

Therapeutic Counselling Intervention



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 **Srinivas Publication**
(A Unit of Srinivas University)

THERAPEUTIC COUNSELING INTERVENTION

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2018**

Forward

Dr. Laveena D'Mello's book on "Therapeutic counseling intervention", which guides people with basic counseling skills while dealing with the people with various challenges from the young to old and problems of the children to geriatrics. Therapeutic counseling has five aspects; Counseling, Approaches to counseling, Counseling children and adolescents, Counseling for Couples and Therapeutic counseling in various areas. The chapters are planned as per the syllabus, given in simple format to make people to understand like guide. The chapters are sub divided and given in detail explanation. This book is very rare among the books which go under the title, counseling, psychiatric counseling, Medical social work etc.

I congratulate the author on writing such a structured book and also congratulate the publisher. I am very certain that this will prove very useful to our students, the social workers, researchers and those who want to gain knowledge about their problems and to overcome from their difficulties.

Preface

The book on Therapeutic Counseling intervention, is training and instructional material prepared for the Graduates and Post Graduate Courses. The subject 'Therapeutic counseling' is included in almost all universities who conduct Master of Social Work (MSW) courses, Health Science and allied courses. The Therapeutic Counseling book covers five chapters of the second year MSW course with Medical and Psychiatric Social Work Specialization. The chapters cover information regarding the basics of counseling, skills, qualities and multiple areas of counseling. This can be not only the guide for the students, but it also useful for those who work at Government as well as Non Government Organizations. The persons who are interested in higher education are also can conduct further studies. The professionals who work for various projects and specialized areas like children, adolescents, career guidance clinics, crises intervention groups, alcoholics, drug edicts, marital and pre marital counseling, senior citizen, geriatric centers, and also the chronic illness groups etc can use as guidelines. It is hoped that the social service minded people, counselors, professionalize will enrich their knowledge through referring several sources and through self-study. There is ocean of knowledge and there is no boundary. While dealing with the clients, each case will be new and unique. Students in helping professions should be persistent and continuous and in quest of knowledge.

Mangalore, Karnataka, India.

Dr. Laveena D'Mello

About the Author



Dr. Laveena D'Mello

Dr. Laveena D'Mello, Assistant Professor, Srinivas University, Mangalore, Karnataka, India, is a Passionate Social Work professional, Trainer, Faculty and a Researcher with Master's degree in Social Work, M.Phil. in Sociology, and Doctor of Philosophy in Sociology. Over last 2 decades of committed experience in Social Development domain, have spent 17 years in teaching and training at Graduate and Masters Level of Social Work Courses. Along with this, have more than 09 years of Social Work Field experience, working with various NGO's and for projects. In addition to this, she is an efficient and preferred trainer in Counseling and Life Skills. Several Training programs were conducted on Group Dynamics, Personality Development, Communication and Psycho-social Education for various organizations, Schools, NGO's, Institutions, Communities, Teachers and parents on Life skills and value education. As an active Researcher, she is glad to share that many research publications have been published on Elsevier's SSRN online journal and stood 16th rank in March 2018. Her deep desire to share the knowledge by publishing books and this is her second book on "Therapeutic counseling intervention" will serve the students of Social Work with Medical and Psychiatric specialization and also other allied field will find this book useful.

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PART -I

COUNSELING

The concept of Counseling- Definition

Meaning: Counseling is the service offered to the individual who is undergoing a problem and needs professional help to overcome it. The problem keeps him disturbed high strung and under tension and unless solved his development is hampered or stunted. Counseling, therefore, is a more specialized service requiring training in personality development and handling exceptional groups of individuals. According to Willey and Andrew Counseling involves two individuals one seeking help and other a professionally trained person helped solved problems to orient and direct him to words goals. Counseling services are therefore required for individuals having developmental problems because of the handicap they suffer in any area of emotional either because of hereditary factors or environmental conditions. Generally, such cases are only about five to seven percent in a population and therefore counseling is required only for such a small number. As compared to guidance which is for percent of individuals. Counseling involves a lot of time for the client to unfold the problem, gain an insight into the complex situation.

Counseling techniques involve active listening, emphatic understanding releasing the pent-up feelings confronting the client and so on counseling, therefore, is offered to only those

individuals who are under serious problem and need professional help to overcome it. The term 'counselling' is used in a number of ways. Very often the term counseling and psychotherapy are synonymously used. In the current usage also, counseling and psychotherapy are used interchangeably. F.P. Robinson describes counseling as aiding normal, people to achieve higher level adjustment skills which manifest themselves as increased maturity, independence, personal integration, and responsibility. The phrase "increasing human effectiveness" is used frequently to describe the goal of counseling. G.W. Gustad has defined counseling as a learning-oriented process, carried on in a simple one to one social environment, in which a counselor, professionally competent in relevant psychological skills and knowledge, seeks to assist the client by methods appropriate to the latter's needs and within the context of the total personnel programme..." In short, counseling -an interpersonal process through which guidance and support are provided to persons with psychological problems. These problems may be personal or interpersonal in nature. Thus Counselling seeks to resolve personal and interpersonal problems through a variety of approaches, and in a way that is consistent with the values and goals of society in general, and that of the client in particular.

Counseling in this sense is not absolutely distinct from guidance and education that the social workers often give through various programmes. Rather, it is an additional skill and understanding of common, yet complex emotional and

personality problems. Through counseling, the counselor helps the person to develop self-awareness and explore the possibilities to develop his/her latent capacities. Thus the scope of counseling is to increase both self-awareness and self-management. Counseling initiates a process of self-transformation in the person. The counselor through their skills helps the client to assess his/her own life, strength and limitation. Thus counseling is the process by which a skilled person aids another person in the total development of his/her personality. Dimensions of Counselling: As mentioned above, the term 'counselling' is used in a number of ways. In order to define and understand the meaning of counseling let's know the each of these dimensions.

First of all, counseling is viewed as a relationship. There is a consensus among all the counselors that a good counseling relationship is a prerequisite to be effective with clients. Some counselors regard the counseling relationship as not only necessary but sufficient for constructive changes to occur in clients (Rogers, 1957). One way to define counseling involves stipulating central qualities of good counseling called the 'core conditions', are empathic understanding, respect for clients' potentials to lead their own lives and congruence or genuineness. Those who view counseling predominantly as a helping relationship tend to be adherents of the theory and practice of person-centered counseling (Rogers, 1961; Raskin and Rogers, 1995). Secondly, counseling is viewed as a therapeutic intervention. It is believed that a set of interventions are required in addition to the relationship to

bring constructive changes in the person. These interventions are counseling methods or helping strategies. Counselors, who have a repertoire of skills, assess and decide of which intervention to use, with which client, when and with what probability of success. These interventions are based on the theoretical orientations of the counselors. For example, psychoanalytic counselors use psychoanalytic interventions, rational emotive theory counselors use rational emotive theory related interventions and Gestalt counselors use Gestalt interventions. Some counselors are eclectic and use interventions derived from a variety of theoretical positions.

Another dimension of counseling is that it is viewed as a psychological process. Counseling is fundamentally associated with psychology. There is the number of reasons for this association. First, the goals of counseling have a mental component in them. In varying degrees, all counseling approaches focus on altering how people feel, think and act so that they may live their lives more effectively. Counseling is not static but involves movement between and within the minds of both counselors and clients. Further, the underlying theories from which counseling goals and interventions are derived are psychological (Nelson-Jones, 1995). Many of the leading counseling theorists have been psychologists: Rogers and Ellis are important examples. Most of the other leading theorists have been psychiatrists: Beck and Berne.

Need of Counselling

Both the normal and psychologically disturbed persons can benefit from counselling. Counselling is considered beneficial to the persons with stress-related mood disturbances and adjustment problems. These disturbances and adjustment problems are sometimes expressed and shared as concerns by the affected individual. The need for counselling may be understood when someone raises concerns like: 'I am feeling lonely.' 'I have lost my job and feel hopeless.' 'I find it difficult to make up my mind about my career.' "I fell tensed all the time.' 'I wish I were better at controlling my anger'. 'I find that my life is becoming meaningless.' In these and such other cases, the person is expressing the need for help from others. Such help is extended by providing counselling services.

People with the following main criteria indicate the need for counselling:

- i. The symptoms are related to stress, but are out of proportion to the stress in duration or severity. For instance, a person disturbed after the sudden death of a loved one, is unable to adjust after several weeks. When the degree of emotional disturbance in such a case is so great that the individual is unable to attend to his or her regular work. Then the individual would probably benefit from counselling.

- ii. The symptoms interfere with psychological, cognitive, biological, social, personal, and/or occupational functioning.

Sometimes physical symptoms may also be present. Interference with psychological functioning means that depression, anxiety, fear, anger or other dysfunctional emotional states are present. Interference with cognitive functioning means that attention and concentration are poor. Mental slowness and mind blocks may become common. Interference with biological functioning means that the person will have disturbance of sleep, appetite and sexual functioning. Interference with social functioning means that there is impairment in the ability and desire to interact normally in social situations. Interference with occupational functioning means decreased work efficiency, making errors at work, avoidance of responsibilities, and/or absenteeism. Interference with personal functioning means decreased involvement in the usual recreational and leisure time activities. This may be associated with physical symptoms like fatigue, lethargy, aches and psychosomatic problems.

Goals of Counselling

After understanding the meaning and concept of counselling an attempt is made to discuss what is achieved through counselling. The counselling has different goals with different clients. For example, the counsellor may provide counselling for assisting client to heal past emotional deprivations, manage current problems, handle transitions, make decisions, manage crises and develop specific lifeskills, etc. Sometimes goals of counselling are divided between remedial goals and growth or developmental goals. Both the remedial and

developmental goals serve preventive functions. Though much of counselling is remedial, its main focus is on the developmental tasks of a vast majority of ordinary people rather than on the needs of more severely disturbed minority (Richard Nelson – Jones: 2000). The goals of counseling are as follows:

i. ***Counselling for healthy development of personality:***

Counselling goal can be for the nourishment of a natural tendency toward psychological maturation which presumably exists in every individual. According to psychologists like Carl Rogers and Abraham Maslow, everyone has a natural tendency towards “selfactualisation”. The counsellors, through their skills and by providing a conducive emotional atmosphere, help the clients to promote this innate positive orientation.

ii. ***Counselling as providing support and guidance:***

While working with people as social worker there are many occasions where individuals seek crisis intervention and short-term support from the social worker. A young man frustrated after completing higher education and not getting suitable employment, a woman severely depressed after the sudden death of her husband, a youth confused and finding it difficult to make choice about career are some of the examples of this. Anyone under acute stress or depression might benefit from this kind of temporary assistance.

iii. ***Counselling as emotional release:*** Suppression of thoughts, feelings and emotions often lead to physical or

mental problem. The counsellors in such cases help the client to deal with their unexpressed feelings and emotions. The client usually benefit from learning to let them go in a way that is not damaging to themselves or to others. A person who has just lost a loved one but is unable to grieve or a person who is furious with his/her boss but holds it in, for these and such other cases counselling is given as emotional release. Venting of emotions can be a great relief to these persons and freedom for such expressions is important aspects of social workers.

iv. ***Counselling for awareness***: Carl Rogers has pointed out that self-awareness, selfacceptance and self-direction are the most important aspects of personality development. Through counselling, the client can be helped to become aware and understand his/her own strengths, potentials, weaknesses and overall personality. The client can gain insight into his/her own thinking, feeling and behaviour. Self awareness helps them to accept themselves and also work to overcome their weakness.

v. ***Counselling for value clarification and change***: Counselling aims at developing a healthy value system in the clients' personality. The socialization process and internalization of values shape the personality of the individual. The value system directs ones thinking, feeling and accordingly the action. Sometimes people are involved in activities which are anti social and/or harmful to themselves or to others. In such a situation,counselling helps as a remedial measure. The counsellor helps the clients to clarify

their values and if needed bring about appropriate changes in the value system of the clients.

Counseling and Psychotherapy: There have been attempts to differentiate between counseling and psychotherapy. Very often both these terms are viewed as overlapping areas and are used interchangeably. Counseling has been characterized by words like educational, vocational, supportive, situational, problem-solving, conscious awareness, emphasis on 'normals' and short-term. Psychotherapy has been described with terms like supportive, reconstructive, depth emphasis, analytical, focus on the unconscious, emphasis on neurotics or other severe emotional and long-term problems. Richard Nelson-Jones (2000) also agrees with the considerable overlap between counseling and psychotherapy. However, in his writings, he uses terms counseling and counselor in preference to therapy and therapist. He regards counseling as a less elite term than therapy. Some of the differences noted by different scholars are psychotherapy focuses on personality change of some sort while counseling focuses on helping people to use existing resources for coping with life better (Tyler, 1961). Psychotherapy deals with more severe disturbance and is a more medical term than counseling. It is important to note that counseling and psychotherapy use the same theoretical modes and 'stress the need to value the client as a person, to listen sympathetically and to hear what is communicated, and to foster the capacity for self-help and responsibility' (BPS Division of Clinical Psychology, 1979). In brief,

psychotherapy is the treatment of psychological disorders by psychological means within the framework of existing psychological theories. It is conducted by the psychologist, psychiatrists, or other mental health professionals that are highly trained in the field.

Psychotherapy is a formal and structured process. However, counseling does not depend on psychological means alone to provide benefits to the client. Counseling may utilize processes such as restructuring the client's environment or recommending leisure pursuits. Counseling is not based upon any specific psychological theory; rather, it uses practical techniques derived from different forms of psychotherapy, as appropriate to the situation. Finally, counseling is far less formal and structured than psychotherapy. It is more flexible. There have always been "counselors"—people who listen to others and help them resolve difficulties—but the word "counselor" has been misused over the years by connecting it with descriptive adjectives to promote products. Thus, one hears of carpet counselors, color coordination counselors, pest control counselors, financial counselors, camp counselors, and so on. These counselors have mostly glorified salespersons, advice givers, and supervisors of children or services.

They are too professional counseling what furniture doctors are to medicine. Counseling as a profession grew out of the progressive guidance movement of the early 1900s. Its emphasis was on prevention and purposefulness—on helping individuals of all ages and stages avoid making bad choices in

life while finding meaning, direction, and fulfillment in what they did. Today professional counseling encompasses within its practice clinicians who still focus on the avoidance of problems and the promotion of growth, but the profession is much more than that. The focus on wellness, development, mindfulness, meaningfulness, and remediation of mental disorders is the hallmark of counseling for individuals, groups, couples, and families across the lifespan. To understand what counseling is now, it is important first to understand the history of the profession and how counseling is similar to and different from concepts such as guidance and psychotherapy.

Guidance: Guidance focuses on helping people make important choices that affect their lives, such as choosing a preferred lifestyle. The decision-making aspect of guidance has long played an important role in the counseling process. One distinction between guidance and counseling is that guidance centers on helping individuals choose what they value most, whereas counseling helps them make changes. Much of the early work in guidance occurred in schools and career centers where an adult would help a student make decisions, such as deciding on a course of study or a vocation. That relationship was between equals and was beneficial in helping the less experienced person find direction in life. Similarly, children have long received “guidance” from parents, religious leaders, and coaches. In the process, they have gained an understanding of themselves and their world.

Guidance is only one part of the overall services provided by professional counseling.

Psychotherapy: Traditionally, psychotherapy (or therapy) has focused on serious problems associated with intrapsychic, internal, and personal issues and conflicts. Psychotherapy, especially analytically based therapy, has emphasized (a) the past more than the present, (b) insight more than change, (c) the detachment of the therapist, and (d) the therapist's role as an expert. Psychotherapy has also been more of a process associated with inpatient settings—some of which are residential, such as mental hospitals—as opposed to outpatient settings—some of which are nonresidential, such as community agencies. However, in more modern times, the distinction between psychotherapy and counseling has blurred, and professionals who provide clinical services often determine whether clients receive counseling or psychotherapy. Some counseling theories are commonly referred to as therapies as well and can be used in multiple settings. Therefore, the similarities in the counseling and psychotherapy processes often overlap.

Counseling: The term counseling has eluded definition for years. However, in 2010, 29 counseling associations including the American Counseling Association (ACA) and all but two of its 19 divisions, along with the American Association of State Counseling Boards (AASCB), the Council for the Accreditation of Counseling and Related Educational

Programs (CACREP), the National Board for Certified Counselors (NBCC), the Council of Rehabilitation Education (CORE), the Commission of Rehabilitation Counselor Certification (CRCC), and the Chi Sigma Iota (counseling honor society international) accepted a consensus definition of counseling. According to the 20/20: A Vision for the Future of Counseling group, counseling is defined as follows:

- Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals. This definition contains a number of implicit and explicit points that are important for counselors as well as consumers to realize.
- Counseling deals with wellness, personal growth, career, education, and empowerment concerns. In other words, counselors work in areas that involve a plethora of issues including those that are personal and those that are interpersonal.
- Counseling is conducted with persons individually, in groups, and in families. Clients seen by counselors live and work in a wide variety of settings. Their problems may require short-term or long-term interventions that focus on just one person or with multiple individuals who are related or not related to each other.
- Counseling is diverse and multicultural. Counselors see clients with varied cultural backgrounds. Those from minority and majority cultures are helped in a variety of ways depending on their needs, which may include

addressing larger societal issues, such as discrimination or prejudice.

- Counseling is a dynamic process. Counselors not only focus on their clients' goals, they help clients accomplish them. This dynamic process comes through using a variety of theories and methods. Thus, counseling involves making choices as well as changes. Counseling

Evolution of Counseling

To understand the history of counseling, we begin with the realization that throughout the years, human beings have found comfort in sharing their problems or telling their story to others. The old saying 'a problem shared is a problem halved' tells us one universal human truth: that when things get difficult or we have to make decisions in our life, sometimes we need someone to listen and 'hear our story' so we can get a better idea of our options. Counseling history can be traced back to tribal times where people would come together in a group and share their experiences and sometimes their dreams. As civilization developed, religion offered a type of counseling, usually by priests who would listen and advise parishioners on their problems (they still do).

In the 1890's, German neurologist Sigmund Freud developed a theory later to be called psychoanalysis, which allowed individuals to tell their problems to a 'psychoanalyst,' an individual trained in interpreting the 'subconscious', that part of our psyche that we are not aware of but influences what we

do. Freud played an important part in the history of counseling, but the actual word “counseling” did not come into everyday language until the 1960’s. Counseling really took off after the Second World War, in 1950’s America. Most of the therapies we hear about today can trace their origins back to a handful of psychologists and psychiatrists (some of whom we will look at in this guide) who developed techniques and theories, sometimes referred to as ‘schools’ of therapy.

The word ‘school’ in counseling does not mean a building or campus. Rather it refers to how psychologists believe human beings develop their view of the world they live in and how they cope with it. The three schools are Psychoanalytical, Behaviourist, and Humanistic, which we will look at later in this guide. There have been many developments in counseling since the 1950’s. A lot of research has taken place and this has given us a better understanding of what makes human beings think and act in certain ways. However, most psychologists and counselors would agree that we are a long way from fully understanding what makes each human being unique. When we consider the history of counseling, it is worth noting that with the introduction of new techniques and research, the history of counseling is still being written today.

Today, we witness the introduction of guidance and Counselling Departments in Primary, Basic and Secondary Schools. The dynamism of the programme cannot be

overemphasized since its main goal is to help mankind regardless of race, age, social status, political and religious affiliation. It is believed that expansions of Guidance and Counselling in various schools, Colleges and communities will help the people develop the positive self-image, self-actualization and lift the self-esteem. It is also hoped that proper implementation of the programme will create a conducive atmosphere in communities for people to live in.

History of counseling and therapy

Family and religion: There has been a long need for counseling in helping individuals with transitions and other difficulties in their lives. The long tradition of counseling is first of family members helping with advice. Parents counsel their children. Grandparents and other family elders offer the wisdom of the years. In a close community, there may also be tribal elders or others with a concern for mental well-being. This role for many years was (and still is) taken on by the priest or religious person. For the individual, the priest offers confidentiality that enables discussion of family matters or things that are secret from the family. The priest meanwhile gets to steadily inculcate religious values, making it a valued relationship on both sides. The church tended to view mental illness as some form of possession and treatment, including exorcism, was of the soul rather than the body. Those with more incurable issues were generally tolerated. The village idiot was found a place in the fields and others were cared for or handled within the community.

The industrial revolution: With the age of the enlightenment and the rise of the industrial revolution through the eighteenth and nineteenth centuries, populations became mobile as they seek employment in towns and cities that were often far from their original homes. This separated them from their natural counselors, although the religious support was still available. Yet with the rise of science, the power of the church declined and it was not always able to give the help that was needed. Capitalism and science also had subtle effects on beliefs, values and general cognition. Everything had to be explained. The work ethic was dominant and hedonism was an option for only a few.

Along with the concentration of towns and cities came the need to protect its citizens and civic organizations such as police forces were developed. In small communities, the power of shame and the threat of banishment is enough to sustain social control. In town, anonymity is an option which brings its own problems. Particularly in America, social mobility was very much a norm. As much to protect the populace as the individual concerned, somewhere between the workhouse, hospital, and prison sat the lunatic asylum. Here, the insane (as well as a few unhappy individuals who had embarrassed their families) were incarcerated with little treatment. Science scoffed at the notion of possession by demons but had little idea what to do beyond basic approaches such as drugging and leeching. In the cruel days of misfit

sideshow, the asylum was just another place to go and laugh at those less fortunate.

