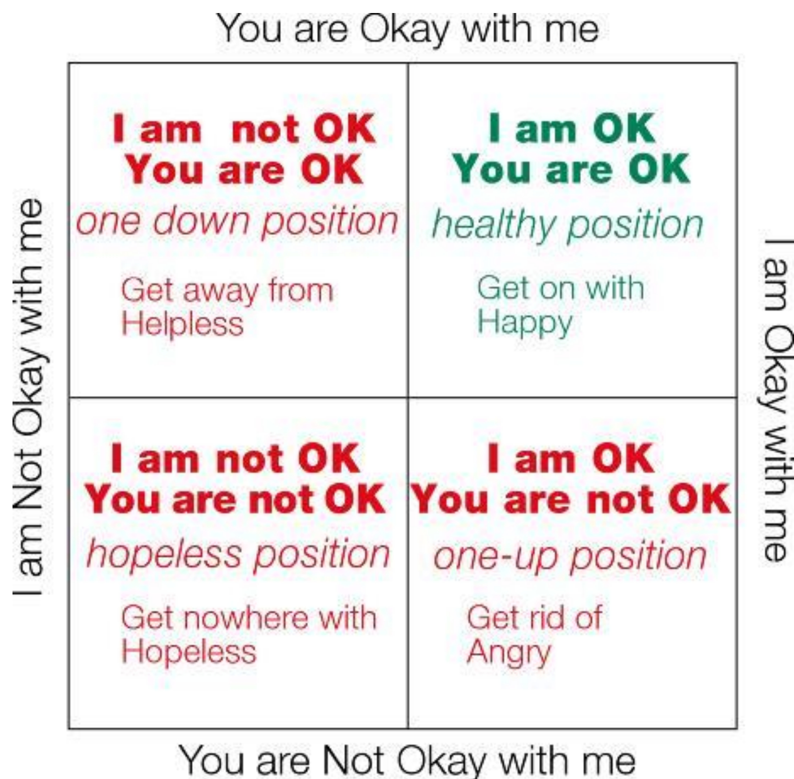
STROKES

Stroke is a unit of recognition. Physical stimulation is a basic human need. Berne described this as stimulus hunger. As we grow and develop our stimulus hunger develops and is partially transferred to a psychological version which Berne describes

as recognition hunger. A stroke can be a look, a nod, a smile, a spoken word, a touch. Any time one human being does something to recognize another human being and that is a stroke. The strokes may be positive (I like you), negative (I don't like you), conditional (the strokes is given only upon the performance of some act) and unconditional (No conditions are implied).

FOUR LIFE POSITIONS

Berne said that in developing life scripts, people put them in the role of being 'ok' or 'not ok'. They see others as being friendly or hostile. The following four life positions represent combinations of how people define themselves and others. Life positions are basic beliefs about self and others, which are used to justify decisions and behaviour.



These life positions are perceptions of the world. We call these "existential positions" because they influence how we view our own and others existence.

I am OK, You are OK

It is the belief that people have basic value, worth, and dignity as human beings. That people are OK is a statement of their essence, not necessarily their behavior. This

position is characterized by an attitude of trust and openness, willingness to give and take, and an acceptance of others as they are. People are close to themselves and to others. There are no losers, only winners. This is a healthy, optimistic and confident position. In this position, there is a lot of respect for self and for others.

I am OK, You are not OK

It is the position in which people project their problems onto others and blame them, put them down, and criticize them. In this position, there is arrogance, lack of trust and a tendency to blame everyone. Others are treated as immature, non-cooperative, and hostile.

I am Not OK, You are OK

In this position, the person is insecure and depressed, never asserts, is not persistent, lets other take over and does what they like. He submits to pressure from both above and below and often lets someone else manage.

I am Not OK, You are not OK

It is known as the position of futility and frustration. Operating from this place, people have lost interest in life and may see life as totally without promise. This self-destructive stance is characteristic of people who are unable to cope in the real world, and it may lead to extreme withdrawal, a return to infantile behavior, or violent behavior resulting in injury or death of themselves or others.

LIFE SCRIPTS

A life script is an unconscious life plan based on decisions made in early childhood about ourselves, others, and our lives. These decisions made sense when we were young and often helped us adapt in the world of our childhood. They do not always make sense when we are adults, but until we discover what our early decisions were, we often repeat the patterns that prove those early decisions to be true. A personal life

script is an unconscious life plan made in childhood, reinforced by the parents, "justified" by subsequent events, and culminating in a chosen alternative. In essence, the life script is a blueprint that tells people where they are going in life and what they will do when they arrive.

THERAPEUTIC PROCEDURES

Structural analysis is a tool by which a person becomes aware of the content and functioning of his or her Parent, Adult, and Child. TA clients learn how to identify their own ego states. Structural analysis helps them resolve patterns that they feel stuck with. It allows them to find out which ego state their behavior is based on.

Script analysis is a part of the therapeutic process by which the life pattern that clients follow is identified. It can demonstrate to clients the process by which they acquired the script and the ways in which they justify their script actions. When clients become aware of their life script, they are in a position to do something about changing their programming.

LIMITATIONS AND CRITICISMS OF TRANSACTIONAL ANALYSIS

TA can be criticized on the ground that its theory and procedures have not been adequately subjected to empirical validation. Transactional analysis practitioners have the potential of working primarily in a cognitive way and not allowing enough room for exploration of feelings. Some TA clients may slip into the use of jargon as an intellectual front behind which they can safely hide.

CLIENT CENTERED THERAPY

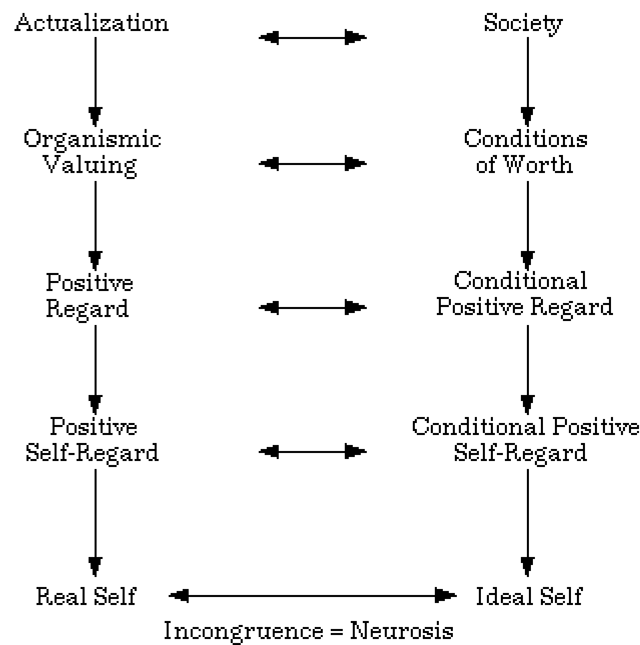
Person-Centered Therapy created by Carl Rogers (1930), is a form of humanistic therapy deals with the ways in which people perceive them consciously rather than having a therapist try to interpret unconscious thoughts or ideas. Person-centered therapy gives more responsibility to the client in their own treatment and views humans in a positive manner. The therapists provide self awareness to the client, helping the

patient to experience previously denied feelings. They will teach the client to trust in themselves and to find directions in life.