The rise of psychotherapy: Hypnotism had been known about for some time (Mesmer lived around the turn of the eighteenth century), and was popular through the nineteenth century and was used as an informal therapeutic method. Nevertheless, it perplexed scientists who were suspicious of its shamanistic roots. With the continued development and dominance of scientific medicine, establishment attention was eventually turned to matters of the mind (something that empiricists had largely ignored as impenetrable). Medical science took over as the caretakers of the mentally disturbed and a new age of and discipline of psychiatry arose towards the end of the nineteenth century. Sigmund Freud was perhaps the most significant pioneer in seeking to understand and treat mental problems, at least in those who lived in normal society but who suffered from emotional and behavioral difficulties. Rather than try to treat mental problems as a physical issue, he chose to listen to them and try to work out what was happening from what they said, and then apply treatment in the opposite direction, again through words. Despite massive leaps, Freud was still trapped by notions of his day, such as the assumption that mental problems had an emotional basis and the derivation of ideas such as libido came from nineteenth-century biological theories. Psychoanalysis thus developed and was evolved by people such as Jaques Lacan and Melanie Klein into the approaches still used today. This was not without some internal division of opinion and Klein

famously split with Sigmund Freud's daughter, the more traditionalist Anna.

Behaviorism and humanism: In the way that a thing creates its opposite, the assumptions of psychoanalysis were challenged in the scientific search for hard evidence, and behaviorism and conditioning became popular for the focus on the external, measurable behavior. In the opposite direction, and particularly in the more liberal America, a different view arose amongst people such as Carl Rogers, Albert Ellis, Eric Berne and Abraham Maslow. These put the person and their experience in the middle of attention, as opposed to the more therapist and method focus of psychoanalysis. This may seem unfair but the humanist approach is just that - human. It sees the client as a collaborative partner, not as a patient to be treated by an expert. Humanism, even more than Behaviorism and quite unlike Psychoanalysis, has a focus on the present rather than the past. Humanism was largely a practitioner of philosophy and was largely ignored by academe for a long time. Nevertheless, its warm message resonated with both therapists and clients and it was widely used. Despite secular leanings, this approach was influenced by Protestant values such as free choice by the individual and the personal journey.

Secular society: With the decline of the church as a social institution that exists at the heart of the community and the lives of its people, there arose a vacuum of meaning and care.

Without the comfort of promised salvation, many lost their sense of purpose in the meaningless daily drudge. And without the sage and certain advice of the priest, the neuroses of industrial living worsened. Cities can be lonely places. With family far away and fickle friends who enjoy the fun but step back when emotional support is needed, a person can be out and dance yet feels terribly alone. In such an environment there is a vacuum, a pent-up need for help towards the making of meaning for individual lives. It was this need, this pull, that created the new disciplines of therapy and counseling. It was the loss created by sundered societies that drove some to despair and others to consider what succor and treatment could be provided to create a more harmonious. Those who wanted just to do good and those who saw the social imperative worked to develop ways and means of putting people back together and back into society. In pursuit of happiness and the American Dream, self-development was a common focus. Even in the First World War, the US army employed psychologists and psychological testing was widespread.

Twentieth-century expansion: Psychotherapy first caught on in a significant way in the USA, helped by a receptive culture and by European analysts who moved there away from fascist oppression. These ideas were then adopted into the American culture. Humanism in particular, as described above, was a particularly American approach. There is a notion of the 'empty self' and an American theme has been the search for meaning and the focus on the individual's story (the

empty self is also a possible cause in the rise of consumerism and advertising). In the latter half of the twentieth century, counseling developed significantly as a distinct profession, differing from therapy at least in the contexts of use and often in the types of issues faced. Counseling happens in the social community, in schools and colleges as well as homes. Counseling is often paid for by the community or is voluntarily offered (such as the Samaritans). Therapy is more likely to be a private practice. Therapy is largely found in the therapist's workroom. Counseling addresses issues from small to large. Therapy tends to deal with the bigger issues. Counseling may be limited. Therapy can continue as long as the client is able to pay.

As with other new domains, there has been a division of viewpoint and evolution of schools of thought. There have been views of counseling and therapy as a means to social change. The counselor-client relationship has been questioned. Even the dynamics resulting from the structure of expert-patient has been questioned. Throughout the development of counseling and therapy, there has been an evolution of thought about the way people are perceived and hence treated. In the days of the lunatic asylum, people were locked up and treated like animals. Freud viewed the person as conflicted and hidden. Behaviorists saw people as predictable machines. Humanists had a more botanical image, with ideas of feeding and growth. The perception can significantly affect the counselor's view and hence how they interact with them

Values and Attitudes of a Counsellor

Meaning of counseling: Introduction to counselling. *What is counselling?*

- A process of supporting a person/people to learn how to solve certain emotional, interpersonal and decision-making problems
- Helping clients to help themselves
- Can be done with individuals/couples/families
- Counseling seeks to resolve Personal and interpersonal problems through a Variety of approaches

Definition of Counseling: Counseling is an interpersonal process through which guidance and support is provided to persons with psychological problems. These problems may be personal or interpersonal in nature.

Aim of counselling: Counselling supports individuals to take charge of their own life by:

- Providing information
- Facilitating emotional adjustment
- Enhancing mental health, by enabling them to:
 - understand and accept the problem
 - develop resources to take adaptable, realistic decisions, and
 - alter their own behaviour to produce relatively enduring, desirable consequences

Counselling is

- Specific to the needs, issues and circumstances of each individual client
- An interactive, collaborative and mutually respectful process
- Goal-directed
- Oriented towards developing autonomy, self-responsibility and confidence in clients
- Sensitive to the socio-cultural context
- Eliciting information, enables the client to review options and develop action plans
- Inculcating coping skills
- Facilitating interpersonal interactions
- Bringing about attitudinal change

Counselling is not

- Telling or directing
- Giving advice
- A casual conversation
- An interrogation
- A confession
- Praying

Common errors in Counselling are

- Judging and evaluating
- Moralizing and preaching
- Labeling
- Unwarranted assurance

An effective Counsellor is

- Sensitive to cultural (contextual/ situational) differences
- Encourages free expression of feelings by the client
- Rewards and facilitates communication by the client
- Enables the client to think of alternative ways of solving problems
- Recognizes one's own limitations and makes referrals when required
- Respects the confidentiality of all that is disclosed
- Does not indulge in easy gossip

Key Qualities of effective counselor are

- Shows acceptance
- Has unconditional positive regard for the client
- Is non-judgemental
- Is an active listener
- Has patience
- Has empathy
- Facilitates congruence
- Is open to experience

Confidentiality

- Confidentiality is vital to the counselling relationship
- Do not gossip or indulge in loose talk
- Do not give personal examples relating to yourself
- Build mutual trust

Counselling skills: Counselling skills are essential for effective communication and the development of a supportive client–counsellor relationship. These include:

- Active listening
- Questioning
- Using silence
- Non-verbal behaviour
- Accurate empathy

Active listening: Active listening is expressed by:

- Counsellor’s verbal and nonverbal cues
- Genuine concern for the client
- Making eye contact
- Assuming relaxed posture to make the client feel relaxed
- Being attentive and congruent
- Appropriately responding to facilitate free expressions and deeper understanding

Do’s for active listening

- Demonstrate attention: nod your head
- Encourage the client to talk: say ‘*Mm-hmm*’, ‘*Yes*’
- Minimize external (TV, telephone, clock, traffic noises) and internal (sudden thoughts, ideas, worries, etc.) distractions
- Acknowledge the client’s feeling, ‘*I can see that you are very sad*’
- Repeat/rephrase to check if you have correctly understood the client
- Paraphrase, reflect, clarify, summarize

Do not

- Interrupt the client
- Personalize or narrate your own experiences
- Moralize
- Be judgemental
- Disregard the client's fear and apprehensions
- Distract the client by attending phone calls, etc.
- Go beyond a professional relationship with the client

Questioning: Types of questions

- Closed
- Open-ended
- Leading

When asking Questions remember

- Ask one question at a time
- Look at the person
- Be brief and clear
- Ask questions that serve a purpose
- Use questions to encourage clients to talk about their feelings and behaviours
- Use questions to explore and understand issues

Using Silence

- Gives time to the client to think about what to say next
- Provides space to experience feelings
- Allows clients to proceed at their own pace
- Provides time to resolve ambivalence about sharing information / thoughts / feelings

- Gives the client the freedom to choose whether or not to continue

Micro skills for building Rapport

- Active listening
- Questioning (closed, open ended and leading)
- Using silence
- Proper non-verbal behavior
- Showing accurate empathy

B. Stages and process of counselling: Process of Counselling

- Counseling is an ongoing process
- The client and the counselor interact with each other to resolve problems
- Counselling involves a person-centered approach
- Essence of counselling is conveyed by ‘GATHER’: Greet, Ask, Tell, Explain and Revisit

Assumption in Counselling Process

- Believes in the client’s capacity to change behaviour
- Facilitates in the client becoming a fully functional person
- Builds self-esteem, self-acceptance and insight
- Encourages problem-solving by the client
- Facilitates a warm, permissive and accepting atmosphere

Counselor’s attitudes

- Acceptance and unconditional positive regard for the client

- Empathy
- Genuineness
- Non-judgmental

Skills of Counseling

- Rapport-building
- Information-gathering
- Attending and listening
- Information-giving
- Predicting
- Coping with burn-out and stress

Stages of Counseling

Stage 1: Rapport-building

Stage 2: Assessment and analysis of the problem

Stage 3: Provision of ongoing supportive counseling

Stage 4: Initiation and planning

Stage 5: Implementation of the plan

Stage 6: Termination and follow-up

Stage 1: Rapport-building

- Assuring confidentiality and discussing the limits of confidentiality
- Allowing ventilation, expression of feelings
- Exploring the problem(s), with the client
- Clarifying the client's expectations of counselling
- Describing the method of working
- Statement from the counsellor about their commitment to work with the client

Stage 2: Assessment and analysis of the problem

- Defining and focusing specifically on the problem.
- Identifying and assessing the gravity of the client's problems
- Explaining and understanding the roles and boundaries of the counselling relationship
- Establishing and clarifying the client's goals and needs
- Taking a detailed history
- Exploring the client's beliefs, knowledge and concerns
- Assessing the impact of the problem on the client's life
- Exploring the resources and support available to the client
- Understanding the level of insight
- Facilitating a summary of the problem by the client

Ways of responding

- Respond to feeling and content
- Respond with a summary
- Respond with a question

Stage 3: Provision of ongoing supportive counselling

Continuing expression of thoughts and feelings

Identifying options

Identifying existing coping skills

Developing further coping skills

Evaluating options and their implications

Enabling behaviour change

Supporting and sustaining work on client's problems

Monitoring progress towards identified goals

Altering plans as required

Providing referral as appropriate

Stage 4: Initiation and planning

- Motivating the client for behaviour change
- Setting attainable goals
- Planning the programme to achieve the goals
- Planning and initiating is done by: (i) identifying the options, (ii) identifying existing coping skills, and (iii) developing further coping skills
- Evaluating options and their implications to enable behaviour change

Stage 5: Implementation of the plan

- Selecting a plan of action
- Sequencing intervention activities
- Putting the plan into action
- Reinforcing and monitoring behaviour change
- Being supportive while the client effects the change

Stage 6: Termination and follow-up

- Assessing the progress of behaviour change
- Assessing coping resources
- Reinforcing follow-up by ensuring that
 - the client is acting on plans,
 - the client is managing and coping with daily functioning,
 - and

—the client has a support system and supports are being accessed.

- Assurance provided to the client of the option to return to counselling as necessary

III. Behavior change communication

An unhealthy behavior must be unlearned and the individual needs to;

- Identify the behavior as harmful
- Understand the alternatives available
- Be able to act on that knowledge
- Receive the support necessary to maintain the behavior

The process of Behavior Change: The behavior change stages are

- Knowledge/awareness
- Significance to self
- Cost-benefit analysis
- Capacity-building
- Provisional Try
- Maintaining Behavior change

The Elements of Behavior change counseling

- Assess the risk and Vulnerability
- Briefing and motivating the needs, beliefs, concerns and readiness of client
- Critical thinking, decision-making and communication skills should be strengthened
- Making a plan

- Resource to reduce the risk
- Reinforcement and commitment
- Supportive environment

Skills of counseling

The Top Ten Basic Counseling Skills: Research is increasingly finding that the type of therapy used is not as important to outcomes as are specific counselor behaviors such as (1) Enthusiasm, (2) Confidence, (3) Belief in the patient's ability to change. Although there is nothing which will ensure change, it would appear that clients are more likely to achieve their goals when a good and positive relationship exists between them and their therapist. In essence, the counselor's interactions with the client are a powerful tool in the helping relationship.

A. Listening: *Attending*– i] orienting oneself physically to the patient (pt) to indicate one is aware of the patient, and, in fact, that the client has your full, undivided attention and that you care. Methods include eye contact; nods; not moving around, being distracted, eye contact, encouraging verbalizations; mirroring body postures and language; leaning forward, etc. Researchers estimate that about 80 percent of communication takes place non-verbally. ii] Listening/observing - capturing and understanding the verbal and nonverbal information communicated by that pt.

Two primary sources of information: Content - what is specifically said. Listen carefully for, not only what a person says, but also the words, expressions, and patterns the person is using, which may give you a deeper insight. Counselors should develop their ability to remember what was said, as well as to clarify what was said or finding out what was not said. Process - all nonverbal phenomena, including how content is conveyed, themes, body language, interactions, etc. Smiling.

B. Empathy: The ability to perceive another's experience and then to communicate that perception back to the individual to clarify and amplify their own experiencing and meaning. It is not identifying with the pt or sharing similar experiences-- not "I know how you feel"!

Primary skills associated with the communication of empathy include:

- nonverbal and verbal attending
- paraphrasing content of client communications
- reflecting patient feelings and implicit messages

a. Attending – involves our behaviors which reflect our paying full attention, in an accepting and supportive way, to the client.

b. Paraphrasing - Selective focusing on the cognitive part of the message – with the client's keywords and ideas being communicated back to the patient in a rephrased, and shortened form.

There are four steps in effective paraphrasing:

- Listen and recall. The entire client message to ensure you recalled it in its entirety and do not omit any significant parts. Identify the content part of the message by deciding what event, situation, idea, or person the client is talking about
- Rephrase, in as concise a manner as possible, the keywords and ideas the client has used to communicate their concerns in a fresh or different perspective.
- Perception check is usually in the form of a brief question, e., “It sounds like...,” “Let me see if I understand this,” which allows the client to agree or disagree with the accuracy of your paraphrasing.

c. Reflecting Patients Feelings: Affective reflection in an open-ended, respectful manner of what the client is communicating verbally and nonverbally, both directly through words and nonverbal behaviors as well as reasonable inferences about what the client might be experiencing emotionally. It is important for the helper to think carefully about which words he/she chooses to communicate these feelings back to the client. The skill lies in choosing words which use different words that convey the same or similar. For example, if a poorly skilled helper reflected to the client that he/she was “very angry and depressed,” when the client had only said they were irritated by a certain event and had felt very sad over the death of a family pet, the result could be counterproductive to the process of change.

C. Genuine: Ability of counselor to be free themselves. Includes congruence between outer words/behaviors and inner feelings; defensiveness; non-role-playing; and being unpretentious. For example, if the helper claims that they are comfortable helping a client explore a drug or sexual issue, but their behavior (verbally and nonverbally) shows signs of discomfort with the topic this will become an obstacle to progress and often lead to client confusion about and mistrust of the helper.

D. Unconditional positive regard: an expression of caring and nurturance as well as acceptance.

- Includes conveying warmth through:
- Also conveying acceptance by responding to the pt's messages (verbal and nonverbal) with nonjudgmental or noncritical verbal & nonverbal reactions.
- Respectability to communicate to the pt the counselor's sincere belief that every person possesses the inherent strength and capacity to make it in life, and that each person has the right to choose his own alternatives and make his own decisions.

E. Concreteness Keeping communications specific: focused on facts and feelings of relevant concerns, while avoiding tangents, generalizations, abstract discussions, or talking about counselor rather than the client. Includes the following functions:

- Assisting client to identify and work on a specific problem from the various ones presented.
- Reminding the client of the task and re describing intent and structure of the session
- Using questions and suggestions to help the client clarify facts, terms, feelings, and goals.
- Use a here-and-now focus to emphasize process and content occurring in the current session, which may help to elucidate the problem being worked on or improving the problem-solving process.

G.Open Questions: A questioning process to assist the client in clarifying or exploring thoughts or feelings. Counselor is not requesting specific information and not purposively limiting the nature of the response to only a yes or no, or very brief answer.

- The goal is to facilitate exploration – not needed if the client is already doing this
- Have an intention or therapeutic purpose for every question you ask
- Avoid asking too many questions, or assuming an interrogatory role.
- The best approach is to follow a response to an open-ended question with a paraphrase or reflection which encourages the client to share more and avoids repetitive patterns of question/answer/question/answer, etc.

H. Counselor Self-Disclosure: The counselor shares personal feelings, experiences, or reactions to the client. Should include relevant content intended to help them. As a rule, it is better to not self-disclose unless there is a pressing clinical need which cannot be met in any other way. Remember empathy is not sharing similar experiences but conveying in a caring and understanding manner what the client is feeling and thinking.

I. Interpretation: Any statement to the client which goes beyond what they have said or are aware of. In interpretation, the counselor is providing new meaning, reason, or explanation for behaviors, thoughts, or feelings so that pt can see problems in a new way. Interpretations can help the client make connections between seemingly isolated statements of events, can point out themes or patterns, or can offer a new framework for understanding. An interpretation may be used to help apt focus on a specific aspect of their problem or provide a goal.

- Keep interpretations of short, concrete (see concreteness), and deliver them tentatively and with empathy.
- Use interpretations sparingly and do not assume a pt's rejection of your insight means they are resistant or that you are right.

J. Information Giving and Removing Obstacles to

Change: Supplying data, opinions, facts, resources or answers to questions. Explore with client possible problems which may delay or prevent their change process. In collaboration with the client identify possible solutions and alternatives.

Micro skills of counseling

- Micro skills focused on alternative perception and construction of reality.
- Micro skills model is not linked to any theoretical approach but to the premise that the skills are useful in multiple theories and settings (corey & corey 2002)

Attempt to practice skills, not solve problems

Micro skill hierarchy

- Determining personal style
- Skill integration different theory – different skill
- Influencing skills/strategies
- Interpretation, logical consequence, self disclosure, feedback, information/advice
- Reflection of meaning
- Focusing
- Confrontation
- Five stage interview structure: A) rapport B) gather data C) mutual goal setting D) working exploring alternatives and confronting incongruity E) terminating and generalization to daily life

- Reflection of feeling
- Encouraging, paraphrasing and summarizing
- Client observation skills
- Open and closed questions
- Attending behaviour ECTC, vocal qualities, body language
- Ethics and multicultural competence

Attending behaviour – basics to communication visual

- eye contact
- Facilitating
- Staring
- Avoiding
- look at the client when talking

Attending behaviour – basics communication – vocal qualities

- Tone
- Speech rate
- Accent
- Speech hesitation
- pitch

Attending behaviour – basics to communication

Verbal tracing and selective attention

- the client has come with a topic of concern
- Stick with the client's story.

- Was the client able to tell the story?
- Stay on topic
- Number of major topic jumps
- Did shifts seem to indicate interviewer interest pattern
- Did the client have the majority of the talk time?

Attending behaviour – basics to communication attentive body language

- Leaning
- Facial expression
- Number of facilitative body movements
- Use encouraging gesture
- When client is uncomfortable talking about a topic, it may at times be better to avoid eye contact

Basic listening sequence: Open and closed questions – as one basic listening sequence

Open ended

- Are those that can't be answered in a few words. They encourage others to talk and provide you with maximum information.
- could, what, how, why, what else – BASIC QUESTION STEM

Basic listening sequence closed questions

- Can be answered in a few words as sentences. They have the advantage of focusing the interview and obtaining the information.
- Is, are, do.....

Observation skill: one of basic listening sequences observing one's own and the client's verbal and non-verbal behaviour as well as discrepancies and incongruities that may occur in the session.

Observation skill- non verbal

- Visuals
- Vocals
- Body language
- ETEC
- Body movement
- Alterations of eye contact during confusion
- Stammering, speech hesitation – while pursuing difficult topics
- Facial expressions- frowning
- Flushing
- Inappropriate smile
- Lips – tight or loose
- Breathing
- Hand & arm gestures – random – indicate confusion
- Smooth, flowing gestures – suggest openness
- Movement synchrony – unconscious complex hand movements together (People sitting in identical position)
- Movement complementarity - e.g. one person talks & the other nods

- Movement dissynchrony – lack of harmony in movement between people who disagree

Observation skill -verbal

- Language is basic to interviewing and counseling
- Selective attention – clients tend to talk about what we are interested in and willing to hear
- Verbal underlining – through vocal emphasis keywords are underlined. It is another helpful clue to determine what is most important to the client
- Concrete/situational clients – provide specifics & examples of their concerns & problems
- Abstract/formal operational – have strengths in self – analysis & reflection on their issues

Observation skill discrepancies and conflict

- E.g My son is perfect. But he doesn't respect me.
- I really love my brother. But I can't get along with him
- With high awareness of verbal and non verbal behaviour high ability to notice conflicts is possible

Encouraging as the skill of active listening

Variety of verbal and non verbal means- to prompt client to continue talking

- Open hand gestures
- Phrases- un-huh
- Simple repetition of key words the client has uttered

- Re statement- repetition of 2 or more words exactly as used by the client
- Appropriate smile
- Interpersonal warmth

Para phrasing as the skill of active listening

- Feed back to the client the essence of what has just been said.
- The listener shortens and clarifies the client's comments.
- Para phrasing is not parroting- but using some of counselors words + important main words of the client

Summarization as the skill of active listening

Similar to paraphrase, but used over a long time span.

Attention to feelings is often part of an effective summarization.