Rogers tells that the client know what is good for him. Evolution has provided us with the senses, the tastes, the discriminations we need: When we are hungry, we find food -- not just any food, but food that tastes good. This is called **organismic valuing**. Among the many things that we instinctively value is the **positive regard**. It is the umbrella term for things like love, affection, attention, nurturance, and so on. It is clear that babies need love and attention. In fact, if they don't receive this positive regard, they certainly fail to thrive i.e. become all they can be. Positive self-regard is the self-esteem, self-worth, a positive self-image, which we achieve by experiencing the positive regard others show us over our years of growing up. Without this self-regard, we feel small and helpless, and again we fail to become all that we can be.

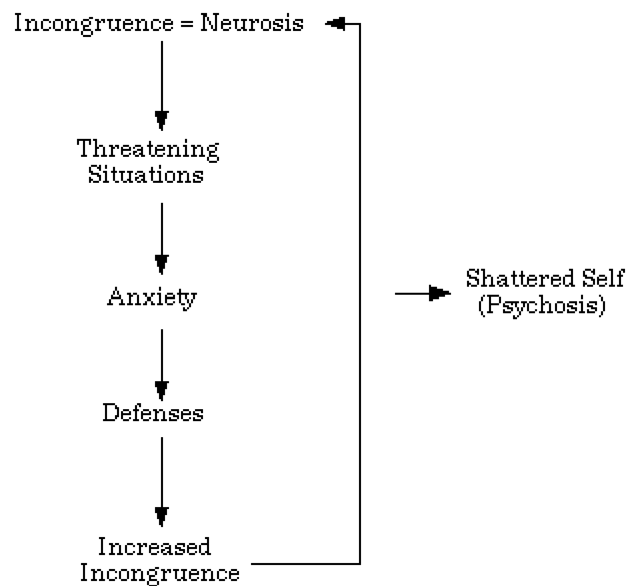
Our society also leads us astray with **conditions of worth**. As we grow up, our parents, teachers, peers, the media, and others, only give us what we need when we show we are "worthy," rather than just because we need it. We get a drink when we finish our class, we get something sweet when we finish our vegetables, and most importantly, we get love and affection if and only if we behave properly.

Getting positive regard on "on condition" Rogers calls **conditional positive regard**. Because we do indeed need positive regard, these conditions are very powerful, and we bend ourselves into a shape determined, not by our organismic valuing or our actualizing tendency, but by a society that may or may not truly have our best interests at heart. Over time, this "conditioning" leads us to have **conditional positive self-regard** as well. We begin to like ourselves, only if we meet up with the standards others have applied to us, rather than if we are truly actualizing our potentials.



INCONGRUITY

Rogers identified the "real self" as the aspect of one's being that is founded in the actualizing tendency, follows organismic valuing, needs and receives positive regard and self-regard. It is the "you" that, if all goes well, you will become. On the other hand, to the extent that our society is out of sync with the actualizing tendency (The inherent tendency of the organism to develop all its capacities in ways which serve to maintain or enhance the organism), and we are forced to live with conditions of worth that are out of step with organismic valuing, and receive only conditional positive regard and self-regard, we develop instead an "ideal self". By ideal, Rogers is suggesting something not real, something that is always out of our reach, the standard we cannot meet. This gap between the real self and the ideal self, the "I am" and the "I should" is called incongruity. The greater the gap, the more incongruity. The more incongruity, the more suffering. In fact, incongruity is essentially what Rogers means by neurosis



Defenses

When we are in a situation where there is an incongruity between the image of our self and the immediate experience of our self (i.e. between the ideal and the real self), we are in a threatening situation. For example, if we have been taught to feel unworthy if we do not get A's on all the tests, and yet we aren't really all that great a student, then situations such as tests are going to bring that incongruity to light -- tests will be very threatening. When we are expecting a threatening situation, we will feel anxiety. Anxiety is a signal indicating that there is trouble ahead, that you should avoid the situation! One way to avoid the situation, of course, is to pick our self up and run. Since that is not usually an option in life, instead of running physically, we run psychologically, by using defenses.

He focuses on two defenses: denial and perceptual distortion. In **denial** we block the threatening situation all together. An example might be the person who never picks up his test or asks about test results, so he doesn't have to face poor grades. **Perceptual distortion** is a matter of reinterpreting the situation so that it appears less threatening. It is very similar to Freud's rationalization. A student that is threatened by tests and grades may, for example, blame the professor for poor teaching. Every time we use a defense they put a greater distance between the real and the ideal. They become ever more incongruous, and find themselves in more and more threatening situations, develop

greater and greater levels of anxiety, and use more and more defenses. It becomes a vicious cycle that the person eventually is unable to get out of, at least on their own. Rogers also has a partial explanation for psychosis: Psychosis occurs when a person's defenses are overwhelmed, and their sense of self becomes "shattered" into little disconnected pieces.

GOALS OF THEORY

The main aim of person centered therapy is not as much to solve problem, but to assists client in their growth process, so they are equipped as human beings who are fully functioning who are able to cope effectively with current and future problems.

A THEORY OF FULLY FUNCTIONING PERSON

Rogers, like Maslow, is just as interested in describing the healthy person. His term is "fully-functioning," and involves the following qualities:

1. Openness to experience: This is the opposite of defensiveness. It is the accurate perception of one's experiences in the world, including one's feelings. It also means being able to accept reality, again including one's feelings.
2. Existential living: This is living in the here-and-now. Rogers, as a part of getting in touch with reality, insists that we not live in the past or the future -- the one is gone, and the other isn't anything at all, yet! The present is the only reality we have.
3. Organismic trusting: the fully functioning person does what he feels right and finds this to result in adequate or satisfying behavior.
4. Experiential freedom: the individuals are free to choose and act. This freedom is an inner freedom, an attitude or realization of one’s ability to think one’s own thought, live one’s own life choosing what one’s want to be and being responsible for one’s self.
5. Creativity: If we feel free and responsible, we will act accordingly, and participate in the world. A fully-functioning person, in touch with actualization,

will feel obliged by their nature to contribute to the actualization of others, even life itself. This can be through creativity in the arts or sciences, through social concern and parental love, or simply by doing one's best at one's job.