- Beginning
- In between the session
- Ending of session

Reflecting feelings –

- as a foundation of client experiences involves observation of emotions, naming them, and repeating back to the client
- Recognize key emotional words expressed by client
- Recognize unspoken feelings expressed non verbally
- Check out for accuracy

Observing feeling

- Verbal feeling
- Non-verbal indications
- Implicit feelings not actually spoken by the client

Paraphrasing and reflection

- the two are closely related and often will be found together in the same statement, but the important distinction is emphasis on content (paraphrase) and emotion (reflection of feeling)

Reflecting feelings

- Sentence stem – it looks like, sounds like
- Feeling label/emotional word – happy, Really down
- Context/brief paraphrase
- Tense of reflection – present-tense more useful than past-tense
- Check out - am I hearing you correctly
- Meena I hear that you are really angry with them because they didn't help you.
- What name would you give to that feeling

Empathy and micro skill

As integrated listening skill enter the world of the client and communicate that we understand the client's world as the client sees and experiences it.

Empathy: Try to drop our own preconceptions and really listen to the other person in order to try to enter their ‘frame of reference’. We do not empathize if we constantly compare the other person’s situation with our own. Empathy involves a certain ‘forgetting of self’ in order to give ourselves up to the other person. Without some appreciation of the other person’s world-view, we run the danger of moralizing, advising and of generally getting the wrong end of the stick.

Qualities of a counselor

Qualities and Skills of a Good Counselor are,

1. They are trustworthy; you feel safe with them.
2. They demonstrate unconditional acceptance, genuineness, and empathy.
3. They try to understand things from your perspective.
4. You can tell that they are for you.
5. They believe in you. They have a sense of hope and confidence in your ability to change or find a solution that will work for you.
6. They give you their full and undivided attention when you are sharing with them. (They never seem impatient, disinterested or distracted.)
7. They listen without interrupting.
8. In a counseling session, you do around 90% of the talking; they only talk about 10% of the time.
9. You can tell they are interested in what you have to say. What matters to you also matters to them. You set the agenda – not them.

10. They help you to find your own solutions instead of giving advice or telling you what you should do.
11. They are warm, calm, sensitive, caring, open, patient and concerned.
12. You feel that you can be your true self when you are with them. You don't feel judged, criticized or written-off.
13. You get the sense that they respect and like who you are.
14. You feel valued by them; they see you as the expert on your own life.
15. They are comfortable with silence.

The Counseling Process-Effective leaders use the four stages of the counseling process

- Identify the need for counseling.
- Prepare for counseling.
- Conduct counseling.
- Follow up.

Identify the Need for Counseling: Quite often organizational policies, such as counseling associated with an evaluation or counseling required by the command, focus a counseling session. However, you may conduct developmental counseling whenever the need arises for focused, two-way communication aimed at subordinate development. Developing subordinates consists of observing the subordinate's performance, comparing it to the standard,

and then providing feedback to the subordinate in the form of counseling.

Prepare for Counseling: Successful counseling requires preparation. To prepare for counseling, do the following:

- Select a suitable place.
- Schedule the time.
- Notify the subordinate (Client) well in advance.
- Organize information.
- Outline the counseling session components.
- Plan your counseling strategy.
- Establish the right atmosphere.

Select a Suitable Place: schedule counseling in an environment that minimizes interruptions and is free from distracting sights and sounds.

Schedule the Time: When possible, counsel a subordinate during the duty day. Counseling after duty hours may be rushed or perceived as unfavorable. The length of time required for counseling depends on the complexity of the issue. Generally, a counseling session should last less than an hour. If you need more time, schedule a second session. Additionally, select a time free from competition with other activities and consider what has been planned for the counseling session. Important events can distract a subordinate from concentrating on the counseling.

Notify the Subordinate Well in Advance: For a counseling session to be a subordinate-centered, two-person effort, the subordinate must have time to prepare for it. The subordinate should know why, where, and when the counseling will take place. Counseling following a specific event should happen as close to the event as possible. However, for performance or professional development counseling, subordinates may need a week or more to prepare or review specific products, such as support forms or counseling records.

Organize Information: Solid preparation is essential to effective counseling. Review all pertinent information. This includes the purpose of the counseling, facts, and observations about the subordinate, identification of possible problems, main points of discussion, and the development of a plan of action. Focus on specific and objective behaviors that the subordinate must maintain or improve as well as a plan of action with clear, obtainable goals.

Outline the Components of the Counseling Session: Using the information obtained, determine what to discuss during the counseling session. Note what prompted the counseling, what you aim to achieve, and what your role as a counselor is. Identify possible comments or questions to help you keep the counseling session subordinate-centered and help the subordinate progress through its stages. Although you

never know what a subordinate will say or do during counseling, a written outline helps organize the session and enhances the chance of positive results.

Plan Counseling Strategy: As many approaches to counseling exist as there are leaders. The directive, nondirective, and combined approaches to counseling were addressed earlier. Use a strategy that suits your subordinates and the situation.

Establish the Right Atmosphere: The right atmosphere promotes two-way communication between a leader and subordinate. To establish a relaxed atmosphere, you may offer the subordinate a seat or a cup of coffee. You may want to sit in a chair facing the subordinate since a desk can act as a barrier. Some situations make an informal atmosphere inappropriate.

Basic Counseling Knowledge and Skills: Basic counseling skills/ Key qualities of an effective counselor comprise

- Showing acceptance
- Showing unconditional positive regard for the client
- Is non-judgemental
- Is an active listener
- Has patience
- Has empathy
- Is congruent

- Is open to experience

It is important to recognize and accept that clients are different and hold attitudes, values, and beliefs different from the counselors. Counseling is not pushing clients to conform to certain ways of living. Counseling micro-skills are essential for effective communication and the development of a supportive client-counselor relationship.

They include:

- Active listening
- Questioning
- Using silence
- Non-verbal behavior
- Accurate empathy
- Active listening is expressed by:
 - Counselor's verbal and nonverbal cues
 - Genuine concern for the client
 - Making eye contact
 - Assuming relaxed posture to make the client feel relaxed
 - Being attentive and congruent
 - Appropriately responding to facilitate free expressions and deeper understanding

There are three different methods of questioning a client; Closed; Open-ended; Leading.

A *closed question* limits the response of the client to one-word answers. Closed questions do not give the opportunity to a client to think about what they are saying. Answers to closed

questions can be very brief, hence non-informative. This often necessitates further questioning. Closed questions are useful to confirm certain answers/decisions taken by the client. E.g. ‘Are you sure you want to take the HIV test? ; ‘Are you confident about disclosing your status to your spouse?’. Closed questions are valuable in the counseling process; however, they need to be used appropriately. *An open-ended question* requires more than a one-word answer. Open-ended questions cannot be answered by a simple ‘Yes’ or a ‘No’. Open-ended questions invite the client to continue talking and are valuable for the counselor to better understand the client’s situation, problems, beliefs, needs and also to decide in what direction they want to take the conversation. *Leading questions* by the counselor unwittingly suggest answers to the client and usually ‘lead’ the client to answer in a manner expected by the Counsellor. These questions are usually judgemental. e.g. ‘You do practice safe sex, don’t you?’ ‘Do you agree that you should always use a condom?’. *Using non-verbal behavior*- The major part of communication is non-verbal. If a person’s body language is not congruent with what he/she is saying the result may be verbal confusion and/or misinterpretation. Effective counselors are extremely sensitive to non-verbal communication from both- counselors to clients and clients to counselors.

During Counseling

- Use clear and simple language. Try and remember locally used terms or words. This will help explain information in a manner that the client will understand.

- Do not assume clients know or do not require specific information. Discuss all practices with all clients. This helps clients to open up and speak to you.
- Assume the client will be embarrassed speaking about sensitive issues especially related to HIV transmission. Hence be sensitive to their needs
- .Ensure the client understands information printed on the consent form before signing. Explain its contents or read it aloud. You may also provide IEC material as background information.
- Consent for testing of minors (less than 18 years) must be sought from the legal guardian (parents, grandparents, in-charge of orphanage etc.).
- Encourage follow-up with clients; for positive clients for treatment, care and support and clients testing negative for the repeat test, if in a window period.
- Make appropriate referrals- STI, TB, other treatment facilities, CBOs, NGOs, etc.

Medical Disclosure: In a healthcare setting, staff who is directly involved in care for the HIV positive person such as the attending nurse or the operating surgeon should be informed of the HIV status either by the client or by the counselor after seeking the consent of the client. Medical disclosure protects both the rights of the client to confidentiality and the rights of the hospital staff to a safe work environment. The disclosed information must be kept confidential by the attending hospital staff.

Follow-up counseling: Follow-up counseling includes all counseling after post-test counseling and should be encouraged for both HIV negative and HIV positive clients who face difficulties in coping with their test result, require further information or have problems reducing their risk of HIV infection. Counseling techniques which the counselor may need to use include crisis counseling, problem-solving techniques, family therapy, counseling for grief, counseling for psychological distress, counseling for suicide prevention and other psychiatric conditions should be used as per the presenting problem.

Practical issues involved in Counseling

Introduction: Counselling is a unique helping process that allows the client an opportunity to learn, feel, think, experience and bring about changes in ways that are socially desirable and personally beneficial. Most clients enter the counseling relationship voluntarily and in some cases through referral services. Although some clients typically expect the counselors to find solutions to their difficulties, the counseling relationship is actually

Collaborative: client and counselor work together towards achieving the goals of counseling. To facilitate the achievement of the goals of counseling, the counselors use learning and interpersonal relationship to establish conditions favorable to client change.

Practical Arrangements for Counselling

The Client: Counselling is providing guidance and support to those with psychological problems that are personal or interpersonal in nature. When the problems are personal, the individual is the focus of counseling. However, at times the problem could be interpersonal in nature. At such times, the group to which the individual belongs can also profit from the counseling sessions and thus be included. For example, when counseling an alcoholic, it is important to counsel his family also. Thus, when problems are interpersonal, the group becomes the focus of counseling. However, individuals in the group may also benefit from independent counseling. For example, during the process of marital counseling sessions, it may be that one spouse requires special sessions separately. Very often, individuals resist being singled out or included in groups for counseling. For example, an alcoholic's wife may indignantly refuse to consider that any aspect of her behavior is contributing to her husband's alcoholism. Another example is a father who believes that he does not require counseling as the problem lies with his delinquent son who is entirely in the bad company of his friends. In such situations, much tact and firmness are required to enlist the involvement and cooperation of the concerned persons.

The place to Conduct Counselling: Counselling is a formal process and should ideally be conducted in a formal setting, such as a counseling center, hospital, or some other appropriately designated place. Unless the circumstances are exceptional, counseling should never take place in domestic

premises or any public place for various reasons. Counseling should not take place in any situation in which frequent interruptions or disturbances disrupt the continuity of the session. Counseling should not take place where privacy is likely to be violated. A client, for example, will not feel comfortable if other persons are present in the counseling room, even if the other persons are busy with their own work.

Seating Arrangement during the Sessions: Ideally a counselor and client should always face each other. Some counselors and clients feel comfortable if they are seated at a desk while some prefer to sit with nothing in between. The most important issue is that both should be comfortably seated, neither too close nor too far apart.

Payment of Fees: The disadvantage of free counseling is that clients take the services less seriously as they do not have to pay for them. In such situations, paradoxically, utilizing free services harms rather than benefit the client. Thus ideally a counselor should charge the client. The charges depend whether the counselor sees the client in his private practice or is part of a service rendered by a non-government organization where charges are fixed by the organization or other settings where fees are decided upon.

Duration of Counselling Session: Counselling sessions are commonly 50 minutes to an hour in duration. Sessions that are shorter may not be adequately therapeutic and sessions that are much longer than an hour may be tiring for both the client and the counselor and lose out on its profitability quotient. In

crisis situations, extended sessions may be helpful. A follow-up session may be for the shorter duration.

A frequency of Sessions: The frequency of sessions depends on the seriousness of the problem faced by the client. In crisis situations, frequent sessions may be required for as long as the crisis exists and if the client is highly stressed. In problems that have been in existence for months or years, once a week sessions may sufficient. A common practice is that sessions are conducted more frequently initially (e.g. 2-3 times a week) and less frequently subsequently (e.g., once a week). Once the goals of counseling have been met, follow-up sessions should be carried out. These could take place from once a fortnight to once a month.

Number of Sessions Required: For few clients, a single session will be sufficient. For some clients, counseling may continue for several months. A majority of clients will require counseling for periods that lie in between the two. The number of sessions and duration of therapy thus depends upon the nature of the problem and the progress that the client has in therapy.

Handling Difficult Situations: Client finds it difficult to open up in therapy. The counselor should create an atmosphere and have genuine attitudes of kindness, patience, and understanding. The counselor who finds that the client is not willing to open up could help such clients by talking about neutral issues, such as education, likes, and dislikes, friends

etc. The counselor should approach the problem areas, such as family or love life, with tact.

As the client begins to feel more comfortable, the counselor can aim at more specific issues.

- Addressing silences during the counseling session
- Silences may mean several things. It could mean
- The client may have finished what he had to say
- He may be thinking of what to say next.
- He may be experiencing a mental block.
- He may be reluctant to discuss the issue further.
- He may be overcome by feelings.
- He may be considering some important thoughts which have just occurred to him or which the counselor might have suggested.
- He may want some reassurance from the counselor concerning an issue which has just been discussed and
- He may be feeling hostile towards the therapy or the counselor

In such situations, the counselor should decide which one of these possibilities is likely to be experienced by the client. The counselor can reflect with the client and find out, what triggered the silence. In some situations, the client may need to be given the opportunity to think his way through. In other situations, the counselor may need to break the silence, guide the client, or shift to other topics for the moment and return to the critical area later. The counselor could probe gently with questions such as, “What are you thinking of”? What is to be done depends best on the understanding and judgment on the

part of the counselor based on the situation assessed and faced by him. There is no hard and fast rule that can be applied given the uniqueness of each client and the diverse problems faced by them and the proceedings of the session.

Handling situations where clients cry: Many counselors find it uncomfortable to attend to clients who begin to cry during a session. Their immediate reaction is to convey to the client “Please, don’t cry; it’s not so bad”. Such a response is inappropriate. Ideally, a client’s tear should not cause embarrassment to the counselor. The tears are signs of the client’s trust, that he is comfortable revealing it to the counselor. An appropriate response of the counselor would be to allow the client to express his emotions, and thus allow the tears to flow. The counselor should not wait for the client to stop crying. This would draw direct attention to the client’s reaction and could make the client embarrassed for crying. The counselor could continue with the discussion, using a softer tone. If he considers it necessary, the counselor may add a sympathetic remark, “This has upset you very’ much, hasn’t it?”

Clients show an excessive and inappropriate emotional reaction: Sometimes, a client may show emotions, which do not match with the situation. A client may weep without any provocation, or show anger or other emotions to an extent that is greater than what the situation demands or calls for. In dealing with such situations it is usually best to allow the

client to run out of steam on their own. Then the counselor can gently, at the same time firmly, examine the reasons for the outburst and help the client to understand the inappropriateness of the reaction. Sometimes, in certain situations, it may be that the counselor may wish to abort the expression of emotion. This may be necessary for situations when the emotions appear histrionic or when the emotions appear to be getting out of control or when repeated expressions of emotions interfere with the progress of the sessions.

Challenges: There is some situation, Counsellor does not know what to do, what to say or do next in the session will sound silly. However, there are situations when counselors are stuck for ideas. They do not know what to say or ask, or how to proceed with the counseling session. Some questions that a counselor could ask to obtain information about the client's problem situation as well as to convey some insightful benefit are as follows: *Tell me about yourself; What do you like about yourself? ;How do you take care of yourself?; How do you know when do you need to take care of yourself?; Who are the people in whom you confide?; How do people around you help you?; How do you allow people around you to help you?; What makes you happy?; What do you do to make yourself happy?; What do you do each day to make Do you want to get up in the morning?; How do you indulge yourself?; What are you not allowed to want?; What are you not allowed to need?; What are you not allowed to feel?; Tell me about a funny side to your problems.; What can you do

about this situation?; What do you like about yourself?;How do you take care of yourself? ; How do you know when do you need to take care of yourself?; Who are the people in whom you confide?; How do people around you help you?; How do you allow people around you to help you?; What makes you happy?; What do you do to make yourself happy?; What do you do each day to make Do you want to get up in the morning?; How do you indulge yourself?; What are you not allowed to want?; What are you not allowed to need?;What are you not allowed to feel?; Tell me about a funny side to your problems.;What can you do about this situation?

Problems of paying attention:Few problems that a good therapist must learn to guard against are briefly discussed

Transference:During the process of counseling as issues are worked upon and the clients share personal details, the clients sometimes develop attitudes towards the counselor that they hold or held towards some significant others in their lives. For example, a client may perceive the counselor's concern and support as that arising from their parent or a client who may perceive the counselor's *tact* guidance as reproof, reminiscent of a critical spouse. This reflection of attitudes that the client develops and expresses towards the counselor is called transference. Transference may become apparent from a change in the client's personal attitudes towards the counselor.

Transference can be either positive or negative. When the counselor is perceived as someone good, it's a positive transference and when he is not very much favored then it is perceived as a negative transference. Transference, in general, should be discouraged because it can interfere with therapy, or make the client dependent on the counselor. Thus, counselors should become aware of this phenomenon to prevent from abiding by a role imposed by the client as it could make the client dependent and can interfere in bringing about therapeutic changes in the client. The client's attitudes towards the therapist can directly be discussed where a strong transference phenomenon is observed.

Counter-Transference: Just as transference phenomenon happens on the part of the client, counter-transference is the attitude that a counselor develops towards the client in the process of the therapeutic alliance. This attitude that the counselor develops towards the client is the attitudes held or hold towards some significant other in his life. For example, a counselor may perceive a client to resemble his daughter/son, or his spouse. Counter-transference too can be positive or negative depending on the way the client is perceived, whether favorably or unfavorably. Counter-transference can interfere with therapy because it can create a lot of bias into the counselor's judgment. A counselor can identify counter-transference when he perceives that his attitudes towards the client have inexplicably changed. Counselors should make all possible efforts to prevent the development of countertransference.

Dependence: Dependence on the part of the client often develops during therapy. It is usually transient and self-limiting and is most evident during the early phases when distress levels are the highest. Dependence needs to be addressed when it becomes too strong, enduring and interferes with the client's ability to adjust in the absence of the counselor. It is always beneficial for the counselor to sit back towards the end of the day and analyze the day's events or do a personal introspection. This will enable the counselor to be on the safe side.

Resistance: Resistance is the phenomenon wherein the client unconsciously and indirectly does not bring forth the changes sought. He fights against the progress of therapy. Resistance occurs as the client finds it hard to make the desired behavioural changes, or because the issues being probed awake deep frightening emotions. Resistance is demonstrated in many ways. It could be missing sessions, coming late for appointments, showing restlessness, prolonged silence, being inattentive during sessions, making superficial responses rather than examining issues with the thoroughness that the counsellor requests, etc. Resistance can be the best deal with by directly examining the observable behaviours and examining the unconscious underlying motives.

External Interference: In some cases the clients may be too much influenced by others, that is, significant others in his life. Thus, external interference from various sources can hinder the course of counselling. For example, significant others in the client's life may offer contradictory counsel, or

may be responsible for stressing the client in ways that undermine the course of therapy. The counsellor must be aware of such interfering influences, and must handle the situation as appropriate to the context.

Other Practical Issues: The following steps provide a good structure for each session to be conducted:

- Summarize what was dealt with in the previous session.
- Discuss the behavioural outcome of the previous session.
- Discuss the assignments given during the previous session.
- Review the previous sessions, if necessary.
- Set the agenda for the current session.
- Proceed with the current agenda.
- Sum up the current session.
- Set assignments for the inter-session interval.
- Set a tentative agenda for the next session.

Homework Assignments: Assignments are practical exercises, which the counsellor sets and agreed upon by the client, which is to be executed by the client in the interval between sessions. Assignments can be introspective exercises. For example, a counsellor may instruct the client to think of all possible explanations for his inability to overcome shyness when talking with his age-mates. Such assignments can be delivered verbally or in writing. Writing is more affective as it reflects the thoughts and records in the paper. This helps the client to think more clearly. Assignments could be behavioural exercises. For example, a counsellor may instruct the client to go and talk to five unknown persons belonging to the person's age

group in an attempt to reduce his shyness. Assignments are important because they give information, they force the client to introspect or implement behaviour change and because the process of therapy is continued in between the counselling sessions.

Recording of Sessions: At the end of each session, the counsellor should make detailed notes that summarize the content of the session. A brief plan for the next session should also be outlined. The purpose of these notes is to record the progress of therapy, to facilitate the recall of the case material, and to facilitate the structuring of the next session. These recordings help the counsellor to introspect and explore the client's situation, reflect upon his responses as a counsellor and examine the possible help that can be offered by him. These recordings have to be kept and maintained in total confidentiality in keeping with the code of ethics.

Drop-Outs: There are times when clients stop coming for therapy. Dropouts occur for one or more of several reasons. The client is unwilling to undertake the changes suggested during counselling. The client finds counselling unhelpful or inconvenient. The client finds counselling no longer necessary because the problem has been solved. Other reasons such as too high fees, other inconveniences, not taken favorably towards the counsellor etc.

Ethics of counseling

Ethical Principles in Counseling: Ethical principles in counseling are one framework that can be used to work through an ethical dilemma. All principles are considered

equal with generally, no one holding greater weight or importance than another. Application of the ethical principles may provide sufficient scope and information to either clarify the dimensions of the problem or even, formulate an acceptable action to address an ethical dilemma. There are five ethical principles considered relevant to counseling:

- a. Respect for Autonomy
- b. Non-maleficance
- c. Beneficence
- d. Justice
- e. Fidelity

Respect for Autonomy: The freedom of clients to choose their own direction – respecting that the client has the ability to make choices free from the constraints of others. The role of the counselor is to acknowledge client autonomy and to respect this right. An autonomous action is one that cannot interfere with the autonomy of another. An individual is to be aware of the choice taken and the effect/ consequences it has on others.

Non-maleficance: This term means to do no harm. It is a concept derived from the medical profession. Autonomy relates to the individual client, non-maleficance refers to the abilities of the counselor. Counselors have a responsibility to avoid utilizing interventions that could or have the potential to harm clients. In practice, e counselors are expected to undertake the thorough evaluation of the client's concerns and apply appropriately determined and explained interventions.