PROCESS

Rogers believed that the most important factor in successful therapy was not the therapist's skill or training, but rather his or her attitude. Three interrelated attitudes on the part of the therapist are central to the success of person-centered therapy:

1. Congruence
2. Unconditional positive regard
3. Empathy

Congruence refers to the therapist's openness and genuineness—the willingness to relate to clients without hiding behind a professional facade. Therapists who function in this way have all their feelings available to them in therapy sessions and may share significant emotional reactions with their clients. Congruence does not mean, however, that therapists disclose their own personal problems to clients in therapy sessions or shift the focus of therapy to themselves in any other way.

Unconditional positive regard means that the therapist accepts the client totally for who he or she is without evaluating or censoring, and without disapproving of particular feelings, actions, or characteristics. The therapist communicates this attitude to the client by a willingness to listen without interrupting, judging, or giving advice. This attitude of positive regard creates a nonthreatening context in which the client feels free to explore and share painful, hostile, defensive, or abnormal feelings without worrying about personal rejection by the therapist.

The third necessary component of a therapist's attitude is empathy ("accurate empathetic understanding"). The therapist tries to appreciate the client's situation from the client's point of view, showing an emotional understanding of and sensitivity to the client's feelings throughout the therapy session. A primary way of conveying this

empathy is by active listening that shows careful and perceptive attention to what the client is saying. In addition to standard techniques, such as eye contact, that are common to any good listener, person-centered therapists employ a special method called reflection, which consists of paraphrasing and/or summarizing what a client has just said. This technique shows that the therapist is listening carefully and accurately, and gives clients an added opportunity to examine their own thoughts and feelings as they hear them repeated by another person.

According to Rogers, when these three attitudes (congruence, unconditional positive regard, and empathy) are conveyed by a therapist, clients can freely express themselves without having to worry about what the therapist thinks of them. The therapist does not attempt to change the client's thinking in any way. Even negative expressions are validated as legitimate experiences. Because of this nondirective approach, clients can explore the issues that are most important to them—not those considered important by the therapist. Based on the principle of self-actualization, this undirected, uncensored self-exploration allows clients to eventually recognize alternative ways of thinking that will promote personal growth. The therapist merely facilitates self-actualization by providing a climate in which clients can freely engage in focused, in-depth self-exploration.

GESTALT THERAPY

Gestalt therapy was founded by Frederick “Fritz” Perls and collaborators Laura Perls and Paul Goodman in 1940. Gestalt therapy is appropriate for clients who lack awareness and feel out of touch with themselves. It integrates the body and mind factors by stressing awareness and integration. At the center of Gestalt therapy lies the promotion of "awareness". The individual is encouraged to become aware of his or her own feelings and behaviors, and their effect upon his environment in the here and now.

VIEW OF HUMAN NATURE

According to Perls, people are self determined, striving for self actualization and they are best understood from a phenomenological perspective. Phenomenology is a discipline that helps people stand aside from their usual way of thinking so that they can tell the difference between what is actually being perceived and felt in the current situation and what is residue from the past. It suggests people are whole complied if inter related parts of the body, emotions, thoughts, sensations and perceptions. Each of these aspects of a person can be understood only within the context of the whole person. The scientific world view that underlies the Gestalt phenomenological perspective is field theory. Field theory is a method of exploring that describes the whole field of which the event is currently a part rather than analyzing the event in terms of a class to which it belongs by its "nature". The Existential Perspective focuses on people's existence, relations with each other, joys and suffering, etc., as directly experienced.

KEY CONCEPTS

Perl has described the following concepts associated with gestalt therapy.

1. An existential phenomenological perspective: From this perspective the therapists attempts to understand client's from client's perspectives and help client's gain personal meaning to existence.
2. Helping the clients to move from dependence to independence: this concept help the client's to transcendence from environmental support to self support. When clients seek counseling they tend to expect environmental support such as reassurance from the counselor. The gestalt therapist avoids reinforcing client's dependency and helps the client to become independent person.
3. Being integrated and centered in now: Perl believed that nothing exists except the now, since the past is gone and future is yet to come. From this perspective the self actualization is centered in the present rather than oriented to the future. It makes the client's aware of what they are experiencing.

DEVELOPMENT OF MAL ADAPTIVE BEHAVIOR

People develop psychological problems in many ways. They can either lose contact with the environment or become so over involved with the environment and they lose touch with the self. Perl labeled the conflict between the top dog (what one thinks to do) and underdog (what one wants to do). He has identified five layers of neurosis that potentially interfere with our being authentically in tough with ourselves:

1. The phony layer: At this layer we pretend to be something we are not. Here the person responds to the environment in an unauthentic way.
2. The phony layer: At this layer the client tries to avoid the psychological pain.
3. The impasse layer: Here the client is in adrift in a sea of helplessness and dread, with no sense of direction, leaving them to wonder how they are going to make it in the environment.
4. The implosive and explosive layer: Both these layers go together and the client may frequently feel vulnerable to feelings.

Conflicts such as these are usually the result of inability to bring together individual needs and environment demands, so that people can be fully present in the now. Gestalt has divided the kinds of problems individual experience into six areas:

1. Lack of awareness
2. Lack of self responsibility
3. Lose contact with environment
4. Inability to complete unfinished business
5. Dichotomizing dimensions of the self (a self perception that results in internal conflict)
6. Denial of needs

GOALS OF THE THEORY

One of the most significant goals of the therapy is helping the individuals assume responsibility for them rather than relying on others to make decision on others. It aims to challenge its clients to move from environmental support to self support in order to mobilize their own resources for dealing with the environment effectively and to make creative adjustments that permit the self to respond to environmental pressures and inner needs. Another goal of the therapy is that clients become complete and integrated so that they function as a systematic whole that consists of feelings, perceptions, thoughts and a physical body whose process cannot be divorced from its more psychological components. Integration means bringing together all of the parts of a person that have been disowned. The therapists also attempts to help clients identify and resolve unfinished business: earlier thoughts, feelings, and reactions that still affect their functioning.

MAJOR METHODS AND TECHNIQUES

The steps in gestalt helping process are four fold: expression, differentiation, affirmation, and choice and integration. Through expression clients are encouraged to tell who they are as fully as possible, even becoming aware of gestures, breathing, voice tone, and facial expression. Once expression has begun, the gestalt therapists begins to experiment with techniques that leads to differentiation, so that clients can differentiate among the parts of their inner conflict. The third crucial stage is the affirmation, which occurs when the client is encouraged to identify with all parts that are emerging into awareness. In the final stage of choice and integration the client is able to choose one's reaction. Some of the techniques are:

THE USE OF STATEMENTS AND QUESTIONS TO FOCUS AWARENESS.

Many interventions have to do with simply asking "what the client is aware of experiencing;" or asking simple and direct questions as, "What are you feeling?" "What are you thinking?" This helps the client to keep in touch with the self. By this technique the client gets in touch with the inner world.

USING PERSONAL PRONOUNS

Awareness can be enhanced and emphasized through the client's verbal behavior or language since client speech patterns are considered to be an expression of their feelings, thoughts, and attitudes. Some aspects of language that might indicate the clients' avoidance of strong emotions or of self-responsibility are the general pronouns such as "it" and "you." Clients are instructed to substitute, when appropriate, the personal pronoun "I" for these pronouns to assume a sense of responsibility for his or her feelings or thoughts (ownership).