Beneficence: Considered the responsibility to do good and to contribute to the welfare of the client (Forester-Miller and Davis 1996). The counselor is expected to do the best for the client and if unable to assist, to offer alternatives as appropriate.

Justice: Justice means to act in a fair or just manner. It is expected that counselors will act in a non-discriminatory manner to individuals or groups. It is the counselor's ability to acknowledge inequity and apply the intervention to suit.

Fidelity: This principle deals with the trust relationship between the counselor and their client. The interests of the client are placed before those of the counselor even if such loyalty (towards the client) is inconvenient or uncomfortable for the counselor. A client needs to be able to trust that the words and actions of the counselor are truthful and reliable. The counselor however, does not need to share every fleeting thought or reaction.

In summary

- There are five 5 ethical principles related to counseling.
- Application of ethical principles may provide a counselor with the solution to an ethical dilemma.
- Counselors acknowledge client autonomy and respect this right unless it interferes with the autonomy of others.
- Non-maleficence is the principle of 'do no harm' in which counselors do not undertake and actively avoid activities that could be detrimental to clients.

- Beneficence involves doing good both within the counseling relationship and as a member of the greater community.
- Justice entitles the client to treatment based on fairness and equity. The counselor actin in a manner that is non-discriminatory.
- Fidelity is based on trust within the client-counselor relationship.

Process and physical requisites for counseling atmosphere

Conduct the Counseling Session: Be flexible when conducting a counseling session. Often counseling for a specific incident occurs spontaneously as leaders encounter subordinates in their daily activities. Such counseling can occur in the field, motor pool, barracks-wherever subordinates perform their duties. Good leaders take advantage of naturally occurring events to provide subordinates with feedback. Even when you haven't prepared for formal counseling, you should address the four basic components of a counseling session. Their purpose is to guide effective counseling rather than mandate a series of rigid steps. Counseling sessions consist of:

- Opening the session.
- Discussing the issues.
- Developing the plan of action.
- Recording and closing the session.

Ideally, a counseling session results in a subordinate's commitment to a plan of action. Assessment of the plan of action (discussed below) becomes the starting point for follow-up counseling.

Open the Session: In the session opening, state the purpose of the session and establish a subordinate centered setting. Establish the preferred setting early in the session by inviting the subordinate to speak. The best way to open a counseling session is to clearly state its purpose. For example, an appropriate purpose statement might be: "The purpose of this counseling is to discuss your duty performance over the past month and to create a plan to enhance performance and attain performance goals." If applicable, start the counseling session by reviewing the status of the previous plan of action. You and the subordinate should attempt to develop a mutual understanding of the issues. You can best develop this by letting the subordinate do most of the talking.

Develop a Plan of Action: A plan of action identifies a method for achieving a desired result. It specifies what the subordinate must do to reach the goals set during the counseling session. The plan of action must be specific: it should show the subordinate how to modify or maintain his behavior. It should avoid vague intentions such as "Next month I want you to improve your land navigation skills." The plan must use concrete and direct terms.

Record and Close the Session: Although requirements to record counseling sessions vary, a leader always benefits by documenting the main points of a counseling session.

Documentation serves as a reference to the agreed upon plan of action and the subordinate's accomplishments, improvements, personal preferences, or problems. A complete record of counseling aids in making recommendations for professional development, schools, promotions, and evaluation reports. Additionally, Army regulations require written records of counseling for certain personnel actions, such as a barring a soldier from reenlisting, processing a soldier for administrative separation, or placing a soldier in the overweight program. When a soldier faces involuntary separation, the leader must take special care to maintain accurate counseling records. Documentation of substandard actions conveys a strong corrective message to subordinates. To close the session, summarize its key points and ask if the subordinate understands the plan of action. Invite the subordinate to review the plan of action and what's expected of you, the leader. With the subordinate, establish any follow-up measures necessary to support the successful implementation of the plan of action. These may include providing the subordinate with resources and time, periodically assessing the plan, and following through on referrals. Schedule any future meetings, at least tentatively, before dismissing the subordinate.

Follow Up: Leader's Responsibilities: The counseling process doesn't end with the counseling session. It continues through the implementation of the plan of action and evaluation of results. After counseling, you must support subordinates as they implement their plans of action. Support may include teaching, coaching, or providing time and

resources. You must observe and assess this process and possibly modify the plan to meet its goals. Appropriate measures after counseling include follow-up counseling, making referrals, informing the chain of command, and taking corrective measures.

Assess the Plan of Action: The purpose of counseling is to develop subordinates who are better able to achieve personal, professional, and organizational goals. During the assessment, review the plan of action with the subordinate to determine if the desired results were achieved. You and the subordinate should determine the date for this assessment during the initial counseling session. The assessment of the plan of action provides useful information for future follow-up counseling sessions.

Physical requisites of counselling

Physical and Psychological Requirements in Guidance and Counselling: Since counselling is a special kind of relationship and that confidentiality is a priority, there must be governing conditions to ensure effective and fruitful interviews. Some of the vital facilities are;

- **A room :** This facility should be spacious to allow the free and comfortable stay.
- **Furniture:** This is an additional requirement to the comfort of the client and surety of acceptance.
- **Mirror:** A mirror at an angle is important to watch the reactions of a client.

- **Proximity:** The distance between the counsellor and the client should at least be about a metre just across the table. It should not be too far nor too near to one another.
- **Record card:** This is a document where details of the counselling sessions are recorded. This document provides data good enough to set a base in case of a referral.
- **Client and Counsellor:** These are human beings at the centre of activities and are an important tool in the counselling process.

Psychological Requirements in a Counselling Session: Apart from the physical requirements for an effective counselling, psychological requirements such as the following are vital;

- **Congruency:** The counsellor enters the session with a balanced mind and not in a state of confusion
- **Empathy:** The situation is non-threatening but good enough for the client to disclose his worries. The counsellor enters the world of the client and imagines the problem was on him. They share the same feelings about the problem.
- **Warmth:** Welcoming the client, non-threatening atmosphere must prevail in a counselling process.
- **Good Listening:** The counsellor offers undivided attention to what the client is saying. Playing around with a phone or radio while talking to the client is not good.

- **Rapport:** The introduction part of a session such as a greeting, offering of a seat reassures the client that the counsellor accepts him.
- **Unconditional Positive Regard:** Treat all clients in the same manner regardless of their status and affiliations.
- **Confidentiality:** This promotes trust and confidence in the counsellor and attracts the sense of security.

Part II

Approaches to Counseling

The main approaches used by professional counselors, psychodynamic, humanistic and behavioral – there are many more approaches but these three are the most commonly practiced. While some professional counselors use only one approach, others are more flexible and might use techniques from more than one method. Although untrained people may possess and develop some skills that are desirable to a counselor, if counseling plays a role in your work or personal life then you should undertake a recognized professional counseling course. Psychodynamic counseling evolved from the work of Sigmund Freud (1856-1939). During his career as a medical doctor, Freud came across many patients who suffered from medical conditions which appeared to have no ‘physical cause’. This led him to believe that the origin of such illnesses lay in the unconscious mind of the patient. Freud's work investigated the unconscious mind in order to understand his patients and assist in their healing. Over time many of Freud's original ideas have been adopted, developed, disregarded or even discredited, bringing about many different schools of thought and practice. However, psychodynamic counseling is based on Freud’s idea that true knowledge of people and their problems is possible through an understanding of particular areas of the human mind, these areas are:

- The Conscious – things that we are aware of, these could be feelings or emotions, anger, sadness, grief, delight, surprise, happiness, etc.
- The Subconscious –these are things that are below our conscious awareness but fairly easily accessible. For example with appropriate questioning a past event which a client had forgotten about may be brought back into the conscious mind.
- The Unconscious – is the area of the mind where memories have been suppressed and is usually very difficult to access. Such memories may include extremely traumatic events that have been blocked off and require a highly skilled practitioner to help recover.

Freud's main interest and the aim was to bring things from the unconscious into the conscious. This practice is known as psychoanalysis. Psychoanalysis is used to encourage the client to examine childhood or early memory trauma to gain a deeper understanding – this, in turn, may help the client to release negativities that they still hold, associated with earlier events. Psychoanalysis is based on the assumption that only by becoming aware of earlier dilemmas, which have been repressed into our unconscious because of painful associations, can we progress psychologically.

Freud also maintained that the personality consists of three related elements:

Id, Ego and Superego

- Id - The Id is the part of our personality concerned with satisfying instinctual basic needs of food, comfort and pleasure – the Id is present from (or possibly before) birth.
- Ego – Defined as “The realistic awareness of self”. The ‘Ego’ is the logical and commonsense side of our personality. Freud believed that the Ego develops as the infant becomes aware that it is a separate being from its parents.
- Superego – The Superego develops later in a child’s life from about the age of three, according to Freud. Superego curbs and controls the basic instincts of the Id, which may be socially unacceptable. The Superego acts as our conscience.
- Freud believed that everybody experiences tension and conflict between the three elements of their personalities. For example, desire for pleasure (from the Id) is restrained by the moral sense of right and wrong (from the Superego). The Ego balances up the tension between the Id wanting to be satisfied and the Superego being over strict. The main goal of psychodynamic counselling, therefore, is to help people to balance the three elements of their personality so that neither the Id nor the Superego is dominant. In contrast to the psychodynamic approach to counselling, childhood events and difficulties are not given the same importance in the humanistic counselling process. Humanistic counselling recognises the uniqueness of every individual. Humanistic counselling assumes that everyone has an

innate capacity to grow emotionally and psychologically towards the goals of self-actualisation and personal fulfilment.

- Humanistic counsellors work with the belief that it is not life events that cause problems, but how the individual experiences life events. How we experience life events will, in turn, relate to how we feel about ourselves, influencing self-esteem and confidence. The Humanistic approach to counselling encourages the client to learn to understand how negative responses to life events can lead to psychological discomfort. The approach aims for acceptance of both the negative and positive aspects of oneself. Humanistic counsellors aim to help clients to explore their own thoughts and feelings and to work out their own solutions to their problems. The American psychologist, Carl Rogers (1902-1987) developed one of the most commonly used humanistic therapies, Client-Centred Counselling, which encourages the client to concentrate on how they feel at the present moment.

Client-Centred Counselling

The central theme of client-centred counselling is the belief that we all have inherent resources that enable us to deal with whatever life brings. Client-centred therapy focuses on the belief that the client - and not the counsellor - is the best expert on their own thoughts, feelings, experiences and problems. It is, therefore, the client who is most capable of finding the most appropriate solutions. The counsellor does not suggest any course of action, make recommendations, ask

probing questions or try to interpret anything the client says. The responsibility for working out problems rests wholly with the client. When the counsellor does respond, their aim is to reflect and clarify what the client has been saying.

A trained client-centred counsellor aims to show empathy, warmth and genuineness, which they believe will enable the client's self-understanding and psychological growth.

- **Empathy** involves being able to understand the client's issues from their own frame of reference. The counsellor should be able to accurately reflect this understanding back to the client.
- **Warmth** is to show the client that they are valued, regardless of anything that happens during the counselling session. The counsellor must be non-judgmental, accepting whatever the client says or does, without imposing evaluations.
- **Genuineness** (sometimes termed congruence) refers to the counsellor's ability to be open and honest and not to act in a superior manner or hide behind a 'professional' facade.

Behavioural Approach to Counselling

The Behavioural Approach to Counselling focuses on the assumption that the environment determines an individual's behaviour. How an individual responds to a given situation is due to behaviour that has been reinforced as a child. For example, someone who suffers from arachnophobia will

probably run away screaming (response) at the sight of a spider (stimulus). Behavioural therapies evolved from psychological research and theories of learning concerned with observable behaviour, i.e. behaviour that can be objectively viewed and measured. Behaviourists believe that that behaviour is 'learned' and, therefore, it can be unlearned. This is in contrast to the psychodynamic approach, which emphasises that behaviour is determined by instinctual drives. Behaviour therapy focuses on the behaviour of the individual and aims to help him/her to modify unwanted behaviours. According to this approach unwanted behaviour is an undesired response to something or someone in a person's environment. Using this approach a counsellor would identify the unwanted behaviour with a client and together they would work to change or adapt the behaviour. For example, a client who feels anxious around dogs would learn a more appropriate response to these animals. Problems which respond well to this type of therapy include phobias, anxiety attacks and eating disorders. Behavioural counsellors or therapists use a range of behaviour modification techniques.

Once the unwanted behaviour is identified, the client and counsellor might continue the process by drawing up an action plan of realistic, attainable goals. The aim would be that the unwanted behaviour stops altogether or is changed in such a way that it is no longer a problem. Clients might be taught skills to help them manage their lives more effectively. For example, they may be taught how to relax in situations that produce an anxiety response and rewarded or positively

reinforced when desirable behaviour occurs. Another method used involves learning desirable behaviour by watching and copying others who already behave in the desired way. In general, the behavioural approach is concerned with the outcome rather than the process of change. The behavioural counsellor uses the skills of listening, reflection and clarification, but rather than use them as a process of revealing and clarifying the client's thoughts and feelings, the skills would be used to enable the counsellor to make an assessment of all the factors relating to the undesirable behaviour.

Theories and Models of Counselling

The field of counselling and psychotherapy are based on various approaches and theories. Understanding the theories is important as it is the knowledge base of counselling. Theories are basically conceptual frameworks for understanding parameters of the counselling process. These parameters can include models for viewing personality development, explaining past behaviour, predicting future behaviour, understanding the current behaviour of the client, diagnosing and treatment planning, assessing client motivations, needs, and unsolved issues, and identifying strategies and interventions of assistance to the client.

Theories of counselling: The helping professionals, depending on the field and nature of their work, apply different theories for counselling. Thus, there are a number of theoretical positions practised by different types of

counsellors. One can't discuss all these theories. Neither is it intended to do that here. Burl E. Gilliland and others (1989) have discussed the eleven theoretical positions in their book.

Models of counseling: These theories help the counsellors to follow a particular approach or model. The term 'model' as used here means a structure of counselling process that shows relationships between the components and tells what is done in counselling and in what sequence. In other words, a model of counselling explains the interaction between two persons and the content and sequence of this interaction in order to make sense and help the counsellor to be effective. There is a number of models devised and practised to help the counselees. However, in all these models, the expected outcome of counselling is some change in behaviour. This change in person occurs through the stages of exploration, understanding and action. In view of this, J.M. Fuster (2005) has attempted to categorise the various models of counselling according to the emphasis they place on one or several of these stages.

Emphasis on action alone: These models of counselling give more emphasis on the client's action without their understanding of what is being done to them. It is intended to bring change in the person's behaviour through action alone. This system of bringing change in behaviour is called behaviour therapy. The counsellors following this model condition the person to act in a particular way. They may also systematically counter-condition the behaviour of the person without his/her realizing why they are doing this to him/her.

This model may prove useful in treating some types of mentally ill patients with whom communication is very difficult.

Emphasis on exploration and understanding: These models of counselling centre around the counsellee's self-exploration and self-understanding. It also emphasizes persons' understanding of the counselling process and his/ her involvement therein. Psychoanalysis, client-centred therapy, trait and factor counselling, existential therapy, transactional analysis, Gestalt Therapy are some of the models of counselling and psychotherapy which comes under this category.

Emphasis on exploration, understanding and Action: This types of counselling models attempt to give emphasis on exploration, understanding and a systematic action programme that flows from the understanding. Carkhuff (1969 and 1977) has presented this integrated model. Exploration and understanding help to plan action effectively. A systematic action programme translates insight into the desired behaviour change.

Supportive and behavioural techniques in Counselling

Introduction: This chapter presents supportive and behavioural techniques used by a counsellor in the process of counselling and helping the clients. The supportive and behavioural techniques come under the category of Insight Therapies. Discussion on all the different supportive and

behavioural techniques will take much more time and space. Therefore, it is planned to introduce some of the techniques commonly applied during the course of counselling under this category. An attempt has been made here to briefly explain the basic concepts, background and some of the common techniques used in supportive and behavioural therapies. This chapter is divided into two parts. In the first part, the basic concept and some of the supportive technique in counselling are discussed. The second part is about the concept and the behavioural techniques.

Techniques in Counselling: Before beginning discussing supportive and behavioural techniques, let us first discuss techniques in counselling. As a process of counselling, during the initial phase of counselling, the goals are set and translated into specific action. The counsellors in the process of counselling use their knowledge, interpersonal skills and experience to help the client attain the goals. While helping the client the counsellor uses various techniques. There are many different techniques that are used to help sort out issues or manage mental health difficulties. Counsellors, psychologists, social workers, and psychiatrists may specialize in a particular approach and/or technique, or they may use a number of approaches/techniques depending on their training and the clients' needs. These techniques can be employed during all the phases of counselling, from beginning to end. The appropriate use and timing of these techniques depend upon the situation and counsellor's assessment of client's problem. There are different techniques that can be broadly split into 3 groups. These include:

Insight Therapies – Techniques under this category are often known as “talk therapy”. Talking about experiences help the client to get an understanding of the difficulties that they may face and sort through possible solutions. The more common types of insight therapy are psychoanalysis, psychodynamic approaches, client-centered approaches, and cognitive therapy. A common form of insight therapy is Cognitive Behavioural Therapy. This therapy looks at changing negative thought patterns and maladaptive beliefs. Maladaptive beliefs are ideas about oneself that may not necessarily be true, but still, have a negative impact on their wellbeing. Cognitive Behavioural Therapy (CBT) is one of the most common forms of counselling.

Behaviour Therapies- Techniques under this category focus on the changing behaviour patterns. Behaviour therapists often use some principles of learning, such as providing punishments for bad behaviour and rewards for good behaviour. This type of therapy may be used to change compulsive behaviours, to help with learning problems, or to modify avoidance behaviours. With this type of therapy, it is assumed that the behaviours are a product of learning in terms of what can and cannot be learned.

Biomedical Therapies - Techniques under this category involves the use of drugs to help to manage mental health difficulties. Drugs may be used to treat anxiety, psychosis or depression. Biomedical therapies are administered by psychiatrist or doctor as s/he prescribes the type and dosage of the drugs that the client needs. It happens that sometimes

these approaches do overlap or the social worker or counsellor uses a combination of approaches to help the client. As every person/client is different, it may be that while one approach is good for one person it may not suit someone else. The social worker as a counsellor sees which of the first two categories of technique he/she is good in. It is possible that he/she may choose to use a mixture of techniques to help the client.

Cognitive & psychoanalytical techniques in counselling

Introduction: This chapter presents cognitive and psychoanalytical techniques used by counsellors in the process of counselling and helping the clients. The cognitive and psychoanalytical techniques come under the category of Insight Therapies. This type of therapy is also known as “talk therapy”. Talking about your experiences will help to get an understanding of the difficulties you may face and sort through the possible solutions. The common types of therapies in this category are psychoanalysis, psychodynamic approaches, client-centered approaches, and cognitive therapy. Discussion on all these different cognitive and psychoanalytical psychotherapies will take much more time and space. Therefore, we plan to introduce some of the techniques commonly applied during the course of counselling under this category.

The Cognitive Techniques in Counselling: Basic Concepts: While discussing the cognitive techniques in counselling one needs to understand its meaning and concept. In counselling,

cognitive techniques are defined as any therapy that is based on the belief that one's thoughts are directly connected to how one feels. Counsellors, who work in the cognitive field, help the clients to solve their present-day problems by helping them to identify distorted thinking that causes emotional discomfort. In these techniques, there's little emphasis on the historical root of a problem. Rather, the emphasis is on identifying the wrong ways with the present thinking which is causing distress to the client.

The cognitive therapies include Rational-Emotive, Cognitive-Behavioural, Reality, and Transactional Analysis. These will be discussed in the later part. The cognitive techniques in counselling are based on the premise that the way a person thinks can affect the way s/he feels and behaves. In the field of mental health, it is felt that faulty patterns of thinking may produce stress related, emotional disturbances such as anxiety, depression, hyper tension, etc. In order to overcome such emotional disturbances and experience better, mental health persons need to change their ways of thinking. Cognitive therapy seeks first to identify dysfunctional thought processes, and next to correct them. The ways of faulty thinking and use of cognitive technique It will be appropriate at this stage to get to know some of the dysfunctional thoughts and the ways of faulty thinking. This will provide one understanding of the faulty ways of thinking and the need for correcting such dysfunctional thought processes. Important dysfunctional ways of thinking include cognitive distortions, repeated intrusive thoughts, unrealistic assumptions and others.

a).**Cognitive Distortions:** These are thinking patterns that distort reality in a negative way, and make persons perceive the world as being more hostile than it actually is. Some of the examples of cognitive distortions are arbitrary inference which refers to the drawing of an unjustified conclusion. Another distortion is selective abstraction which means focusing of attention on one detail or one aspect and ignoring the other aspects or the rest of the picture. Sometimes it is over-generalization in which a general conclusion is drawn based upon a limited event without exploring the totality of the event. Further at times it is magnification which means exaggerations of small things or event which is well known as making mountains out of molehills. And sometimes it is minimization which is an undervaluation of positive attributes. While dealing with the cases of emotional disturbances the counsellor needs to identify the distortions in the thinking pattern that cause the emotional disturbance and help the client to overcome them.

b)**Repeated Intrusive (automatic) Thoughts:** These are negative thoughts that dominate the conscious mind. These thoughts are also called repeated intrusive thoughts. Under this category of thoughts the person either shows low self regard and lack of self confidence or excessive self depreciation. Persons thinking with low self regard while expressing their thoughts usually use statements like- I can't do it, I am not able to do it, I am going to fail, etc. Likewise the person with excessive self depreciative thoughts criticizes himself/herself and expresses like, "I should not have done that", "I should have been more careful", etc. Another

category of such thought pattern is excessive self blame or scapegoat. In the case of persons with thoughts of self blame, they assume more blame for whatever happens. These kinds of thoughts are often expressed like “I behave badly with others”, “I have wasted my life”, “It is my entire fault”. On the other hand persons with the scapegoat type of thinking, blame others. For failure or undesirable situations, others are blamed. For example, a person who is not very successful in his career says, “I could not have a successful career because of my family”. There are thoughts about ideas of deprivation. The person with the thoughts about ideas of deprivation focuses more on liabilities or limitations than the assets or strength. For example people with such thought pattern always express their thoughts like, “I am so poor”, “I don’t know English”, “My friends have been to America, I haven’t even been to Delhi”, etc. Further, the people with the thoughts of irrational injunctions insist on assuming more responsibilities or difficulties. Such thoughts can be understood from their statements like, “I should do more for my family”, “I ought to work harder and earn more money”, etc.

Unrealistic Assumptions: This is another dysfunctional way of thinking which causes emotional disturbances to the person. The unrealistic assumptions are expectations or goals which may not be achievable and the person thinks that s/he must or should attain those goals. Failure to attain these goals often lead to ideas of decreased self-worth. Some of the examples of unrealistic assumptions are: “Everyone must love me.” “I should never fail in anything that I do”. “I must stand

first in the class”. “I must be perfect”, “I cannot be happy unless I have a lot of money” etc. Unrealistic assumptions make the person unhappy and bring disturbance in the family. With regards to the occurrences of such thoughts, it must be noted that certain faulty thought processes often occur together. It is seen that depressed persons tend to have a negative view of themselves with their current experience and of the future. As a result of the cognitive distortions, at times, they develop cognitive triad. The cognitive triad is a combination of three negative thoughts together. The person tends to feel hopeless, helpless and worthless. Counsellors need to identify such thoughts and help the client to think rationally.

The Cognitive Techniques

After discussing the patterns of distorted thinking, we will discuss the techniques used by counselors in helping the clients with emotional disturbance due to distorted thoughts. The clients having distorted thoughts often come to the counselors in a miserable state of mind. As mentioned in the beginning the cognitive techniques in counseling are based on the premise that the way a person thinks can affect the way s/he feels and behaves. In order to overcome such emotional disturbances and feel better, mental health persons need to change their ways of thinking. Cognitive therapy seeks first to identify dysfunctional thought processes, and next to correct them.

The common characters of the cognitive approach include a collaborative relationship between clients and counselors, homework between sessions. It will be of short duration. These techniques are effective for treating mild depression, anxiety, and anger problems. Some of the important techniques can be mentioned as rational emotive, cognitive behavioral, reality and transactional analysis.

Rational-Emotive: The rational-emotive approach to counseling is based on the theory developed by the American Psychologist Albert Ellis. His theory is that everyone has emotions. But some have emotions which are either too intensive or last too long for their own good. He suggests that intense emotions should last only a few moments and if they are more enduring than this, then the person needs to look closely at his/her way of thinking. According to the theory, which Ellis calls an ABC theory of events and emotions, the events themselves do not cause Emotions, it is rather what we learn to believe or think about these events, create the emotions. He further suggests that emotions are so intense that they interfere with normal life. The rational-emotive counselor helps the counselee to understand how and why his/her thinking is illogical. Further, the counsellor demonstrates the relationship between irrational ideas and unhappiness. The aim is to help the person to change the way of thinking and to abandon irrational ideas. This is done by directly contradicting, by encouraging, persuading and at times insisting that the clients try some activity which will counteract. Although the counsellor attacks the beliefs of the client, this approach can be very supportive in helping the

client to try new ways of thinking and examining the subsequent emotional and behavioural responses. As in reality therapy, one of the main tasks of the counselling relationship is to encourage and motivate the client for new behaviours

Cognitive-Behavioural: A common form of insight therapy is Cognitive Behavioural Therapy. This therapy looks at changing negative thought patterns and maladaptive beliefs. Maladaptive beliefs are ideas about oneself that may not necessarily be true, but still, have a negative impact on their wellbeing. Cognitive Behavioural Therapy is one of the most common forms of counselling. For the behaviourist, counselling involves systematic use of a variety of procedures that are intended specifically to change behaviour in terms of mutually established goals between a client and a counsellor. The procedures employed to encompass a wide variety of techniques drawn from knowledge of learning processes. This means that counselling outcomes should be identifiable in terms of overt behavior changes. Three examples of behavioural change appropriate to counselling are the altering of behavior that is not satisfactory, the learning of the decisionmaking process, and problem prevention (Gibson:2008). In many ways, practicing behavioural counsellors follow an approach similar to that of other counsellors in clarifying and understanding the needs of their clients. They use reflection, summarization, and open-ended inquiries. Behavioural counsellors however, take a more directive role rather than many counsellors in initiating and directive therapeutic activities. Sessions tend to be structures

and action oriented. Behavioural counselors often take on roles of a teacher or a coach.

Reality Therapy: Another technique of counselling that has gained popularity in recent decades is that of Reality therapy. It was developed by William Glasser, an American psychiatrist. Reality therapy holds that people are responsible for their behaviour. Glasser believes that man's basic problem is moral, in the sense that being responsible is the requirement for mental health. He defines responsibility as 'the ability to fulfill one's needs and to do so in a way that does not deprive others of the ability to fulfill their needs'. Sometimes, counselors identify that the person seeking help has the feeling of failing in his/her responsibility. The way to help the people with such feeling of failure is to involve them, through the counselling relationship, in behaviour which will lead them to success.

Transactional Analysis: Transactional analysis is another cognitive-behavioural technique. It assumes that a person has the potential for choosing and redirecting or reshaping one's own destiny. Eric Berne did much to develop and popularize this theory in the 1960s. It is designed to help a client review and evaluate early decisions and to make new, more appropriate choices. Transactional analysis places a great deal of emphasis on the ego, which consists of three states: Parent, Adult, and Child. Each of these states can take charge of the individual to the point that his or her observable behaviour indicates "who's in charge" (Adult, Parent, or Child). When one of the three ego states is unwilling to relinquish its control

and asserts it rigidly, especially in inappropriate ways, the client is in difficulty and in need of psychological assistance. The client is assisted in gaining social control of his or her life by learning to use all ego states appropriately. Transactional analysis views normal personality as a product of healthy parenting. (I am OK, You're OK). The ultimate goal of counselling, by using transactional analysis, is to help the client change from inappropriate life positions and behaviours to more productive behaviours. An essential technique in the transactional analysis is the contract that precedes each counselling step. This contract between the counsellor and the counselee is a way of training or preparing a person to make his/her own decision. In addition to the contract technique, the transactional analysis also utilizes questionnaires, life scripts, structural analysis, role-playing, analysis of games and rituals, and "stroking" (reinforcement).

The Psychoanalytical Techniques in counseling:

Having discussed the cognitive techniques of counseling we will now discuss the psychoanalytical techniques in counselling. Prior to discussing the psychoanalytical techniques, let's first understand its theoretical basis and basic premise on which this technique is based on i.e. psychoanalysis.

Basic Concept: Psychoanalysis is a system of psychology derived from the discoveries of Sigmund Freud. Psychoanalytic theory views the personality as divided into three major systems; the id, the ego, and the superego. The id is inherited and thus is present from birth. The id is believed

by many to work on the pleasure principle and provides the drive for the pursuit of personal wants. The ego is viewed as the only rational element of the personality. The ego also has contact with the world of reality. Because of this, it controls consciousness and provides realistic and logical thinking and moderates the desires of the id. The Superego represents the conscience of the mind and operates on a principle of moral realism. It represents a person's moral code, usually based on one's perceptions of the moralities and value of society. As a result of its role, the superego in a sense is responsible for providing rewards, such as pride and self-love, and punishments, such as feelings of guilt or inferiority to its owner. Thus the superego is most aware of the impulses of the id and seeks to direct the ego to control the id. As a result, psychoanalytic theory views tension, conflict, and anxiety as inevitable in humans and that human behaviour is therefore directed toward reduction of this tension. In order to handle this tension, conflict and anxiety the mind uses certain unconscious processes called ego defense mechanisms. Everybody uses such defence mechanisms. Some ego defence mechanisms are termed mature; they promote adaptation. Other defence mechanisms are dysfunctional; they predispose to psychological or interpersonal maladjustment.

Defense mechanisms and psychoanalytical techniques: In order to have more clarity, while discussing the psychoanalytical techniques, let's discuss some of the commonly employed dysfunctional defense mechanisms.

Projection: It is about ascribing one's own thoughts, feeling and impulses to others. For example, a person who is untrustworthy tends to think that others are untrustworthy.

Denial: is the refusal to accept the reality of a conflict or stress. It may be perhaps because of the issue being too threatening to be acknowledged. A classical example is of the alcoholic who refuses to admit that he is dependent on liquor; although everyone knows that he cannot stop drinking, he insists that he can give up the habit anytime he chooses to.

Acting Out: is the immature expression of emotions because of a failure to keep them under adequate check. Example of such defence mechanism is a person who shouts on a drop of a hat, slams doors easily dissolve into tears, or otherwise highly demonstrative.

Passive aggressive behaviour is the display of resentment in subtle forms. A woman, who is angry with her husband, may prepare dishes that he positively dislikes. Forgetting, coming late, failing to comply with instructions, etc. are other ways of showing resentment in non-obvious and nonaggressive ways. Passive aggressive behaviour is shown by persons who, by virtue of their personality or their position, are unable to show their resentment openly.

Regression: is returning to an earlier form of behaviour or stage of development. This usually occurs when the more mature or appropriate behaviour is blocked by feelings of uncertainty, anxiety, fear, conflict, or lack of reward. This can

be seen in terms of the exhibition of childishness, helplessness, or immature behaviour.

Identification is the manifestation of behavioural patterns that unconsciously imitate those of the significant other. Identification gives one satisfaction or compensation by identifying with others and their achievements. For example, an aggressive, violenttempered young man may have unconsciously absorbed the behavioural characteristics of his punitive father.

Displacement represents the movement away from one object to another that is less threatening or anxiety producing. A common form of displacement is sublimation, wherein unacceptable urges may be channeled into more acceptable behaviours. Displacement takes place when a person vent out feelings and frustrations not in the situation in which they arose, but in other situations. A classical example is: ‘The boss reprimands a person. He man shouts at his wife. The wife punishes the son. The son kicks the dog and the dog bites the cat.’ Each individual in the chain cannot show anger and frustration to the person who provoked the anger; and so, takes it out on another who cannot retaliate. The feelings are thus ‘displaced’.

Rationalization is a commonly practiced defense mechanism that seeks to justify or provide a seemingly reasonable explanation to make undesirable or questionable behaviours appear logical, reasonable, or acceptable. It is frequently used to modify guilt feelings because the valid or true explanation for the behaviour would produce feelings of guilt or anxiety.

Rationalisation is dysfunctional when it leads to the repeated making of excuses for failures instead of taking corrective measures.

The counsellor must be alert to the possible role of various dysfunctional defence mechanisms in the client's problems. His/her role is one of helping the client to understand and correct these maladaptive responses to stress. In the psychoanalytical context, then, reducing tension becomes a major goal of counselling. Because personality conflict is present in all people, nearly everyone can benefit from professional counselling. Psychoanalytic theory usually views that client being weak and uncertain, need assistance in reconstructing normal personalities. The counsellor is in the role of the expert who facilitates or directs this restructuring.

The client is encouraged to talk freely, to disclose unpleasant, difficult, or embarrassing thoughts. The counsellor provides interpretation as appropriate, attempting to increase client's insights. This in turn may lead to working through the unconscious and eventually to achieving the ability to cope realistically with the demands of the client's world and society as a whole. In this process, among the techniques the psychoanalytic counsellor may employ, are projective tests, play therapy, dream analysis, and free association. Some of the Psychoanalytic Techniques As we mentioned above, psychoanalysis is mainly interested in the exploration of the unconscious mind. It strives to probe into the deeper part of the psyche and get to those issues that were not resolved

during cognitive development. It does not aim simply to uncover these issues, but rather to understand and experience them so that a change in character can occur.

PART III

Counseling children and adolescents

Work with children: Young children apparently confident and carefree stepping from the utter dependency of childhood to the struggle towards independence, so characteristic of adolescence is indeed at the crossroads. The emotionally disturbed child is problem to herself and a problem to others. For want of attention, his problem may be mounting-up and he becomes the maladjusted individual. All the time knew or unknown to himself the child is unhappy sometimes he may express his unhappiness in anti-social behavior. At other times he may be so withdrawn, so introvert as to erect a wall between himself and the rest of the world. The lack of foresight of child partly accounts for his inability to cope with people and situations. Adults who deal with, children, especially parents and teachers ought to understand that. Working with children involves the same process as working with adolescents or adults which requires a caring relationship with genuine empathetic understanding in order to promote disclosure, confrontation with oneself, to build insight and action planning for the purpose of the definition of working with children. We refer to children as persons who have not yet reached puberty, however, it is obvious that there is a big difference between a four-year-old and a 10-year-old. As a general principle the, more matured the person or client, the less it is necessary to employ the special counseling procedures.

Emotional disturbances in children: Emotional disturbances are quite common, emotional disturbances are not to be overlooked, precisely because they are 0 does not take them seriously. It would be necessary to give our attention to this concern that can build up its destructive blocks in human personality.

Children's problems in relation to their need: Children's problems areas large as their capacity to bear stress. Children need security. The child who can count on the affection of his elders need not spend his energies in playing.

Controlling the emotions: The child is to develop frustration, tolerance, and then he must learn to assess the situation that has blocked a drive and must understand, why he could not do? what he wanted to do?. The preadolescent stage is worthy of attention, the child is lonely without parental participation in play and conversation, the juvenile is lonely if he is rejected by his fellows. The juvenile is lonely if he is rejected by his follows. Juvenile tend to segregate into groups whose members have similar interest.

The School: The school environment is moreover, so important part of child's life that the teacher's control of the environment may be an important aid to developing wholesome emotional adjustment. The teachers and parents must help him to function so effectively that he will have fewer frustrations and disappointments.

Characteristics of work with children: The children are very dependent on adults.

- Dependency phenomena are normal in case of children.
- The children are very sensitive. They want support, appreciation.
- The children need acceptance and understanding, non-verbal acceptance is very effective. The skin to skin contact with children is very important.
- The children are not able to take complete responsibility; we have to share the responsibility with parents- and the persons significant to the child. Don't take the responsibility of children yourself.
- Excessive responsibility is very injurious to the child's personality. We cannot command children to forgive and forget the bitter experiences from the home.
- Re-assurance is very important for the child, children want reassurances from others.
- The importance of play materials, play as a media. The child is not able to express his feelings. But through the play, the child can express many of his feelings and emotions.

Before working with the children it is important to have an understanding of nature and, the purpose of counseling children. We need to be clear about our goals and to have clear ideas about how these goals can be achieved. They have identified four different levels at which goals can be set up.

Goals for working with children

1. Fundamental goal
2. Parents goal
3. Counselor goals or workers goal
4. Child's goal

1. Fundamental goals: These goals are globally applicable to all children in therapy. They include the following:

- a. To enable the child to deal with painful emotional issues.
- b. To enable the child to feel good about himself or herself.
- c. To enable the child to accept her limitations and strengths and to feel ok about them.
- d. To enable the child to change behavior that has negative consequences. To enable the child to function comfortably and adoptively within the external environment at home or school.

2. Parents Goal: Goals have to be set by parents why they bring their child for' therapy. They are related to the parent's own agenda and are usually based on the child's current behavior.

3. Counselor's goal or worker's goal': Goals formulated by the counselors, these goals are formulated by the counselor as a consequence of a hypothesis which the counselor may have about, why the child is behaving in a particular way. For eg: if the child's problem is bed wetting, the counselor may have a hypothesis that the problem of bed wetting is a the consequence of the child's emotional issue; hence the

counselor goal may be addressing and resolving the child's emotional issues.

4. **Child's goal:** These goals emerge during the therapy session and are effectively children own goals, although the child will usually be unable to verbalize them. They are based on materials if the child brings to the sessions, but sometimes these goals will match the counselor's goals and sometimes they may not. Another important aspect of counseling children is the child-counselor relationship. The relationship is of major importance in influencing positive outcome from therapy.

Some important skills

- a) Child like the relationship: Eg: Go and sit with the child, tell the child to play along with you.
- b) Keep confidentiality.
- c) Encouragement and support, Reinforcement and enforcement.
- d) Stimulation for participation.
- e) You should be able to recognize, describe and respond to the feelings of the children.

Attributes of the child counselor relationship: We believe that the child's relationship with the counselor must be all of the following:

- a) A connecting link between the child's world and the counselor.
- b) Exclusive

- c) Safe
- d) Authentic
- e) Confidential
- f) Non-intrusive
- g) Purposeful

Child relationship should be connecting link between the child's world and the worker. The relationship is 'primarily about the connecting with the child and staying with the child's participation. The child may see the environment in which he lives quite differently from the way in which his parents see. The work should start from within the 'child's framework. This should be done without any judgment. It is important for the child to stay with his own values, beliefs, and attitudes rather than influenced by the worker's values, beliefs, and attitudes. The worker must aim to minimize the influence of his own experience so that his connection with the child's experience of the world is as complete as possible. This is just trying to understand child's world.

The child counselor relationship should be exclusive. The counselor needs to establish and maintain good rapport with the child so that trust is developed. The child should experience a unique relationship with the counselor which is not comprised of any others such as parents or siblings. For the therapeutic relationship, the child needs to feel accepted by the counselor. The child should not be allowed to think that counselor's views on her or him have been influenced by the parents or significant others. The relationship, therefore, needs to be exclusive. It means not allowing others to be included

without the child's permission. The child counselor relationship should be safe. The counselor must create a permissive environment in which the child feels so free to act out and to gain mastery over her or his feelings. The counselor should set limits to behave positively in each session and he should follow three basic rules while limit setting;

- a) The a child is not permitted to injure herself or himself.
- b) The a child is not permitted to hurt the worker.
- c) The a child is not permitted to damage the property.

Safety needs must also be considered when choosing materials for play therapy equipment or toys that can be easily broken may be a source of anxiety for many children. Most children don't want to be held responsible for damaging property. The child counselor relationship should be authentic. The relationship should be genuine and honest, where the interactions are one between two real people. It cannot be superficial where the counselor cannot pretend. The authentic relationship allows the child to expose the inner self and this leads to a deep level of trust .and understanding. The authenticity in relationship means allowing natural spontaneous interplay between them counselor and the child to occur without inhibition or censorship and without unnecessary anxiety.

The child counselor relationship should be confidential. The child counselor relationship should be non-intrusive. There is a danger in asking too many questions because the child may fear being asked to disclose information which is private or too scary to share. If this happens the child will feel intruded.

Similarly, it can be risky to use information about the child which counselors already have obtained from parents or caretakers other agencies which may lead to withdrawal into silence or will engage in the distracting activity. The child counselor relationship should be purposeful. If the child clearly understands the reasons for coming to see a counselor then the client-counselor relationship has the potential to be purposeful. It is important for the counselor to know what information the child has received about coming to counseling. This needs to be done in the presence of both parents and the child, that there are no misunderstandings between or a difference between expectations.

Conclusion: The objective of working with a child is to establish communication. The worker or counselor must learn how the young client interacts with the significant others in his or her world. It is also necessary to find out whether the client believes that he or she is loved, competent and attractive.

Work With adolescence

Adolescence are the products of the past, stewards of the present and the treasures of the future. Youth is a period between adolescence and adult status, ranging from 17 years to 25 years. Youth is a fresh opportunity to the society. They can either mould the society or mar it. So youth is the best human resource available. The youth of today are going to determine the destiny of the tomorrow's world. Dr. B.J Prashantham, in his book "Therapeutic Counselling", says that

they are the products of the past, stewards of the present and treasures of the future. Youth, as we know it today, is a new phenomenon. It is period between adolescence and adult status. It is period of relative freedom from adult responsibilities and relative freedom for rapid physical changes. The-period of youth ranges from 17 to 25 years. In India, due to financial reasons, the youth are dependent on their parents for many more years than the west. The stage of youth generally ceases with stable self-supporting employment. In other words, youth ceases when the individual accepts the responsibilities. Youth contribute a substantial section of Indian population. Out of the country's population the 15-30 age group constitutes about 55% which means that 42 crores of youth are in India today.

Characteristics of Youth: this part of life is referred as the most confusing, challenging, frustrating and fascinating. The young person changes physically, sexually, emotionally and intellectually. He becomes aware of his own emerging adulthood and responsibilities. He moves away from dependence and protective confines of the family. It is a significant period characterized by the need to adjust to physical changes. Secondly, by the influence of great social pressures and thirdly, by the challenge of making life determining decisions about values, beliefs, identity, career and one's relationships with others and those of opposite sex.

Biological need to free himself from his parents: youth has a biological need to free himself from his parents. He is striving

for 'adult status. He can't achieve this until he is free from his parents.

Greater need for comradeship: Youth has a greater need for comradeship with his fellow youth. They try to be a good mixer and get on with his friends. Youth's inner security is realized by companionships . Experience of love or being loved is one of the greatest nature's mechanisms for reducing the level of anxiety and tension.

Urge to revolt against established society: Youth has an urge to revolt against the established society. He sees society as materialistic and morally corrupt. This conflicts with his idealism and he revolts against it. They would like to change our materialistic society into humanistic society. This may be high Youth has an urge to revolt against established society. This may be high sounding words. He strives for something better. They react against restrictions which the society imposes upon them. As a result,t they ignore their opportunities and take an idealistic approach.

Youth is a period of full sexual awareness and sexual potency: One is aware of the attraction to the opposite sex. There is a great curiosity to know about sex its function in life. Different kinds of experimentation go on among the youth in order to understand and affirm their manhood and womanhood. They read books on sex and discuss it with their friends and since they do not have an appropriate mode of sex education in schools and colleges and some of their ideas

about sexually are bizarre and erroneous. Frustration arising out of the apparent uselessness of education in getting a job, leads to anti-social activities, suicides etc.