NONVERBAL BEHAVIOR.

Awareness can also be enhanced by focusing on nonverbal behavior and may include any technique that makes the clients more aware of their body functioning or helps them to be aware of how they can use their bodies to support excitement, awareness, and contact. The parts of the body that therapists may attend to include the mouth, jaw, voice, eyes, nose, neck, shoulders, arms, hands, torso, legs, feet, and the entire body. The therapist, for example, may point out to and explore with the client how he or she is smiling while at the same time expressing anger.

EMPTY CHAIR TECHNIQUE

The empty chair technique can be used to help the client work through conflicting part of the personality such as approach avoidance conflict. The technique involves placing an empty chair in front of the client. The client is asked to start a conversation with the empty chair by stating the reasons of the problem. Then the client is asked to sit in the chair and respond to the arguments placed by the client previously.

DREAM WORK

Work is most important in Gestalt therapy. The aim is to "bring dreams back to life and relive them as though they are happening now." Working with the clients' dreams requires developing a list of all the details of the dream, remembering each person, event, and mood in it and then becoming each of these parts through role-playing, and inventing dialogue. Each part of the dream is thought to represent the clients' own contradictory and inconsistent sides. Dialogue between these opposing sides leads clients toward gradual insight into the range of their feelings and important themes in their lives.

ENACTMENT AND DRAMATIZATION

Enactment increases awareness through the dramatizing of some part of the client's existence by asking him or her to put his or her feelings or thoughts into action such as instructing the client to "Say it to the person (when in group therapy)," or to role-play using the empty chair technique. "Put words to it" is also often said to the client. Exaggeration is a form of enactment in which clients are instructed to exaggerate a feeling, thought or a movement in order to provide more intensity of feelings. Enactment can be therapeutic and give rise to creativity.

GUIDED FANTASY

Guided fantasy (visualization) is a technique some clients are able to use more effectively than using enactment to bring an experience into the here and now. Clients are asked to close their eyes (if comfortable) and, with the guidance of the therapist, slowly imagine a scene of the past or future event. More and more details are used to describe the event with all senses and thoughts.

MORAL PERSPECTS:-

The "moral precepts" (or rules for patients to live by) of Gestalt therapy are described by Naranjo (1970Jj.

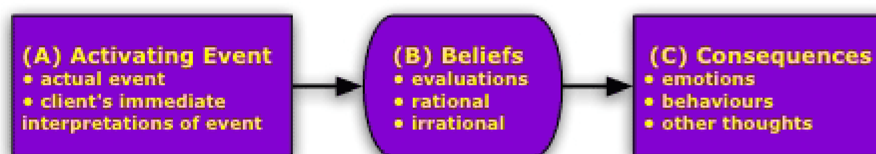
1. Live now (Be concerned not with the past or the future but with the present.)
2. Live here. (Be concerned with what is present, not with what is absent.)
3. Stop imagining. (Experience only the real.)
4. Stop unnecessary thinking. (Be oriented toward hearing, seeing, smelling, tasting, and touching.)
5. Express directly. (Do not explain, judge, or manipulate.)
6. Be aware of both the pleasant and the unpleasant
7. Reject-all "shoulds' and "ought" that are not your own.
8. Take-complete responsibility for your actions, thoughts, and feelings.
9. Surrender to being what you really are.

Gestalt therapists expect that as result of their involvement in the Gestalt process clients will improve in the following ways: have increased awareness of themselves; assume ownership of their experience rather than making others responsible for what they are thinking, feeling, or doing; develop skills and acquire values that will allow them to satisfy their needs without violating the rights of others; become aware of all their senses (smelling, tasting, touching, hearing, and seeing); accept responsibility for their actions and the resulting consequences; move toward internal self-support from expectations for external support; to be able to ask for and get help from others and be able to give to others.

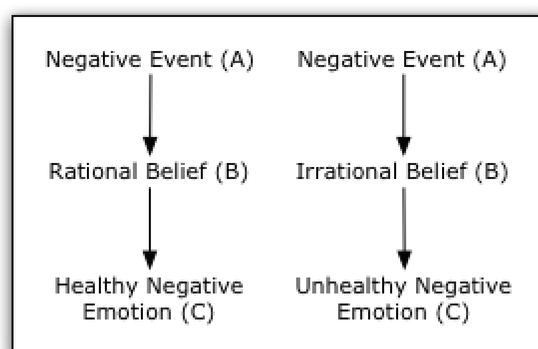
RATIONAL EMOTIVE THERAPY

Rational Emotive Behavior Therapy (REBT) is a form of psychotherapy created by Allbert Ellis in the 1950's. REBT is based on the premise that whenever we become upset, it is not the events taking place in our lives that upset us; it is the beliefs that we hold that cause us to become depressed, anxious, enraged, etc. The idea that our beliefs upset us was first articulated by Epictetus around 2,000 years ago: "Men are disturbed not by events, but by the views which they take of them." REBT proposes a 'biopsychosocial' explanation of causation – i.e. that a combination of biological, psychological, and social factors are involved in the way humans feel and behave.

REBT employs the 'ABC framework' — depicted in the figure below — to clarify the relationship between activating events (A); our beliefs about them (B); and the cognitive, emotional or behavioural consequences of our beliefs (C).



The figure below shows how the framework distinguishes between the effects of rational beliefs about negative events, which give rise to healthy negative emotions, and the effects of irrational beliefs about negative events, which lead to unhealthy negative emotions.



EXAMPLE OF EMOTIONAL EPISODES

A1. Activating event – what happened:

Friend passed me in the street without acknowledging me.

A2. Inferences about what happened:

He's ignoring me. He doesn't like me.

B. Beliefs about A:

I'm unacceptable as a friend – so I must be worthless as a person. (Evaluation)

C. Reaction:

Emotions: depressed.

Behaviours: avoiding people generally.

Note that ‘A’ alone does not cause ‘C’ – ‘A’ triggers off ‘B’, and ‘B’ then causes ‘C’. Also, ABC episodes do not stand alone: they run in chains, with a ‘C’ often becoming the ‘A’ of another episode – we observe our own emotions and behaviours, and react to them.

WHAT TYPE OF THINKING ARE PROBLEMATIC FOR THE CLIENT

To describe a belief as ‘irrational’ is to say that:

1. It blocks a person from achieving their goals, creates extreme emotions that persist and which distress and immobilize, and leads to behaviours that harm oneself, others, and one’s life in general.
2. It distorts reality (it is a misinterpretation of what is happening and is not supported by the available evidence);
3. It contains illogical ways of evaluating oneself, others, and the world: demandingness, awfulising, discomfort-intolerance and people-rating.