Effects of the problem and non-satisfaction of needs

- a. Anxiety: imaginary fears, tension, fear of reality and responsibility, loneliness and alienation.
- b. Social Maladjustment: Juvenile delinquency, truancy, rebellion, crime.
- c. Psycho-neurotic disorders: depressive reactions, obsessive compulsive disorder and disassociate reactions.
- d. Behavioural problem: aggression, destruction, stubbornness, hostility, egoism.
- e. Mental deficiency: not being able to cope in the class. Serious mental behaviour disorders are phobias, indecision and feelings of impending catastrophe .

Some of the youth struggles with their problems alone. 'There may be loneliness, alienation, day dreaming, withdrawal, apathy, lack of interest in studies and activities, tension, fear of reality and responsibility, rebellion which lead to psycho somatic illness.

Role of the social worker

- a. There is an urgency to help the youth. It is now or never understand and recognize the need for help.
- b. Earn their confidence and establish a trusting relation and help them to recognize the need for help.

- c. Honesty and respect mixed with compassion and firmness can be the best point to begin with youth counseling.
- d. Show that you understand them and are with them by your empathy, understanding and supportive responses.
- e. Help them to identify their problem. See their problems from their point of view not from an adult's point of view.
- f. Goal setting: once you begin to identify the problem, decide what you want to accomplish in counseling. The goal may include stimulating, self-understanding, self-acceptance, self-esteem and building better communication with others.
- g. Help them to acquire skills or change of behaviour.
- h. Stimulate self actualization.
- i. Help them to know that you are there whenever they need you.
- j. Do not overlook peer group pressures. He needs to be taught that at times he may have to stand alone.

Conclusion: youth is a time of turbulent awakening to Love and beauty but also it is darkened by loneliness and despair when their needs are not met. Youth have the potential to build and to construct. It is our duty to build them up into human beings who cared and loved.

Life Skills for children

Understanding Life Skills: Life skills refer to a large group of psychosocial and interpersonal skills that promote mental

wellbeing and that leads to a healthy and productive life. Health is defined as a “state of complete physical, mental and social well being and not merely the absence of disease or infirmity.” (World Health Organization) Life skills develop competencies and actual behaviors. They result in personal actions, actions directed to others and actions to change the surrounding environment in a healthy, safe way. There are many definitions of life skills. The World Health Organization (WHO, 1993) defines life skills as “the abilities for adaptive and positive behavior that enables individuals to deal effectively with the demands and challenges of everyday life.” WHO (1994) has also identified a core set of life skills for the promotion and well being of children and adolescents.

Core Life Skills

- Problem-solving
- Decision-making (including goal setting)
- Critical thinking
- Creative thinking (including value clarification)
- Communication skills
- Interpersonal skills (including assertiveness)
- Self-awareness
- Empathy
- Coping with stress
- Coping with emotions

Life skills are often categorized in different ways.

Whichever way life skills are categorized, they all address similar issues. Some of the classifications include Communication, relationship and decision-making skills; Thinking, social and negotiation skills; and Decision-making, Interpersonal Communication, values, emotions, saying no, and our future. These are referred to as generic life skills; they help people deal effectively with the demands and challenges of everyday life. Life skills are sometimes confused with skills such as; Livelihood skills – ex. Applying for a job, Work habits etc.; Daily living skills – Managing personal finance, preparing meals; Learning skills – How to read and write, Hobbies; Health skills – Brushing teeth, first aid.; Survival skills- How to seek police help, Contacting help lines.

Life skills also include Decision making, Negotiating skills, Creative thinking, Critical thinking, Effective communication, Interpersonal skills, Self Awareness, Self Esteem, Empathy and Coping with emotions & stress.

Responsible Decision Making: A process and skill acquired which enables one to make decisions after examining the choices and the consequences and which are consistent with one's values and goals. Responsible Decision Making Steps: Define the problem, Consider the consequences of each, Consider family and personal values, Choose one alternative, and Implement the decision.

Negotiating Skills: Negotiation allows one to solve an issue, problem or conflict. It is a process of adjustment. It is a way

to get one's needs accomplished without using anger, intimidation, insubordination, aggressive behavior or force. **Creative Thinking:** This contributes to both decision making and problem-solving by enabling us to explore the available alternatives and various consequences of our actions or non-actions.

Critical Thinking: This helps the adolescent to recognize and assess the factors that influence attitudes and behavior namely – values, peer pressure, and other pressures.

Effective Communication: The ability to express ourselves, both verbally and nonverbally in ways that are appropriate to our cultures and situations. It means not only being able to express opinions and desires but also needs and fears. Also being able to ask for advice and help in the time of need.

Interpersonal Skills: To be able to develop and nurture supportive networks and able to end relationships constructively. **Self Awareness:** Includes recognition of ourselves, of our character, of our strengths and weaknesses, desires and dislikes.

Self Esteem: Is closely identified with self-respect, Includes a proper regard for oneself as a human being and an accurate sense of one's personal place within the large society of family, friends, associates, and others.

Empathy: The ability to understand and accept others who are different from ourselves, to put oneself in the other person's shoes that are being nurtured and tolerant.

Coping With Emotions: Involves recognizing the effect of emotions on ourselves and others, being aware of how emotions influence behaviors and being able to respond to emotions appropriately.

Coping With Stress: Involves recognizing the sources of stress in our lives, recognizing how these affect us and acting in ways that help to control our levels of stress. Also learning how to relax to minimize your tensions.

The need for life skills

Life Skills are Critical for Young People: Life skills address the whole individual and therefore can lead to overall, sustained life-long behavior change. The life skills approach asserts that if children and young people are provided with the opportunity to learn skills in a supportive environment, they can confidently manage their lives in a positive manner while serving as valuable resources to their friends, families, and community.

Life Skills lead to Behavior Change: Knowledge Must Impact Attitudes and Values to Change Behavior. Life skills are one approach that changes attitudes and values to affect behavior. Attitudes and values influence our behavior. Life skills activities provide opportunities to understand and assimilate information and to reflect on one's beliefs and attitudes. An increased sense of competence is cultivated by practicing skills. These efforts, when encouraged in a supportive environment, lead to changes in behavior

World Health Organizations' definition of life skills

“Life skills are abilities that help us to adapt and behave positively so that we can deal effectively with the challenges of everyday life.”

Life skills: Decision-making, goal setting, problem-solving, coping with stress, coping with emotions, negotiating, friendship, interpersonal relationships, empathy (concern for others), critical thinking, creative thinking, resisting peer pressure, assertiveness.

Livelihood skills: Time management, getting a job, interview, computer, cooking, driving etc

Learning skills: Reading, reporting, numeracy etc

Technical/health skills: Cleaning teeth, condom, road safety, giving oral rehydration etc

Outcomes of life skills: Teamwork, self-esteem, learning from each other, confidence etc

The most important life skills are grouped into five related areas. They are called the core skills. Here is a list of the areas and one example of how each core skill is developed in a life skills session:

The five core life skills and examples of a life skills activity

1. Decision-making and problem: solving. A group of children decide with the educator to give up smoking and help others do the same. They set goals to encourage themselves

and each other and try to think what problems and benefits may be. A group of older boys shout at and threaten two girls. The girls have to work out whose help to seek if this happens again.

2. Critical thinking & Creative thinking: A girl is able to assess the risks involved in accepting an invitation from a male stranger to accept a lift across the town.-A young person is able to think about different future job options and to think how to work towards these options.

3. Communication & Interpersonal relationships: - A child is able to discuss problems with parents or an appropriate adult- A child is able to resist peer pressure when his friends ridicule his refusal to drink alcohol.

4 Self-awareness and empathy: - A young woman develops an awareness of her sexual feeling and how these feelings can 'take over' sensible decisions. This awareness helps her avoid situations where she might risk unsafe sex.- A group of children think about how they can help a disabled child who is alone a lot.

5 Coping with Stress & Emotion: - A child learn how to cope with the conflicting pressures of needing to work and wanting to study- A boy learns to cope with the anger he feels towards his abusive father

Essential Life Skills: Life skills basically help people become successful in their personal as well as professional spheres. Life skills are divided into several classifications namely:

essential life skills, life skills for success, financial management skills, problem solving skills, leadership skills, critical life skills, negotiation skills, critical thinking skills, and job skills. Life skills are hardly taught in school, and for the most part, people learn it through trainings and experience. Life skills training series will help you become more familiar with different life skills so that you will be better equipped to handle difficulties, improve yourself, overcome your weaknesses, and be able to fit well in any environment. This section is all about giving you a clear and concise overview on each essential life skill that you need to know about. In theory making decisions sounds really easy: you are given two or more options to choose from, and you simply decide which option you think is best for you. However, in reality, making decisions can become much more complicated than this. Your ability to make the right decisions can mean the difference between enormous success and mediocrity, and it is a critical life skill that needs to be learnt to perfection. While making basic decisions, such as which flavor of ice cream to buy, are relatively simple, things become complicated when you begin making decisions that can affect others negatively, or where making the wrong decision can have adverse effects on your life.

Often, many people do not like making decisions and will actually avoid them. A leader is a person who is always able to make a decision and stick with it. The people who fail tend to be those who make a decision but then are indecisive about following through on it. Typically, people will put off decision making to the last minute, take unreasonably excess

time to collect more than necessary info, or wait to see if the problem will go away on its own. Whereas a successful person is capable of making good decisions and can also make these decisions within a short period of time. The first step in becoming an effective decision maker is to make decisions in a timely manner. This does not mean one should rush; when you are considering an action which could have adverse consequences on yourself or others, it is wise to seek the advice of others and think critically about any choice. However, at the same time, you should not spend too much time doing this, as this is called procrastinating, and when you do this, you are prone to failure. Even if the final decision you make is wrong, a strong leader will always learn from them, and will not repeat the same mistake twice.

Decision making

When making a decision, especially a critical one, there are a number of things that you will want to take into consideration. The first thing that you should consider is the downside of any choice you make. If the liability involved with any major decision is heavily adverse, the best option is to say "no." As a decision maker, you must protect both yourself and those under you. If an option has too many negative consequences, you simply cannot afford to go down that path.

The second thing that should always consider is the cost/benefit analysis. Picking any given option which is available to you will have costs and benefits. The trade-offs of any given decision will typically come in the form of resources and the benefits that you will gain by sacrificing

them. A skillful leader is one who will always consider the cost/benefit analysis when making a critical decision. The best decisions to make are those which have a fairly low cost combined with a benefit that is very high. Whenever you encounter an option where the benefits exceed the cost, it should be obvious to you that this is the best option to choose. In contrast, the worst decisions are those that have a high cost with a benefit that is too low. The next thing you must consider is the parties that will be a part of the decision. Even if you are the leader of an organization, and you have the final say in any decision that is made, your choices will affect other people, and if it affects them in an adverse way, it could damage your position and reputation as a leader. Therefore, you must always consider the advice of those who are most likely to be affected by any decision that you make. By asking others for input, you gain the ability to see beyond your own eyes and can consider the perspectives of others, who may be able to see things that you are incapable of seeing.

Make Quick Decisions

While asking for input and taking the time to gather info is a good idea when it comes to making a decision, there are times in which decisions must be made quickly, where there is simply not enough time to get a consensus. The best example of this is an emergency. If the situation is urgent, taking the time to gather a consensus could be disastrous, and may convey the impression that the leader is ineffective. This is not a situation that a leader wants to find themselves in.

Life Skills: Important As A Part of Formal Learning

Life skills are important because they give children and young people more control to improve their lives. We all want life skills learning to work and have an impact on the behaviour and choices made by children and young people. In the UK, (and in many other countries) some of these Life Skills are embedded in the Primary and Secondary school curriculum. Although they are not often examined so one wonder how this part of the curriculum is managed (and prioritised) by busy teachers. One of my soapbox subjects is the central importance to the FORMAL curriculum and that this subject needs to be done in a self conscious way. It's not enough to say Life Skills are being developed through other subject areas. Yeah right! ...and I was not born to this opinions. I am a convert and resisted for many years! It's important that while focusing teaching life skills that we keep an eye on three other key areas that make life skills learning work. These four key areas work are like the wheels on the bus. Some of you may already know my metaphor! These wheels they must all be pumped up and in good shape for the bus to move forward! These four areas are:

Development and teaching of life skills in any setting be it in schools, churches and in health-related institutions has a lot of advantages/ benefits to it:-

- Life skills teaching enables one to have improved or high self esteem by building confidence in him/herself hence good self image
- Adoption of risk free behaviours like abstinence is a result of life skills education to an individual. Here,

choosing abstinence as a way of preventing HIV/STIs and unintended pregnancies has positive implication to an individual hence no acquisition of HIV/STIs and unintended pregnancies.

- Development of positive attitudes. One is able to develop a positive attitude towards him/her and also to others who they interact in their everyday life.
- Life skills enable an individual to learn how to communicate effectively with people and no conflicts will arise and if anyone is able to address calmly.

Self-awareness is defined as the ability to know yourself better and understanding of yourself in terms of abilities, cognition, emotion, habits, strengths, and weaknesses, values and positions in life and the society at large. It can also involve awareness of one's unique way of thinking, feeling, behavior. Personality can be determined by the following factors, namely

Heredity is one of the key factors influencing personality. It involves passing of genetic materials to offspring from its parents or ancestors. This always explains why offspring resemble their biological parents. The genetic materials that individuals inherit give children a unique way of thinking, expression of emotions and behavior. The various genetic materials that can be inherited include physical dispositions such as heights, personality traits such as courage or laziness. The environment is the second key factor influencing personality. The key two environments are the social and physical environment. The social environments include

family, schools, religious institution, friends and peers whereas physical environment to influences personality for example being brought up in a harsh wore torn poverty ridden environment cannot manifest personality attribute similar to one brought up in a safe, secure and affluent environment. Effective management of stress involves the coping mechanisms one employs when faced with stressful situation /events in life. It will imply an attempt to deal with the sources of stress or control or reactions stress. It can also mean our defense against the stress inherits in living. Here the learner's personal and current effective ways of managing stress are as follows:-

- Identification of the root cause of stress. Here, an individual has to fund away of knowing the exact source of stress and if possible try to categorize whether the source of stress is psychological, emotional, physiological and spiritual and finally try to find possible solutions to each source of stress.
- Cognitive reconstruction is the ability of an individual to interpret or perceive the source of stress or a stressful situations in a positive manner so that it cannot impact negatively on him/her for example if one perceives stress sources in a negative manner can block or hinder him/her to see the positive side of stress hence ineffective coping mechanism.
- Exercises is an effective way the learn uses currently to manage stress. This should be a programmed way of achieving physical fitness. This includes regular aerobic

exercise. Exercise benefits individual become less physiologically reactive to stressors.

- Sharing forms part of the effective way of managing stress according to the learner. Here, if confronted by a stressful event like job-related kind of stress for example too much work and challenging, sharing with a colleague forms part of therapy as one may be supported psychologically hence building on his/her skills for the preparation to handle such a similar situation in his line of duty.
- Eating a balanced diet: a person's body needs nutritious food supplements in order to function normally. Failure to enrich your daily diet will mean the body may lack some food supplements which are very important in the body. For example, when one lacks to eat even one meal in a day there is a loss of energy and the remedy for it is to eat to regain energy for normal functioning of the body.

Since stress has many negatives that impacts on mankind, there is need to put in place or employ some strategies for management of stress. Here, strategies will mean the approaches used by an individual in coping effectively with the many stressors in human daily life. These strategies include:-

- When a stressful situation might be controllable the best strategy for management is turning life threat into challenges by focusing on ways of controlling it. For example instance when a counselor fails to address client issues, he/she might in future consider to go and

attend some refresher courses to update his /her skills for effective delivery of counseling services to his clients

- Changing goals: when faced with an uncontrollable situation a reasonable strategy is to adopt new goals and practical in view of a particular situation for example, a counselor who has been reported several times harassing clients sexually might at some point abandon his/her profession of being a counselor and venture into a different career because is/her frequent exposure with client might lead to dismissal from practicing or in jail.
- Massage therapy appears to be an effective strategy for management of stress as it appears to slow down the heart and relax the body. It also increases alertness for example of massage therapies are Swedish. Massage uses muscles manipulation and these standard massage techniques which is widely used. Another massage therapy entails reflexology that involves manipulation especially acupuncture points in the hands and feet.
- Muscles relaxation technique: because stress is associated with physiological arousal, health psychologists emphasize the importance of relaxation training. This is the most basic relaxation technique which helps in reducing stress. It involves the successive tensing and relaxing of each of the major muscles group of the body. By doing so, one learns to distinguish muscle tension from relaxation and eventually to relieve anxiety by immediately relaxing one's muscles. Progressive relaxing has been effective in reducing

symptoms of physiological arousal including high blood pressure.

- Stress management programs forms part of the strategies for managing stress. This is because for the past decade according to research an increase in stress management programs which typically combine regular exercise relaxation training and cognitive behavioral therapy. Stress management programs have been effective strategy for reduction of physiological arousal and anxiety in individuals.

Self-esteem is how one feels about him/her self and how confident he/she feels in his/her abilities or how much one loves him/herself and the worthy he/she attaches to himself. Research has indicated that high self-esteem in the key to overall happiness and fulfillment in human life and again society has programmed to a human being to believe that they need to accomplish certain things in life and be successful in their lives. The achievement of high self-esteem is depicted by the following or traits namely:-

- People who have high self-esteem always feel worthy of love and approval. These people approve of themselves and are not desperate for other approval.
- Know what is important people with high self-esteem know what is very important in their lives. They are aware of their values better, for example, they value honesty, respect and always discipline in their way of dealing with other people.

- Aware of their strengths and weakness. These people build their strengths and accept their weakness as a part of their and a challenge to make them grow in life.
- People with high self-esteem also know what they will and will not accept. They always create their own rules and principles in life which make them unique from the rest of the people.
- Finally, they have an opinion and not afraid of sharing. They are always ok with people's thinking otherwise but are not going to change their opinion to please other people.

Therapy for Children and Adolescents

Our goal in working therapeutically with children and adolescents is to provide them with coping strategies that will last a lifetime. Our first step is to determine the need for therapy, based on the youngster's problems, developmental level, and his or her ability to cooperate with treatment. We help children and teenagers to become more self-aware and to better understand their thoughts/feelings. We help them to learn new solutions to address continuing problems. Goals for therapy may be specific (such as change in behavior, improved relationships), or more general (decrease anxiety levels, improve self-esteem). The length of treatment depends on the complexity and severity of the presenting problems. As needed, we also provide emotional support and parent education/training as part of your child's treatment.

Common child/adolescent treatment issues

Anxiety: Children face daily academic and social challenges. Sometimes this generates extreme, unrealistic worries that may or not be based on reality. These children are often very self-conscious, rigid, and have frequent somatic complaints -- such as headaches and stomach aches -- that don't seem to have a physical basis. At The Center For Psychology, we provide treatment that can help youngsters become aware of the sources of their anxiety and develop adaptive coping strategies such as learning how to change negative thought patterns to positive ones.

Depression: Diagnoses of childhood and adolescent depression have skyrocketed in recent years. Younger children -- who don't have sophisticated communications skills -- are likely to manifest their depression through physical complaints and behavioral problems. Adolescents may start experiencing academic problems, social isolation, irritability and/or self-destructive behavior. A variety of psychotherapeutic techniques have been shown to be effective in treating juvenile depression. For example, Cognitive behavioral therapy and supportive therapy help youngsters examine and correct negative thought patterns and self-image.

Attention Deficit/Hyperactivity Disorder (ADHD)

Children and adolescents who have ADHD have trouble paying attention in school and at home and are typically much more active and/or impulsive than others of the same age. These behaviors contribute to significant problems in

relationships, learning, and behavior. ADHD affects as many as 12% of all school-age children. It is more common in boys than in girls.

Common symptoms exhibited by children with ADHD include:

- poor impulse control
- frequently losing things
- difficulty listening and following directions
- poor organization and time management
- trouble making plans
- forgets things
- being easily distracted

It is believed that ADHD is caused by the inability to produce enough chemicals in areas of the brain that are responsible for organizing thought. Research shows that ADHD is more common in children who have close relatives with the disorder. Often times ADHD medication may be warranted as an adjunct to psychotherapy. Communication between your therapist and pediatrician or psychiatrist can be helpful in making these decisions and monitoring your child's progress.

Asperger's syndrome: Asperger's Disorder, as it's known as diagnostically, is a mild form of autism. Children with Asperger's are often socially isolated and tend to have idiosyncrasies or quirks. Many of these youngsters have difficulties with a change in their routines and may become preoccupied with and/or particularly knowledgeable about a subject area of interest. Children with Asperger's have trouble

interpreting non-verbal cues and are often overly sensitive to tastes, sounds and textures. The psychologists at The Center For Psychology work closely with these children on developing social skills and adaptability to help them better understand and navigate the social world.

Body image problems/eating disorders: The most common types of eating disorders are Anorexia (starving oneself) and Bulimia (eating and purging). These disorders seem to revolve around a distorted body image and issues of control. Therapy is a key part of treating eating disorders, along with monitoring by a medical professional. Parents and other family members are important in helping a person become more accepting of their body shape/size and to encourage healthy eating habits.

Anger management: Angry outbursts or tantrums are fairly common for younger children and this behavior often disappears as they grow older. However, when youngsters remain angry and oppositional, it creates serious challenges for parents. We work with these children to improve their self-control and communication skills so that they can talk about how they feel and know that they are being heard, thereby diminishing their frustration. We work with parents to develop appropriate behavioral plans at home to promote positive parenting and effective discipline.

Performance anxiety: It can happen in the classroom, on the ball field or on stage -- a child becomes immobilized out of a fear that he or she will do something wrong. Performance anxiety can lead to under-performing in school and miss out

on important developmental experiences. It is important to build the confidence and self-esteem of these children, as well as to help them eliminate negative thought patterns.

Phobias: Some amount of fear and anxiety is common to everyone. For example, young children are often afraid of the dark or of large animals. These fears often fade as they get older. However, when fears become irrational and/or get in the way of normal activities, they can develop into phobias. Phobias are fears of particular situations or things that are not inherently dangerous and which most people do not find troublesome. Therapy helps children understand their fears and learn to cope rather than developing patterns of avoidance or other maladaptive reactions.

Shyness: Shy children tend to avoid unfamiliar situations and often have difficulty in social interactions. Their anxiety might increase when they feel they are "on display", such as when meeting someone new or having to speak in front of others. A shy child is much more comfortable watching the action from the sidelines rather than joining in. Most children feel shy from time to time, but in some children, these tendencies intensify with age and can develop into an anxiety disorder. Parents can help by providing children with opportunities to interact with their peers and by role modeling appropriate social behavior. It may be helpful to consult with a professional if you have concerns about shyness and whether or not your child may be suffering from anxiety.

Sleep problems: Sleep problems of childhood can include difficulties falling asleep or staying asleep that are often

associated with separation fears or fear of the dark. The key to addressing sleep problems is identifying the specific thoughts/fears that are preoccupying your child. It is important that children and adolescents get the proper amount of sleep that they require for growth and development (insert statistics here?) Poor sleeping habits are linked to many psychological problems and can increase feelings of irritability or tantrum behavior.

Repetitive behavior: Like so many other childhood issues, bad habits (such as biting nails, thumb-sucking and hair pulling) are common and may continue into adulthood. However, when the habit becomes unhealthy, harmful, or excessive - psychological intervention may be warranted. Often these behaviors have their root in anxiety and addressing these underlying clinical issues in the context of psychotherapy can be helpful in resolving these behaviors. Children can also benefit from learning positive coping strategies to help them when they face future challenges/stressors.

Toileting problems: Children who are at least 5 years old and continue to wet their bed or clothes should be evaluated by the pediatrician to rule out medical conditions. Sometimes high levels of stress or other psychological issues can contribute to bathroom accidents or withholding. Your psychologist can work with you and your child to deal with these behaviors and promote healthy habits.

Psychotherapy for Children and Adolescents: Different Types

Psychotherapy is a form of psychiatric treatment that involves therapeutic conversations and interactions between a therapist and a child or family. It can help children and families understand and resolve problems, modify behavior, and make positive changes in their lives. There are several types of psychotherapy that involve different approaches, techniques, and interventions. At times, a combination of different psychotherapy approaches may be helpful. In some cases a combination of medication with psychotherapy may be more effective.

1. Cognitive Behavior Therapy (CBT) helps improve a child's moods, anxiety, and behavior by examining confused or distorted patterns of thinking. CBT therapists teach children that thoughts cause feelings and moods which can influence behavior. During CBT, a child learns to identify harmful thought patterns. The therapist then helps the child replace this thinking with thoughts that result in more appropriate feelings and behaviors. Research shows that CBT can be effective in treating a variety of conditions, including depression and anxiety. Specialized forms of CBT have also been developed to help children coping with traumatic experiences.

2. Dialectical Behavior Therapy (DBT) can be used to treat older adolescents who have chronic suicidal feelings/thoughts, engage in intentionally self-harmful behaviors, or have

Borderline Personality Disorder. DBT emphasizes taking responsibility for one's problems and helps the person examine how they deal with conflict and intense negative emotions. This often involves a combination of group and individual sessions.

3. Family Therapy focuses on helping the family function in more positive and constructive ways by exploring patterns of communication and providing support and education. Family therapy sessions can include the child or adolescent along with parents, siblings, and grandparents. Couples therapy is a specific type of family therapy that focuses on a couple's communication and interactions (e.g. parents having marital problems).

4. Group Therapy is a form of psychotherapy where there are multiple patients led by one or more therapists. It uses the power of group dynamics and peer interactions to increase understanding of mental illness and/or improve social skills. There are many different types of group therapy (e.g. psychodynamic, social skills, substance abuse, multi-family, parent support, etc.).

5. Interpersonal Therapy (IPT) is a brief treatment specifically developed and tested for depression, but also used to treat a variety of other clinical conditions. IPT therapists focus on how interpersonal events affect an individual's emotional state. Individual difficulties are framed in interpersonal terms, and then problematic relationships are addressed.

6. Play Therapy involves the use of toys, blocks, dolls, puppets, drawings, and games to help the child recognize, identify, and verbalize feelings. The psychotherapist observes how the child uses play materials and identifies themes or patterns to understand the child's problems. Through a combination of talk and play the child has an opportunity to better understand and manage their conflicts, feelings, and behavior.

7. Psychodynamic Psychotherapy emphasizes understanding the issues that motivate and influence a child's behavior, thoughts, and feelings. It can help identify a child's typical behavior patterns, defenses, and responses to inner conflicts and struggles. Psychoanalysis is a specialized, more intensive form of psychodynamic psychotherapy which usually involves several sessions per week.

Psychodynamic psychotherapies are based on the assumption that a child's behavior and feelings will improve once the inner struggles are brought to light. Psychotherapy is not a quick fix or an easy answer. It is a complex and rich process that, over time, can reduce symptoms, provide insight, and improve a child or adolescent's functioning and quality of life. At times, a combination of different psychotherapy approaches may be helpful. In some cases, a combination of medication and psychotherapy may be most effective. Child and adolescent psychiatrists are trained in different forms of psychotherapy and, if indicated, are able to combine these forms of treatment with medications to help alleviate the child or adolescent's emotional and/or behavioral problems.

Common Child and Adolescent Mental Health Issues

Children and adolescents receive mental health services for a variety of reasons. It is important to recognize that any problem needs to be considered in context with a child's development. As children and adolescents grow, they are changing in a variety of ways. There are predictable ranges of cognitive, emotional, and social growth according to the age of a child and kids will experience shifts in their thinking, mood and behavioral patterns as they mature. During these periods of growth, it can be difficult for families to know when a change reflects the normal challenges in child development or, rather, signs and symptoms of something that more significantly interferes with their child/teen's happiness, and/or function within their family, at school, or with social connections. Consulting a trained and licensed mental health professional who is experienced in working with children and teens can help shed light on the nature of the problem and help in providing options for solutions.

Some child/adolescent areas that might be addressed by mental health services include:

- Developmental delay in speech, language, or toilet training
- Learning, attention, or social skill problems
- Behavioral problems (such as excessive anger, aggression, acting out, opposition at school or home)
- Peer problems, relationship difficulties

- Episodes of sadness, tearfulness, or irritability
- Difficulties with regulating mood
- Changes in appetite or sleep
- Social withdrawal or isolation
- Fearful behavior that results in avoidance or gets in the way of healthy development
- Obsessions or compulsions
- Experiencing bullying or bullying other children
- Excessive school absenteeism or tardiness
- Test anxiety
- Development of or an increase in physical complaints (such as headache, stomachache, or not feeling well) despite a normal physical exam by your doctor
- Management of a serious, acute, or chronic illness
- Signs of alcohol, drug, or other substance use (such as solvents or prescription drug abuse)
- Problems adjusting to transitions (following separation, divorce, or relocation)
- Bereavement issues
- Experiencing or witnessing a traumatic event including sexual, physical, or emotional abuse
- Signs of self-destructive behavior, such as head-banging, cutting, or extreme risk-taking
- Repeated thoughts of death, suicide, or losing a peer or loved one to suicide.

Adolescent Therapy: There are several different types of mental health therapy approaches that are considered credible and evidence-based and have been shown to be effective for

various kinds of presenting child/adolescent concerns. These therapy approaches include, but are not limited to Cognitive-Behavioral; Interpersonal; Family-Systems; Dialectical Behavioral; Client -Centered; Group; Play; Psychoanalytic; and Milieu. Research indicates that in addition to the therapy approach, the relationship with the therapist is key to successfully reaching therapy goals. Therapists best assist others when the therapist feels competent to handle the problems and concerns, when the therapist has enough experience to carry out treatment, and when there is a good fit between the child/adolescent/family and the therapist. There are some common characteristics of helpful child/adolescent therapy. While not every therapist will be able to provide all characteristics of helpful therapy at all times, and no therapy comes with a guarantee; reviewing the areas below might assist the search for a good start to a therapeutic relationship

For child/adolescent work, the therapist will be open to discussing how they might cultivate a relationship of comfort, trust, and good boundaries with the child/adolescent and the parents. A helpful therapist can usually engage a reluctant child. A good fit between child/adolescent and the therapist is not only about the therapist's treatment approach or education or experience, but is also related to their ability to show their genuine interest in the child, willingness to listen and to understand the world as the child understands it, and a priority for supporting the child/adolescent in their communication of their feelings with their family. For child/adolescent work, the therapist, without blame or judgment to the child/adolescent or family, will support the child and the family to think

through the problem at hand and to find specific ways to reach better health and development. The therapist will highlight the child's strengths and will assist in the family's understanding of the problem as an obstacle that needs functional strategies and solutions.

For child/adolescent work, the therapist will regard the priority of the family system and will support the family as the primary structure of care for the child/adolescent. Therapy is temporary and a step in a process of building upon healthy development. For child/adolescent work, the therapy will address the cultural traditions and beliefs of the child/tee/family. Therapy will regard these areas during the development of therapy goals. A child/adolescent therapist will assist the child/adolescent and family to create support networks and to practice healthy patterns between therapy meetings. Therapists who are trained and experienced with kid/teen populations are trained to communicate in a direct and creative fashion with children and with their families. If the child/adolescent or parent has questions or concerns about anything that happens during the therapy process, the therapist will be open to discussing questions or concerns.

Attention Deficit Hyperactivity Disorder: Attention-deficit/hyperactivity disorder (ADHD) is a brain disorder marked by an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development. Inattention means a person wanders off task, lacks persistence, has difficulty sustaining focus, and is

disorganized; and these problems are not due to defiance or lack of comprehension.

Hyperactivity means a person seems to move about constantly, including in situations in which it is not appropriate; or excessively fidgets, taps, or talks. In adults, it may be extreme restlessness or wearing others out with constant activity. Impulsivity means a person makes hasty actions that occur in the moment without first thinking about them and that may have a high potential for harm; or a desire for immediate rewards or inability to delay gratification. An impulsive person may be socially intrusive and excessively interrupt others or make important decisions without considering the long-term consequences.

Signs and Symptoms: Inattention and hyperactivity/impulsivity are the key behaviors of ADHD. Some people with ADHD only have problems with one of the behaviors, while others have both inattention and hyperactivity-impulsivity. Most children have the combined type of ADHD. In preschool, the most common ADHD symptom is hyperactivity. It is normal to have some inattention, unfocused motor activity and impulsivity, but for people with ADHD, these behaviors:

- Are more severe
- Occur more often
- Interfere with or reduce the quality of how they function socially, at school, or in a job

- Inattention: People with symptoms of inattention may often:
 - Overlook or miss details, make careless mistakes in schoolwork, at work, or during other activities
 - Have problems sustaining attention in tasks or play, including conversations, lectures, or lengthy reading
 - Not seem to listen when spoken to directly
 - Not follow through on instructions and fail to finish schoolwork, chores, or duties in the workplace or start tasks but quickly lose focus and get easily sidetracked
 - Have problems organizing tasks and activities, such as what to do in sequence, keeping materials and belongings in order, having messy work and poor time management, and failing to meet deadlines
 - Avoid or dislike tasks that require sustained mental effort, such as schoolwork or homework, or for teens and older adults, preparing reports, completing forms or reviewing lengthy papers
 - Lose things necessary for tasks or activities, such as school supplies, pencils, books, tools, wallets, keys, paperwork, eyeglasses, and cell phones
 - Be easily distracted by unrelated thoughts or stimuli
 - Be forgetful in daily activities, such as chores, errands, returning calls, and keeping appointments
- Hyperactivity-Impulsivity: People with symptoms of hyperactivity-impulsivity may often:
 - Fidget and squirm in their seats
 - Leave their seats in situations when staying seated is expected, such as in the classroom or in the office

- Run or dash around or climb in situations where it is inappropriate or, in teens and adults, often feel restless
- Be unable to play or engage in hobbies quietly
- Be constantly in motion or “on the go,” or act as if “driven by a motor”
- Talk nonstop
- Blurt out an answer before a question has been completed, finish other people’s sentences, or speak without waiting for a turn in conversation
- Have trouble waiting his or her turn
- Interrupt or intrude on others, for example in conversations, games, or activities

Diagnosis of ADHD requires a comprehensive evaluation by a licensed clinician, such as a pediatrician, psychologist, or psychiatrist with expertise in ADHD. For a person to receive a diagnosis of ADHD, the symptoms of inattention and/or hyperactivity-impulsivity must be chronic or long-lasting, impair the person’s functioning, and cause the person to fall behind normal development for his or her age. The doctor will also ensure that any ADHD symptoms are not due to another medical or psychiatric condition. Most children with ADHD receive a diagnosis during the elementary school years. For an adolescent or adult to receive a diagnosis of ADHD, the symptoms need to have been present prior to age 12.

ADHD symptoms can appear as early as between the ages of 3 and 6 and can continue through adolescence and adulthood. Symptoms of ADHD can be mistaken for emotional or disciplinary problems or missed entirely in quiet, well-

behaved children, leading to a delay in diagnosis. Adults with undiagnosed ADHD may have a history of poor academic performance, problems at work, or difficult or failed relationships. ADHD symptoms can change over time as a person ages. In young children with ADHD, hyperactivity-impulsivity is the most predominant symptom. As a child reaches elementary school, the symptom of inattention may become more prominent and cause the child to struggle academically. In adolescence, hyperactivity seems to lessen and may show more often as feelings of restlessness or fidgeting, but inattention and impulsivity may remain. Many adolescents with ADHD also struggle with relationships and antisocial behaviors. Inattention, restlessness, and impulsivity tend to persist into adulthood.

Risk Factors: Scientists are not sure what causes ADHD. Like many other illnesses, a number of factors can contribute to ADHD, such as:

- Genes
- Cigarette smoking, alcohol use, or drug use during pregnancy
- Exposure to environmental toxins during pregnancy
- Exposure to environmental toxins, such as high levels of lead, at a young age
- Low birth weight
- Brain injuries

ADHD is more common in males than females, and females with ADHD are more likely to have problems primarily with inattention. Other conditions, such as learning disabilities,

anxiety disorder, conduct disorder, depression, and substance abuse, are common in people with ADHD.

Treatment and Therapies: While there is no cure for ADHD, currently available treatments can help reduce symptoms and improve functioning. Treatments include medication, psychotherapy, education or training, or a combination of treatments.

Medication: For many people, ADHD medications reduce hyperactivity and impulsivity and improve their ability to focus, work, and learn. Medication also may improve physical coordination. Sometimes several different medications or dosages must be tried before finding the right one that works for a particular person. Anyone taking medications must be monitored closely and carefully by their prescribing doctor.

Stimulants: The most common type of medication used for treating ADHD is called a “stimulant.” Although it may seem unusual to treat ADHD with a medication that is considered a stimulant, it works because it increases the brain chemicals dopamine and norepinephrine, which play essential roles in thinking and attention. Under medical supervision, stimulant medications are considered safe. However, there are risks and side effects, especially when misused or taken in excess of the prescribed dose. For example, stimulants can raise blood pressure and heart rate and increase anxiety. Therefore, a person with other health problems, including high blood pressure, seizures, heart disease, glaucoma, liver or kidney disease, or an anxiety disorder should tell their doctor before taking a stimulant.

Talk with a doctor if you see any of these side effects while taking stimulants:

- decreased appetite
- sleep problems
- tics (sudden, repetitive movements or sounds);
- personality changes
- increased anxiety and irritability
- stomachaches
- headaches

Non-stimulants. A few other ADHD medications are non-stimulants. These medications take longer to start working than stimulants, but can also improve focus, attention, and impulsivity in a person with ADHD. Doctors may prescribe a non-stimulant: when a person has bothersome side effects from stimulants; when a stimulant was not effective; or in combination with a stimulant to increase effectiveness. Although not approved by the U.S. Food and Drug Administration (FDA) specifically for the treatment of ADHD, some antidepressants are sometimes used alone or in combination with a stimulant to treat ADHD. Antidepressants may help all of the symptoms of ADHD and can be prescribed if a patient has bothersome side effects from stimulants. Antidepressants can be helpful in combination with stimulants if a patient also has another condition, such as an anxiety disorder, depression, or another mood disorder.

Psychotherapy: Adding psychotherapy to treat ADHD can help patients and their families to better cope with everyday problems.

Behavioral therapy is a type of psychotherapy that aims to help a person change his or her behavior. It might involve practical assistance, such as help organizing tasks or completing schoolwork, or working through emotionally difficult events. Behavioral therapy also teaches a person how to: monitor his or her own behavior; give oneself praise or rewards for acting in the desired way, such as controlling anger or thinking before acting. Parents, teachers, and family members also can give positive or negative feedback for certain behaviors and help establish clear rules, chore lists, and other structured routines to help a person control his or her behavior. Therapists may also teach children social skills, such as how to wait their turn, share toys, ask for help, or respond to teasing. Learning to read facial expressions and the tone of voice in others, and how to respond appropriately can also be part of social skills training.

Cognitive behavioral therapy can also teach a person mindfulness techniques or meditation. A person learns concentration. The therapist also encourages the person with ADHD to adjust to the life changes how to be aware and accepting of one's own thoughts and feelings to improve focus and that come with treatment, such as thinking before acting or resisting the urge to take unnecessary risks.

Family and marital therapy can help family members and spouses find better ways to handle disruptive behaviors, to encourage behavior changes, and improve interactions with the patient.

Education and Training: Children and adults with ADHD need guidance and understanding from their parents, families, and teachers to reach their full potential and to succeed. For school-age children, frustration, blame, and anger may have built up within a family before a child is diagnosed. Parents and children may need special help to overcome negative feelings. Mental health professionals can educate parents about ADHD and how it affects a family. They also will help the child and his or her parents develop new skills, attitudes, and ways of relating to each other.

Parenting skills training (behavioral parent management training) teaches parents the skills they need to encourage and reward positive behaviors in their children. It helps parents learn how to use a system of rewards and consequences to change a child's behavior. Parents are taught to give immediate and positive feedback for behaviors they want to encourage and ignore or redirect behaviors that they want to discourage. They may also learn to structure situations in ways that support desired behavior.

Stress management techniques can benefit parents of children with ADHD by increasing their ability to deal with frustration so that they can respond calmly to their child's behavior.

Support groups can help parents and families connect with others who have similar problems and concerns. Groups often meet regularly to share frustrations and successes, to exchange information about recommended specialists and strategies, and to talk with experts.

Tips to Help Kids and Adults with ADHD Stay Organized

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- Keeping a routine and a schedule. Keep the same routine every day, from wake-up time to bedtime. Include times for homework, outdoor play, and indoor activities. Keep the schedule on the refrigerator or on a bulletin board in the kitchen. Write changes on the schedule as far in advance as possible.
- Organizing everyday items. Have a place for everything, and keep everything in its place. This includes clothing, backpacks, and toys.
- Using homework and notebook organizers. Use organizers for school material and supplies. Stress to your child the importance of writing down assignments and bringing home the necessary books.
- Being clear and consistent. Children with ADHD need consistent rules they can understand and follow.
- Giving praise or rewards when rules are followed. Children with ADHD often receive and expect criticism. Look for good behavior, and praise it.

For Adults: A professional counselor or therapist can help an adult with ADHD learn how to organize his or her life with tools such as:

- Keeping routines
- Making lists for different tasks and activities
- Using a calendar for scheduling events

- Using reminder notes
- Assigning a special place for keys, bills, and paperwork

Breaking down large tasks into more manageable, smaller steps so that completing each part of the task provides a sense of accomplishment. Attention Deficit Hyperactivity Disorder Attention-deficit/hyperactivity disorder (ADHD) is a brain disorder marked by an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development. Inattention means a person wanders off task, lacks persistence, has difficulty sustaining focus, and is disorganized; and these problems are not due to defiance or lack of comprehension. Hyperactivity means a person seems to move about constantly, including in situations in which it is not appropriate; or excessively fidgets, taps, or talks. In adults, it may be extreme restlessness or wearing others out with constant activity. Impulsivity means a person makes hasty actions that occur at the moment without first thinking about them and that may have a high potential for harm, or a desire for immediate rewards or inability to delay gratification. An impulsive person may be socially intrusive and excessively interrupt others or make important decisions without considering the long-term consequences.

Signs and Symptoms: Inattention and hyperactivity/impulsivity are the key behaviors of ADHD. Some people with ADHD only have problems with one of the behaviors, while others have both inattention and hyperactivity-impulsivity. Most children have the combined type of ADHD. In preschool, the most common ADHD

symptom is hyperactivity. It is normal to have some inattention, unfocused motor activity and impulsivity, but for people with ADHD, these behaviors: are more severe; occur more often; interfere with or reduce the quality of how they functions socially, at school, or in a job Inattention

People with symptoms of inattention may often:

- Overlook or miss details, make careless mistakes in schoolwork, at work, or during other activities
- Have problems sustaining attention in tasks or play, including conversations, lectures, or lengthy reading
- Not seem to listen when spoken to directly
- Not follow through on instructions and fail to finish schoolwork, chores, or duties in the workplace or start tasks but quickly lose focus and get easily sidetracked
- problems organizing tasks and activities, such as what to do in sequence, keeping materials and belongings in order, having messy work and poor time management, and failing to meet deadlines
- Avoid or dislike tasks that require sustained mental effort, such as schoolwork or homework, or for teens and older adults, preparing reports, completing forms or reviewing lengthy papers
- Lose things necessary for tasks or activities, such as school supplies, pencils, books, tools, wallets, keys, paperwork, eyeglasses, and cell phones
- easily distracted by unrelated thoughts or stimuli
- Be forgetful in daily activities, such as chores, errands, returning calls, and keeping appointments

Hyperactivity-Impulsivity: People with symptoms of hyperactivity-impulsivity may often:

- Fidget and squirm in their seats
- Leave their seats in situations when staying seated is expected, such as in the classroom or in the office
- Run or dash around or climb in situations where it is inappropriate or, in teens and adults, often feel restless
- Be unable to play or engage in hobbies quietly
- Be constantly in motion or “on the go,” or act as if “driven by a motor”
- Talk nonstop
- Blurt out an answer before a question has been completed, finish other people’s sentences, or speak without waiting for a turn in conversation
- Have trouble waiting his or her turn
- Interrupt or intrude on others, for example in conversations, games, or activities

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Career counselling

Career counseling and career coaching are similar in nature to traditional counseling. However, the focus is generally on issues such as career exploration, career change, personal career development and other career-related issues. Typically when people come for career counseling they know exactly what they want to get out of the process, but are unsure about how it will work. In the UK, career counseling would usually be referred to as careers advice or guidance. Career counseling is the process of helping the candidates to select a course of study that may help them to get a job or make them employable. A career counselor helps the candidates to get into the career that suited to their aptitude, personality, interest, and skills. So it is the process of making an effective correlation between the internal psychology of a candidate with the external factors of employability and courses. Career

counselors work with people from various walks of life, such as adolescents seeking to explore career options, or experienced professionals contemplating a career change. Career counselors typically have a background in vocational psychology or industrial/organizational psychology. The approach of career counseling varies, but will generally include the completion of one or more assessments. These assessments typically include cognitive ability tests and personality assessments. The two most commonly used assessments are the Strong Interest Inventory and the MBTI.