TWO TYPES OF DISTURBANCE

REBT suggests that human beings defeat or ‘disturb’ themselves in two main ways:

(1) by holding irrational beliefs about their ‘self’ (ego disturbance) or (2) by holding irrational beliefs about their emotional or physical comfort (discomfort disturbance).

Ego disturbance represents an upset to the self-image. It results from holding demands about one’s ‘self’, e.g. ‘I must … do well / not fail / get approval from others’; followed by negative self evaluations.

Discomfort disturbance results from demands about others (e.g. ‘People must treat me right’) and about the world (e.g. ‘The circumstances under which I live must be the way I want’).

FOUR TYPES OF EVALUATIVE BELIEF

REBT proposes that there are four types of evaluative thinking that are dysfunctional for human beings:

Demandingness refers to the way people hold unconditional shoulds and absolutistic musts – believing that certain things must or must not happen, and that certain conditions (for example success, love, or approval) are absolute necessities.

REBT suggests that there are three basic musts:

1. Demands about the self;
2. Demands about others;
3. Demands about the world.

Demands about the self will lead to ego disturbance; demands about others and the world will lead primarily to discomfort disturbance. Also, as well as being involved with core beliefs, demands also occur with beliefs about specific situations.

Awfulising occurs when we exaggerate the consequences of past, present or future events; seeing them as the worst that could happen. Awfulising is characterised by words like ‘awful’, ‘terrible’, ‘horrible’.

Discomfort intolerance, often referred to as ‘can’t-stand-it-itis’, is based on the idea that one cannot bear some circumstance or event. It often follows awfulising, and can fuel demands that certain things not happen.

People-rating refers to the process of evaluating one’s entire self (or someone else’s); in other words, judging the total value or worth of a person. It represents an overgeneralization whereby a person evaluates a specific trait, behaviour or action

according to some standard of desirability or worth. They then apply the evaluation to their total person – eg. ‘I did a bad thing, therefore I am a bad person.’

THE THREE LEVELS OF THINKING

Human beings appear to think at three levels: (1) Inferences; (2) Evaluations; and (3) Core beliefs.

Inferences: In everyday life, events and circumstances trigger off inferences about what is ‘going on’ – that is, we make guesses about what we think has happened, is happening, or will be happening. Inferences are statements of ‘fact’ (or at least what we think are the facts – they can be true or false).

Evaluations: More significantly from the REBT perspective, as well as making inferences about things that happen, we go beyond the ‘facts’ to evaluate them in terms of what they mean to us. Evaluations are sometimes conscious, sometimes beneath awareness. Irrational evaluations consist of one or more of the four types of beliefs listed earlier.

Core beliefs: Guiding a person’s inferences and evaluations are their underlying, general core beliefs. An example of a general core belief that would apply to the inference and evaluation we are using as our example could be: ‘For me to be worthwhile as a person I must have someone who loves me unreservedly.’

GOALS OF REBT

The goal of REBT is to help people change their irrational beliefs into rational beliefs. Changing beliefs is the real work of therapy and is achieved by the therapist

disputing the client's irrational beliefs. For example, the therapist might ask, "Why must you win everyone's approval?" Disputing is the **D** of the ABC model. When the client tries to answer the therapist's questions, s/he sees that there is no reason why s/he absolutely must have approval, fair treatment, or anything else that s/he wants.

Insight

Albert Ellis and REBT contend that although we all think irrationally from time to time, we can work at eliminating the tendency. It's unlikely that we can ever entirely eliminate the tendency to think irrationally, but we can reduce the frequency, the duration, and the intensity of our irrational beliefs by developing three insights:

1. We don't merely get upset but mainly upset ourselves by holding inflexible beliefs.
2. No matter when and how we start upsetting ourselves, we continue to feel upset because we cling to our irrational beliefs.
3. The only way to get better is to work hard at changing our beliefs. It takes practice, practice, practice.

TECHNIQUES USED IN REBT

1. Cognitive techniques

Rational analysis: Analyses of specific episodes to teach the client how to uncover and dispute irrational beliefs (as described earlier) are usually done in-session at first; then, as the client gets the idea, they can be carried out as homework.

Devil's advocate: This useful and effective technique (also known as reverse role-playing) is designed to get the client arguing against their own dysfunctional belief. The

therapist role-plays adopting the client's belief and vigorously argues for it; while the client tries to 'convince' the therapist that the belief is dysfunctional. It is especially useful when the client sees that a belief is irrational, but needs help to consolidate that understanding.

Reframing: Another strategy for getting bad events into perspective is to re-evaluate them as 'disappointing', 'concerning', or 'uncomfortable' rather than as 'awful' or 'unbearable'. A variation of reframing is to help the client see that even negative events almost always have a positive side to them, listing all the positives the client can think of.

2. Imagery techniques

The 'blow-up' technique: It involves asking the client to imagine whatever it is they fear happening, then blow it up out of all proportion till they cannot help but be amused by it. Laughing at fears will help get control of them. Again, the use of this technique requires sensitivity and appropriate timing.

3. Behavioural techniques

Exposure: possibly the most common behavioural strategy used in REBT involves clients entering feared situations they would normally avoid. Such 'exposure' is deliberate, planned and carried out using cognitive and other coping skills.

Shame attacking: This type of exposure involves confronting the fear of shame by deliberately acting in ways the client anticipates may attract disapproval (while, at the same time, using cognitive and emotive techniques to feel only concerned or disappointed).

Homework: Probably the most important REBT strategy is homework. This can include such activities as reading, self-help exercises, and experiential activities.

Therapy sessions are really ‘training sessions’, between which the client tries out and uses what they have learned.

EXISTENTIAL THERAPY

No single individual is responsible for the development of this therapy. The theoretical origins of this therapy can be traced to existentially oriented philosophy. Victor E Frankl, Rollo May has contributed to a greater extent the basic concept and other tents of this therapy.

View of human nature

The therapy focuses on attempting to understand the human conditions. It rejects a fixed view of human nature but instead contends that each person must ultimately define his or her own personal existence.

Key concepts

The following five key concepts form the basis for existential therapy.

1. Uniqueness of the individual

The existential position suggests that no two people are alike and each one is unique. To become aware of one’s uniqueness, it is necessary to encounter oneself as a separate and distinct individual. An important process is to have the experience of existential aloneness. This can be painful experience as a person attempts to encounter the meaning of one’s existence. It can also help a person discover the capability of becoming autonomous.

2. The search for meaning

Victor Frankl’s logotherapeutic approach evolved out of this experience as a prisoner of war in a Jewish concentration camp during World War II. He described these experiences as well as the basic principle of logotherapy in his book Man’s search for meaning. Logotherapy suggests that the most prominent psychological problem facing people is lack of meaning in life, which he called as existential vacuum. Frankl

believed that a person can experience meaning by feeling valued or needed which in turn can create a purposeful existence.

3. The role of anxiety

The therapy differentiates between two types of anxiety. One is normal or healthy anxiety called existential anxiety, and the other is unhealthy anxiety referred as to the neurotic anxiety. Neurotic anxiety is not healthy because it is an anxiety reaction that is not proportionate to the situation and can overwhelm the person. Existential anxiety suggests that some degree of anxiety can be positive, since it can motivate a person to make the necessary changes in life. Another positive aspect of anxiety is that if often occurs when a person faces a difficult situation. A person that flees from this anxiety will not be able to learn from the challenges of life. From this perspective, existential believe one can draw meaning from pain and suffering.

4. Freedom and responsibility

Existential therapy contends that freedom and responsibility are interrelated. Although people are free to choose their own destiny, they must take responsibility for their action. Existentialists help clients become aware of their choices and the control they can exert over their own destiny.

5. Being and non being

Being and non being are also interrelated. The reality of death brings meaning to life. Being and non being are also related to freedom and responsibility. People are free to be of not to be. If individuals choose to be, they must assume responsibility for their existence.

Goals of the therapy

The goals of existential therapy relate directly to the key concepts. They can be directed at helping clients (a) discover their own uniqueness (b) find personal meaning (c) use anxiety in a positive sense (d) become aware of their choices and the need to take responsibility for choices and (e) not see death as nemesis but as an eventual reality that gives meaning and significance to life.

Techniques

Frankl's logotherapy utilizes specific techniques. He described two techniques that are central to his approach.

Paradoxical intention: It involves asking the client to do what they fear doing, such as asking them to stutter if they fear stuttering. It is a technique that helps a client overcome anticipatory anxiety by redefining success and failure.

Dereflection: It is procedure that involves helping the clients focus on strengths rather than weakness.

ADLERIAN THERAPY

Adlerian therapy focuses on the feelings of self that arise from interactions and conflicts. This sense of self can also be called ones ego. The ego is the central core of personality; it is what makes someone an individual. Adlerian therapy is a therapy of teaching, informing and encouraging the client, in order to help the client fix basic mistakes in their personal logic, and the therapeutic relationship is a collaborative one. His idea of individual psychology is based on the unique motivations of individuals and the importance of each individual perceived niche in society.

View of human nature

Adler held an optimistic view of people. He believed people were basically positive with the capability of self determination. This view of human nature stimulated the development of humanistic movement in psychology, which focuses on the dignity and worth of the individual. Adler also emphasized that behavior is holistic, interrelated, teleological, in that it has purpose and is directed towards a goal and phenomenological because it can be understood from the client's frame of reference.

Key concepts

Adler described a number of key concepts that male up the structure of Adler's theory of personality. The following 10 principles are central to this theory.

1. The creative self

This concept was Adler's "crowning achievement as personality theorists". It lies at the heart of Adlerian theory of personality. The creative self is the center of nucleus from which the life movement generates. Freud calls this center the ego. For Adler, the creative self emphasized that each person has the potential to creatively interact with the world.

2. The concept of teleological movement

Adler saw all behavior in terms of movement, nothing was static. This movement is teleological in nature since it has a purpose and is directed toward a goal. According to Adler, a person can move on the useful or useless side of life. Movement on the useful side is characterized by cooperative efforts, whereas movements on the useless side are narcissistic in nature. According to their private logic, individuals would behave in a manner that appears to improve their position. This concept can be useful to understand the motivation behind misbehavior.

3. Behavior can be understood from an interpersonal perspective

Adler emphasized that behavior can best be understood from an interpersonal perspective. This spirit was captured by the poet John Donne when he said, "No man is island". Adler believed that people do not behave in isolation from others but in relation to others. This reasoning can be used to identify goals of misbehavior. For example, parents can develop a tentative hypothesis by asking themselves how they feel when their children misbehave. Feelings of annoyed could indicate their child has a goal of attention; feeling of angry or threat could suggest a goal of power.

4. The psychology of use

Adler stressed that all behavior has a use or payoff that is usually unconscious in nature. Emotions serve a use in helping proper a person toward a goal.

This concept can also be used to understand the symptoms associated with psychopathology.

5. A phenomenological perspective

The phenomenological perspective provides an understanding of client's from their internal frame of reference. Adler suggested that what individuals perceive is biased according to the past experience. He referred to this phenomenon to understand client's interpretation of experiences

6. Emphasis on social interest

Adler's gemeinschaftsgefuhl has been translated into English as social interest. It refers to an inborn tendency to cooperate and work with others for the common good. Adler related this concept to mental health when he observed that social interest is the barometer of mental health. He suggests that all people need love and affection.

7. The life style

The term life style refers to the person's basic orientation to life; the set of patterns of recurrent themes that run through his or her existence. According to Adler the life style is relatively fixed by age 4 or 5. Once established, the individual's life style guides the assimilation and utilization of future experiences.

8. A holistic psychology

Adler's individual psychology means the individual is indivisible and undivided. It is therefore a holistic psychology, which attempts to understand the overall life style as a unified whole. Adlerians are interested in assessing how the person organizes the self as a whole person with interrelated and coherent beliefs, perceptions and goals. This position is similar to the holistic health concept, which views the mind and the body as an interacting system, not as separate entities.

9. Striving for significance

Adler believed that people have a basic tendency to avoid feelings of inferiority by striving for superiority. A person could therefore compensate for feelings of inadequacy in one area by excelling in another aspect of life. In this example, striving

for superiority should not be viewed as an attempt to feel superior over others. Instead it amounts to a striving for significance and worth as an individual and is a major motivational force.

10. The family constellation

It encompasses many factors associated with a person's family or origin, such as birth order, family size and the relationship between family members. Adler believed that each person's family constellation was unique and could therefore make a significant impact on the development of the life style. Adler was particularly interested in the birth order and how it would affect a person's development. The oldest child receives more attention and is spoiled and therefore likes to be the centre of attention. If there is only two children, the second will behave as if they are in a race to the first child, and they will act in opposite ways from the first. The middle child often feels squeezed out. The youngest is the baby, they are more pampered, creative, rebellious, revolutionary and avant-garde. An only child does not learn to share and co-operate with other children and must therefore learn to deal with other adults.

Goals of the therapy

The major goals of the Adlerian psychotherapy are

1. Increasing client's social interest
2. Helping client's overcome feelings of discouragement and reducing inferiority feeling
3. Modifying client's views and goals and changing their life scripts.
4. Changing faulty motivation
5. Helping client's feel a sense of equality with others.
6. Assisting client to become contributing members of the society.

Techniques

Spitting in the soup

This technique can be used when the client engage in manipulative behavior. Spitting in their soup involves pointing out the real motive or purpose of client's

behavior in order to weaken its effectiveness. Eg; The client may say “my husband is such a drunkard and I don’t know why I am put up with him?”. The counselor could respond by saying “because you wish to get a lot of sympathy from others”.

The push button technique

This technique is based on rational emotive therapy. It involves having the client to concentrate on pleasant and unpleasant experience and the feelings they generate. When clients discover that their thoughts influence their emotions, they recognize that they can take control of their emotional response. The concept symbolizes the amount of control client’s can exert when they push the button and put a stop to self defeating processes. They can then create a constructive way of reacting to their situation, producing more positive emotional response.

Catching oneself

In this technique, patients learn to notice that they are performing behaviors which they wish to change, when they catch themselves, they may have an "Aha" response. The clients are encouraged to use humor when they catch themselves, learning to laugh at how ridiculous their self defeating tendencies are.

Acting as if

In this technique, clients are asked to "act as if" a behavior will be effective. Clients are encouraged to try a new role, the way they might try on new clothing. This technique promotes ‘can do’ spirit and a self fulfilling prophecy which help the client’s experience success.

Task setting and commitment

Adlerians do not believe that change occurs by osmosis. They believe instead that it takes work and effort to change. Task setting and commitments are therefore essential aspects of Adlerian psychotherapy. Home work assignments can be useful in this regard by providing a structure through which clients can try out now modes of behaving.

REALITY THERAPY

Reality therapy is an approach to psychotherapy and counseling. It was developed by the psychiatrist Dr. William Glasser in 1965. Reality therapy is a considered a cognitive-behavioural approach to treatment. Reality therapy provides a model of building relationships by instructing helpers to create a need-satisfying counseling environment. The five basic needs of all humans are survival; love and belonging; power; freedom and fun. So, in a helping relationship, the helper must create an environment where it is possible for the person being helped to feel safe; to feel connected to the helper in some way; to be listened to and respected; to have some choices; and to have some fun or learning with the helper. After creating this need-satisfying environment and working hard to maintain it throughout the relationship, the helper can move on to the actual problem.

Principles

1. Focus on the present and avoid discussing the past because all human problems are caused by unsatisfying present relationships.
2. Avoid discussing symptoms and complaints as much as possible since these are often the ineffective ways that client choose to deal with (and hold on to) unsatisfying relationships.
3. Understand the concept of total behavior, which means focus on what clients can do directly-act and think. Spend less time on what they cannot do directly; that is, changing their feelings and physiology. Feelings and physiology can be changed indirectly, but only if there is a change in the acting and thinking.
4. Avoid criticizing, blaming and/or complaining and help clients to do the same. By doing this, they learn to avoid these extremely harmful external control behaviors that destroy relationships.
5. Remain non-judgmental and non-coercive, but encourage people to judge all they are doing by the Choice Theory axiom: Is what I am doing getting me closer to

the people I need? If the choice of behaviors is not getting people closer, then the counselor works to help them find new behaviors that lead to a better connection.

6. Teach clients that legitimate or not, excuses stand directly in the way of their making needed connections.

7. Focus on specifics. Find out as soon as possible who counselees are disconnected from and work to help them choose reconnecting behaviors. If they are completely disconnected, focuses on helping them find a new connection.

8. Help them make specific, workable plans to reconnect with the people they need, and then follow through on what was planned by helping them evaluate their progress. Based on their experience, counselors may suggest plans, but should not give the message that there is only one plan. A plan is always open to revision or rejection by the client.

9. Be patient and supportive but keep focusing on the source of the problem, disconnectedness.

Core ideas

Make plans and perform actions

The client's self-evaluation is a critical and crucial first step. Plans are the heart of successful reality therapy. The counselor helps the client make a workable plan to reach a goal. It must be the client's plan, not the counselor's. The essence of a workable plan is that the client can implement it. It should be based on things under the client's control. For example: You can't make the company give you a promotion but you can look for a promotion, lobby for it and apply for the job when it comes up. Reality therapy strives to empower people by emphasizing the power of doing what is their control. Doing is at the heart of reality therapy.

Behavior

Behavior, in reality therapy, is composed of four aspects, or vectors: thinking, acting, feeling, and physiology. We can directly choose our thoughts and our acts; we have great difficulty in directly choosing our feelings and our physiology (sweaty

palms, headaches, nervous tics, racing pulse, etc.) Emotions (feelings) are a wonderful, immediate and alive source of information about how we are doing and whether we are happy with what is going on in our lives. But it is very hard to choose and to change our emotions directly. It is easier to change our thinking - to decide, for example, that we will no longer think of ourselves as victims or to decide that in our thoughts we will concentrate on what we can do rather than what we think everybody else ought to do. So Reality Therapists approach changing "what we do" as a key to changing how we feel and to getting what we want.

Control

Control is a key issue in reality therapy. Control gets us into trouble in two primary ways: when we try to control other people, and when we use drugs and alcohol to give us a false sense of control. At the very heart of the theory is the core belief that the "Only person I can really control is myself. If I think I can control others I am moving in the direction of frustration. If I think others can control me (and so are to blame for all that goes on in my life) I tend to do nothing and again head for frustration". There may indeed be things that "happen" to us and for which we are not personally responsible but we can choose how we handle these things. Trying to control other people is a vain naive hope, from the point of view of reality therapy. It is a never-ending battle, alienates us from others and causes endless pain and frustration.

Focus on the present

While traditional psycho-analytic and counseling often focus on past events, reality therapy lies in the present and the future. Practitioners of reality therapy may visit the past but never dwell on it. In reality therapy, the past is seen as the source of our wants and of our ways of behaving, not as a cause. This is because it is our present perceptions that influence our present behaviour and so it is these current perceptions that the reality therapy practitioner helps the client to work through.

UNIT IV

ROLES AND FUNCTIONS OF PSYCHIATRIC SOCIAL WORKERS

Psychiatric OPD's

Psychiatric OPD is a very important department in a hospital. All the patients suffering from psychiatric complaints of minor, major, chronic are examined here. OPD of a psychiatric hospital provide diagnostic, curative, preventive and rehabilitation services. The roles of psychiatric social worker in psychiatric OPD are as follows:

1. Intake of the patient: The basic work of any psychiatric social worker is to accept the client and get the basic information from them.
2. Mental status examination is done by the psychiatric social workers.
3. They provide psycho social education to the family members about the nature of illness, explain the causative factors for the illness, explaining the need of support to the patients by the family members and making the family members accept the reality.
4. Referral services: They refer the patients to other agencies where specialized treatment is given. Sometimes the mental illness is associated with physical illness, so the clients are also referred to physicians. Referral services are done according to the actual need of the client and depending on the financial situation of the client.
5. Resource mobilization: The psychiatric social worker uses the available resources for the betterment of the client. Resource mobilization forms a part of the referral services which aims at enabling the client avail their rights.
6. Motivating the client and the family: The psychiatric social worker motivate the client for treatment and regular intake of medicines. He also motivates the client's family for further follow ups.
7. Record maintenance
8. Individual psychotherapy

Psychiatry specialty clinics

The psychiatric specialty clinic is a second area in which the psychiatrist and the psychiatric social workers are associated. It includes the neurological clinic, neuropsychiatric clinics, mental hygiene clinics and psychiatric clinics. Some of them are connected with general hospitals and some with mental hospitals. It includes both the OP and the IP departments to treat people with psychiatric illness. The roles of social workers in psychiatric specialty clinic are:

1. Conducting case work
2. Conducting group work

3. Conducting awareness programmes
4. Counseling to patients and family members
5. Giving psychological support to patients and family members
6. Conducting research
7. Financial assistance with other agencies for helping the patients
8. Conducting camps
9. Resource mobilization
10. Providing psycho education

De addiction centers

Addiction is the craving or dependence on any substance and the absence may cause anxiety. The dependence may be both physical and psychological. De addiction center is where the people who are addicted to alcohol or other drugs come for treatment to recover from their addiction or to take treatment for their relapse. The role of social worker in such de addiction center includes:

1. Assessment of the extent of the problem which include the family, background, health condition and the assessment of current position of the client.
2. Motivating the client for regular treatment.
3. Giving awareness about the ill effects of drugs
4. Conducting group meeting
5. Restoration of the client in the family
6. Help the client to quit smoking and drinking by conducting individual therapy, group therapy and family therapy.

Child guidance clinic

Children with behavior, conduct, emotional and psychiatric problem are treated. The children below the age of 16 are admitted for treatment. The roles of social workers in child guidance clinic are:

1. Intake process

2. Family history taking
3. Conducting parent group meeting
4. Diagnosis
5. Treatment plan
6. Modifying the life style
7. Training for parents to bring their child
8. Referral
9. Resource mobilization

UNIT V

REHABILITATION OF PSYCHIATRIC PATIENTS

Psychiatric rehabilitation

Rehabilitation may be defined as the combined and the coordinated use of medical, social, educational and occupational measures for training and retraining the individual for the highest possible level of functional ability.

Role of social worker in rehabilitation

The current view is that the responsibility of a psychiatric hospital dies not end when the treatment is over. The purpose of psychiatric rehabilitation is to make productive people from non productive people. The roles of social worker in rehabilitation are:

1. Planning the assessment
2. Planning the use of resource mobilization
3. Planning for training
4. Provide placement services
5. Provide referral services
6. Engaging the patients in different activities.

Reintegration of the patient in the family and the community

In case of mental illness the client's family is not ready to accept the client. The client's parents may accept the client but the client's spouse and the in laws family may not accept them. This may be due to many reasons like:

1. Though the patient is recovered completely there is greater suspicion and doubt on the client. This is so because, due to mental illness and the impact of auditory hallucination the client may have uttered some girls or boys name, or have spoken ill of someone in the family. This may be taken seriously by the spouse and harm the relationship.
2. During the course of illness the client might have used abusive words and this may be remembered by the family members even after the cure of the client.
3. Due to social status the family may be reluctant to accept the client even if the client is fully recovered.
4. Sometimes the client may be a wandering mentally ill and finding the details about the family is the biggest problem.

These factors may make the process of reintegration difficult. It is the duty of the social workers to integrate the client and the family. The social worker should provide psycho social education to the family members and explain the impact of illness so that the family members understand the client and his problems.

Role of psychiatric social worker in team work

The mail main purpose of psychiatric care is restoration and promotion of mental health and prevention of mental illness. For the achievement of this purpose, several professionals such as the psychiatrists, psychologists, psychotherapists, psychiatric nurses, and psychiatric social workers are working together as a team. The services of each professional are equally important and necessary for a effective team work. A proper understanding and mutual respect for each others are needed for better services for the patients. The roles of social workers in team are:

1. Providing case work and group work services to the patient and family members for the purpose of diagnosis and treatment.
2. Assisting the individual to determine and resolve specific problems in his environment and interpersonal relationship.
3. Helping the team for providing a humanistic approach to the patient
4. Act as intermediate between other professionals and patients.

Partial hospitalization

According to American Association of Partial Hospitalization, “Partial hospitalization is defined as a time limited ambulatory, active treatment programme that offers therapeutically coordinated and structured clinical services within a stable therapeutic environment”. The term partial hospitalization may include:

Day hospitalization: It is a psychiatric treatment program that patients attend 5 days a week from 8.30 am to 5.00 pm. The patients have breakfast and dinner at home and have lunch at hospital.

Night hospitalization: A program in which patient usually work or goes to school and return to hospital for dinner and they sleep in the hospital.

Evening and weekend hospital care: A programme in which patient functions in job or at school and return to the hospital for evening and weekend programs.

Therapeutic community

It is defined as hospital environment used for therapeutic procedures. It provides responsibility to a population for mental health delivery. In this method the treatment is given to the client in community based centers. It avoids the unnecessary hospitalizations and focuses on prevention and promotion of health. Continuous care is provided with the help of multidisciplinary team approach.

Day care centers

The day care should be located outside the hospitals and in the community. It should be attached to the outpatient service rather than the inpatient service. They look after the client during the day time and in the night they go back to their own homes.

Half way homes

They provide accommodation for a short period of time to stabilize and correct the patients during the crisis period where they learn certain skills for their own betterment.

Sheltered homes

It is a homogenous setting in which people with particular disability or illnesses are work together.

Transitory homes

They provide training to the patient for certain skill where the inmates are transferred from one house to another based on their skill training and skill progress.

UNIT I

Psychiatric Social Work

Psychiatric social work is the application of social work methods and practices in the field of psychiatry. It is the social work practiced in psychiatric settings, de addiction centers etc. It is both a science and art as the social work belongs to discipline of art and psychiatry belongs to discipline of science. Psychiatric patients cannot be treated by medicines alone. He needs both psychological and social treatment. Social treatment is necessary because a person's social conditions get disturbed due to psychiatric illness. Psychiatric social worker needs knowledge in both the fields of psychiatry and social work.

HISTORICAL DEVELOPMENT OF PSW

In the beginning the psychiatrists were interested to understand the personality of the patients in relation to their social environment. They appointed some agents for collecting the family back ground of the patients. These agents collected case histories from the patients and acted as an intermediate between the patient and the family members. They were the pioneer social workers in the field of psychiatry. In **1905**, Massachusetts General Hospital established social service department. Dr. Putam who was in charge of the neurological clinic appointed a full time social worker in his clinic under his personal supervision.

In 1906, psychiatric social work was initiated at the Manhattan State Hospital in New York City, by the New York State Charities Aid Association. Here, the psychiatric social worker visited patients' families to obtain collateral information needed by psychiatrists, relative to family background and past life experiences. They just acted as after care agents and clinics in United States began to employ social workers. The pioneer social workers and the aftercare agents inspired many people to act as social workers in the field of psychiatry.

In 1913, Boston psychopathic hospital established as social service department under the leadership of Dr. Ernest Sutherland and Dr. Mary C Jarret, who was