Challenges of career counseling/guidance: One of the major challenges associated with career counseling is encouraging participants to engage with it. For example, in the UK 70% of people under 14 say they have had no careers advice while 45% of people over 14 have had no or very poor/limited advice. Another issue is the spread of careers advice opportunities. For example, 40% of doctors in training found it difficult to get appropriate careers advice. In a related issue, some client groups tend to reject the interventions made by professional career counselors preferring to rely on the advice of peers or superiors within their own profession. Jackson et al. found that 44% of doctors in training felt that senior members of their own profession were best placed to give careers advice. Furthermore, it is recognized that the giving of career advice is something that is widely spread through a range of formal and informal roles. In addition to career counselors, it is also common for teachers, managers, trainers and HR specialists to give formal support in career

choices. Similarly, it is also common for people to seek informal support from friends and family around their career choices and to bypass career professionals altogether. Today increasingly people rely on career web portals to seek advice on resume writing and handling interviews; as also to research on various professions and companies. It has even become possible to take vocational assessments online.

Career Testing: An objective form of career counseling is through an aptitude test or a career test. Career testing is now usually done online and provides insightful and objective information about which jobs may be suitable for the test taker based on a combination of their interests, values, and skills. Career tests usually provide a list of recommended jobs that match the test takers.

Work with Women: Introduction: Women constitute half of the human resources. In a male-dominated society, the status of women is very low. Though discrimination has been modified over a period of time, the magnanimity of the existence of women's problems makes it an important necessity for the people of public concern to work for women to liberate them from such problems.

Problems of women: Problems of women are numerous and interconnected. Every woman faces problems in varied forms and degree. Problems can be classified into problems of educated and uneducated women, problems of married, unmarried and widow, separated and divorced woman, urban

and rural women, employed and unemployed women and so on.

Problems of educated

- a)Obstacles from family members to work outside.
- b) Difficulty in finding a suitable and comfortable job.
- c)Unequal pay, discrimination in job selection.
- d) Harassment at workplace.

Problems of Uneducated women

- a)Lack of knowledge of their rights.
- b) Lack of freedom in the family, sexual abuse.
- c)Lack of opportunity to use their ability.
- d) Financial dependency on family members.
- e)Too much dependency on men.
- f) Poor self-image and fear of moving outside.

Problems of working women

- a)Women are denied an acknowledgment of their work.
Hence sometimes underpaid.
- b) Physical abuse, verbal harassment, sexual exploitation.
- c)Discriminatory wages.

Problems in family

- a)Women are taken for granted. Cannot make decisions on her own as she is considered inferior to other members in the family.
- b) Dowry harassment.
- c)Dependency on the husband.

- d) Health problems due to heavy work.
- e) Misunderstanding and doubt by the partner.
- f) Adjustment with alcohol-dependent husband.

Problems of married and unmarried women:

- a) Misunderstanding and adjustment problems.
- b) Physical and sexual abuse by a husband.
- c) Dowry harassment, wife beating, child rearing, too many responsibilities.
- d) Problems of health.
- e) Subordination.
- f) Nagging husband, house husband.

Working with Women

- a) Awareness programmes.
- b) Training programmes give new skills for income generating schemes.
- c) Assist women in building self-image.
- d) Encourage individual and collective action and networking for women empowerment.
- e) Instill leadership skills and political consciousness to be the active member in local politics.
- f) Form self-help groups.
- g) Savings: Economic the empowerment that is small savings could be introduced in the rural and urban area.
- h) Group work: Mahila mandalas, ladies club, recreational groups, women federations can be planned.

- i) Self employment: The women should make a contribution to/ the activities by making some investment. Make them independent entrepreneurs.
- j) Non-formal education.
- k) Provide them knowledge of policies and programmes for women by the state and central government.

PART – IV

Counseling for Couples

Pre-marital counselling

A happy and fulfilling marriage has been consistently linked in studies to greater health and a sense of well-being. Unfortunately, current divorce rates continue to hover around 50%, and many more couples are not satisfied with their relationships. Sexual problems, financial stress, infidelity, communication problems, domestic violence, cultural factors, religion, health and age related concerns all represent areas commonly addressed in therapy/ counseling. The psychologists and therapists who work with couples at the Miami Counseling & Resource Center utilize the latest research findings and techniques to help bring about positive relationship changes. Learning healthy communication skills, productive conflict resolution strategies, realistic expectations, intimacy building, and parenting skills, couples practice new patterns of interaction under the guidance of their sensitive and caring mental health professional. Pre-marital counseling is offered to any committed couple who wants to strengthen their bond, work on differences, and look into the future at possible difficulties that may arise. Doesn't your relationship deserve the nurturing and attention necessary to enrich your life? When people want to get married they enter into a certain contract whose end is marriage. The time between their entering into a contract and marriage is called the period of engagement. The engaged need to prepare for their marriage and they may come for help or they may crop up

certain problems during the engagement period for which they need counseling.

The engaged go through four stages of their relationship namely:-

- Rapport- the first process aims at building a relationship in which feel at ease, able to communicate and understand the partner.
- Self-revelation- once rapport has been built up the engaged automatically engage in self revelation like reveal one's values, political and religious beliefs etc.
- Mutual dependency- rapport building and self-revelation lead the engaged to a feeling of mutual dependency or interdependence. The partner becomes a source of special emotional reward which one cannot get from other types of relationship.
- Intimacy need fulfillment- developing closeness to another being and ability to disclose freely one's innermost thoughts and feelings and feel a sense of comfort and joy in doing this.

Goals of premarital counseling: Encouraging interpersonal dialogue between the engaged- the engaged are encouraged to talk about themselves, their expectations, hopes, dreams, plans and their life together.

- Some people are very reluctant to begin the talk such cases the counselor can provide certain points as guidelines for discussion.

- They can speak about their encounter, what attracted them to each other, what they like most in each other, their likes and dislikes, expectations of each other etc.
- Providing information- the counselor can put them in contact with some experienced couple or people specially meant to prepare the people in the period of engagement. There are variety of books, journals, seminars, movies etc. can enlighten the engaged and provide adequate information.
- Correcting faulty information- people enter into marriage with faulty ideas and have lot of surprises and shocks.
- Making an evaluation

A. Maturity- physical maturity: psychological maturity- the ability to look life realistically, active concern for the well being of the partner, ability and willingness to share and make a compromise, ability to tolerate delay in the sense of forgoing immediate gratification in order to receive a greater benefit in the future, ability to face problems and seek solution.

B. Compatibility- what way they are agreeable to each other: Those marriages with the approval of both sets of parents, lack of conflict with the parents, similarity of age, satisfaction with the amount and intensity of affection being received from each other, sharing of common interest and acquaintance for more than a year are said to be successful.

C. marital happiness- the areas for marital happiness are:

- a. Possession of positive personality trait
- b. The similarity of cultural backgrounds
- c. Socially responsive personality
- d. Harmonious family environment
- e. Compatible religious orientation
- f. Satisfying occupation and working conditions
- g. Commitment to each other
- h. Romance which adds spice to marriage

Sexual attraction which is needed for being attached to each other

- a. Complete administrative details
- b. Premarital counselling- the areas that call for special consideration and counseling skills are:
- c. Chronological immaturity
- d. Wide chronological age difference
- e. Wide gap in education
- f. Different cultural background
- g. Vast status difference
- h. Different religion
- i. Pregnant bride
- j. Grieving or rebounding partner- eg. Loss of spouse by death, divorce etc.
- k. Serious physical, mental and emotional handicap
- l. Serious drug involvement
- m. Antisocial personality
- n. Financial insecurity
- o. Counseling techniques
- p. Combination of Conjoint and Group sessions

Couples with marital problems

Marital problem is a concept that comes within the boundaries of marriage. Marriage in simple terms would mean a relationship, a bond, a union, a commitment and a new life.

Characteristics of marital problems

1. Differences of perception, understanding and interpreting events and actions.
2. Polarization that is accuse and blame each other and prove that each one of them is right.
3. Relationship sometimes warm and sometimes it is cold.
4. Communication pattern.

Areas of problem

- Communication.
- Lack of sensitivity.
- Strong hold of ego.
- Lack of self identity.
- Paranoid personality.
- Traumatic life experiences.
- Work and recreation.
- Parenting.
- Lack of sexual satisfaction.
- Romantic concepts-of marriage and early marriage.
- Pre-marital sexual relations and extra-marital affairs.
- Wide gap of education of partners.
- Religion and mixed marriages.

- Substance abuse

Different approaches to work with the couples

- Insight approach: Provide insight to the behaviour of the couple.
- Communication approach.
- Marital Therapy: Therapy includes individual sessions and group sessions.
- Behaviour Therapy: Relief of personal distress.

Role of the Social Worker

- Build awareness of self and encourage them.
- Organize family life education programme.
- Organize legal training programmes
- Build the relationship that is mature and healthy.

Marriage counseling: Also called couples therapy, is a type of psychotherapy. Marriage counseling helps couples of all types recognize and resolve conflicts and improve their relationships. Through marriage counseling, you can make thoughtful decisions about rebuilding your relationship or going your separate ways. Marriage counseling is often provided by licensed therapists known as marriage and family therapists. These therapists have graduate or postgraduate degrees — and many choose to become credentialed by the American Association for Marriage and Family Therapy (AAMFT). Marriage counseling is often short term. Marriage counseling typically includes both partners, but sometimes

one partner chooses to work with a therapist alone. The specific treatment plan depends on the situation.

Marriage Counseling- Need Professional Help

There's no question — marriage can be challenging. Maybe marriage counseling should be something you register for when you tie the knot. Much like a new set of dishes that gets scratched from constant use, relationships can also show wear and tear over the years. So how do you know if your marriage has hit a rough patch or it's something more serious... requiring professional help?

Sign 1: Poor Communication. : a Licensed Marriage and Family Therapist in Los Angeles, urges couples to seek professional help when they aren't able to talk about their problems. According to Novell, "When It's just too frightening to even bring issues up — from sex to money, or even annoying little habits that are being blown out of proportion, a therapist's job is to help the couple become clear about their issues and to help them understand what they are truly talking about."

Sign 2: Your Sex Life has Significantly Changed: Most feel that when there is a loss of intimacy, there are problems. While this is true, it is also important to be mindful of a sudden increase. Founder and Executive Director of [Prairie Family Therapy](#) in Chicago, warns that either an absence or a sudden increase of sex in your relationship can signal danger. "If you have not been having regular or passionate sex and all of a sudden your partner behaves like a courting lover or

wants to experiment with new activities that s/he has never expressed an interest in before, it could indicate that he is experiencing feeling of arousal that are not originating from his relationship with you!”

Sign 3: Holding on to the Past : the founder and President of the Critical Therapy Center in New York City, suggests that it might be a good idea to talk to a professional when there has been a traumatic event in your lives, like the loss of a child or an affair — and one partner cannot let the past go. “Whatever the situation, every person processes trauma differently.”

Sign 4: A Reoccurring Issue: “One type of red flag that usually can be greatly helped by therapy is an issue that has been difficult in the relationship from the beginning, but regardless of endless discussions, never seems to pass,” explains “When you see that the same issues are coming up again and again in disagreements, it is a good sign they are not effectively being resolved and the couple is at a ‘sticking point.’” Dr. Gurner encourages couples to seek help to save “many years of trouble down the road.”

Sign 5: Finances: Disagreements over money are one of the top reasons couples find themselves in conflict. If your spouse keeps you in the dark about family finances or feels the need to control everything related to money, it may be time to speak up. Christine K. Clifford, CEO/President of [Divorcing Divas](#), suggests you say, “I want to be aware of our debt, our monthly bills, the balance on our mortgage, how many

savings/checking accounts we have, etc.” Clifford explains, “If your spouse objects, it’s time to see a counselor.”

Sign 6: Kids: Yes, children are a blessing, but they can also add stress to your marriage, especially if the two of you are not a united front. Clifford suggests seeking counseling if you disagree with each other’s parenting styles and frequently argue about how your children should be raised. “Think Katie Holmes — and how she doesn’t want Suri raised as a Scientologist,” states Clifford. “These are major issues that need to be resolved.”

Sign 7: You Still Love Your Spouse: If you still love your [spouse](#), really want to make things work, and haven’t been successful, then consider finding a counselor. Dr. Gurner also stresses the point that you need to seek advice before things escalate and you truly despise the other person. “Be a proactive couple who strives to solve issues before they tear at the fabric of your deepest bonds of trust and intimacy.”

PART – V

Skills of Therapeutic counseling

Senior Citizens/ Working with aged

Old age consists of ages nearing or surpassing the life expectancy of human beings, and thus the end of the human life cycle. Euphemisms and terms for old people include oldpeople, seniors, senior citizens, older adults, the elderly, and elders . Old people often have limited regenerative abilities and are more prone to disease, syndromes, and sickness than younger adults. The organic process of aging is called senescence, the medical study of the aging process is gerontology, and the study of diseases that afflict the elderly is geriatrics. The elderly also face other social issues such as retirement, loneliness, and ageism. The aging process is, of course, a biological reality which has its own dynamic, largely beyond human control. However, it is also subject to the constructions by which each society makes sense of old age. In the developed world, chronological time plays a paramount role. The age of 60 or 65, roughly equivalent to retirement ages in most developed countries, is said to be the beginning of old age. In many parts of the developing world, the chronological time has little or no importance in the meaning of old age. Other socially constructed meanings of age are more significant such as the roles assigned to older people; in some cases, it is the loss of roles accompanying physical decline which is significant in defining old age. Thus, in contrast to the chronological milestones which mark life stages in the developed world, old

age in many developing countries is seen to begin at the point when the active contribution is no longer possible.

Role of a Social Worker

- communication, including sensitive listening and awareness of non-verbal communication
- taking time to assess needs, starting where the older person is
- supporting people with managing crises that arise from loss and change, e.g. bereavement, changing physical and mental health
- supporting people whose lives are constrained by illness and disability
- practical help
- generating and organizing resources
- Working with other professionals
- Helping the helpers, including carers and colleagues
- Combating ageism.

Aging-savvy social workers serve as “navigators” through the complicated healthcare and social service systems. They help families by gathering information about the array of services available to them, coordinating care across various health systems, facilitating family support, and providing direct counseling services. According to the Consortium of New York Geriatric Education Centers, “Gerontological social work interventions are directed at enhancing dignity, self-determination, personal fulfillment, quality of life, optimal

functioning, and ensuring the least restrictive living environment possible.”

Ways of social work

- **Clinical interventions** – They may provide therapy for an elderly client who feels lonely or who are suffering depression or anxiety. Geriatric social workers encourage their clients to pursue stimulating activities, helping to arrange group outings. They can help clients cope with aging by recording “life stories” and help people say their goodbyes through writing letters, phone calls, videos, etc.
- **Service interventions** – Many social workers act as a link between their clients and the numerous public and private programs designed for the aging. Social workers help clients apply for appropriate services. They help sort out any problems in the delivery of these services.
- **Advocacy** – A geriatric social worker can provide an older adult with an Advance Directive form and explain how to correctly complete it. They are also a frontline defense for stopping elder abuse: a geriatric social worker is mandated by law to report to any suspected elder abuse to Adult Protective Services.

For families in a caregiving situation, geriatric social workers are an invaluable resource. Social workers also offer direct assistance for families, such as providing family-support services, suggesting useful technologies, and facilitating the coordination of medical care. Many geriatric social workers

also offer counseling services, which often deal with end-of-life issues, bereavement, and other concerns common to senior citizens. They can help guide families through the transition from the home environment to long-term care, assist with filing the necessary paperwork, and help with access to end-of-life care planning (living wills, advance directives, DNR orders). They act as a liaison between the patient, family members, and healthcare staff and can make sure you stay informed about your loved one's condition.

Education: Working with the elderly demands a level of education that can be daunting to pursue. A social worker often must have a master's degree to achieve certain levels of career advancement, and additional education is mandatory to maintain licensing. Due to the shortage of resources for adult-focused care versus child-focused situations, you may have to relocate to obtain all of the education you need. However, many universities have begun to realize the importance of training social workers in the challenges facing all demographics, so hopefully it will be easier to find employment.

Personal Skills: To work with the elderly, one must have compassion and patience. Having a younger person come in to help or evaluate a situation can seem demeaning to some older people. You may be called names or told you are "too young" to understand their situation. While the majority of senior citizens are a joy to know, just like any people group, there is always a rough patch. Furthermore, if an individual is the victim of abuse or neglect, this may amplify the negativity in

their personality. Another trait necessary is the ability to deal with severe mental illness. Many people in nursing home environments are there because of dementia, Alzheimer's, or some other mentally debilitating illness that requires constant care. For this reason, many patients are fearful and confused. It is vital the social worker is able to discern between what is fact and fiction in this person's mind while having the gumption to take on the challenge of dealing with the individual's unintentional inconsistency.

Professional Skills: Academically and professionally, there are various social work skills for working with the elderly that must be obtained. As mentioned earlier, those who will find the most success in the field will be those who earn a master's in social work (MSW) degree. The coursework for this may include the following:

- a) Human Differences, Social Relationships, Well-Being, and Change Through the Life Course
- b) Organizational, Community, and Societal Structures and Processes
- c) Foundation Skills for Social Work Practice
- d) Basic Social Work Research
- e) Introduction to Social Welfare Policy and Services
- f) Adulthood and Aging
- g) Policies and Services for the Elderly
- h) Policies and Services for Adults
- i) Evaluation in Adults and Elderly
- j) Social Work with the Elderly
- k) Death, Loss, and Grief

Differently able

All students present various challenges to educators in terms of how to best educate and meet the needs of each individual. Differently-able children present special challenges as well. One way to address the needs of differently-able students is to use music as a means to teach and develop each child. Most children, even those with multiple disabilities, respond in some manner to music. If you gear music activities toward your students' needs and abilities, you can potentially help your student to experience personal gains in a variety of ways. The lack of competent physical and mental faculties; the absence of legal capacity to perform an act. The term disability usually signifies an incapacity to exercise all the legal rights ordinarily possessed by an average person. Convicts, minors, and incompetents are regarded to be under a disability. The term is also used in a more restricted sense when it indicates a hindrance to marriage or a deficiency in legal qualifications to hold office. The impairment of earning capacity; the loss of physical function resulting in diminished efficiency; the inability to work. In the context of Workers' Compensation statutes, disability consists of an actual incapacity to perform tasks within the course of employment, with resulting wage loss, in addition to a physical impairment that might, or might not, be incapacitating. Under federal law, the definition of a disability, for Social Security benefits purposes, requires the existence of a medically ascertainable physical or mental impairment that can be expected to result in death or endures for a stated period, and an inability to

engage in any substantial gainful activity due to the impairment.

Disability 1) a condition which prevents one from performing all usual physical or mental functions. This usually means a permanent state, like blindness, but in some cases is temporary. In recent times society and the law have dictated that people with disabilities should be accommodated and encouraged to operate to their maximum potential and have the right to participate in a societal and governmental activity without impediments. Hence, access by ramps, elevators, special parking places and other special arrangements have become required in many statutes. 2) a legal impediment, including being a minor who cannot make a contract, or being insane or incompetent, as determined by others.

Causes: Prenatal; Perinatal; and Postnatal

Counseling skills

- Being a good listener
- Empathizing
- Non-judgmental
- Confidentiality
- Acceptance

Measures to overcome barriers

- Holding regular PTA meeting

- Involving parents in other co-curricular activities like taking children out for a picnic.
- Giving respect to their suggestions for improvement of the child.

Role of the counselor

Facilitator

- sharing success stories of other parents
- encourage them to reach out to parents of other children with disabilities
- Build their own support system.
- To celebrate together their achievements and goodness of life.
- Helping parents to overcome their embarrassments, inferiority complex and hiding of the facts.

Agent of change in the mindset of pupils and community at large steps to achieve change:

- encourage the child to participate in co-curricular activities
- spread information about YUVA helpline. Their services are for the differently abled to give themes like I can do
- Community awareness
- Street play
- Celebrate 3rd December as ability day
- Acceptance of their child with disabilities
- Early interventions, planned, systematic and consistent effort with love, firmness, patience and perseverance

- Reaching out to network with other parents and other service providers in disability sector and developing and maintaining a positive outlook on their lives.

Instructions: Assess each child's ability levels and personal needs. You can do this through formal and informal assessments. Review individualized education plans (IEPs) along with other records concerning the students in order to gather information on needs and performance. Lead children with deficits in social skills in musical activities that encourage positive social interaction. For instance, in an elementary school level, you could use a simple song called "Shake a Hand." The lyrics are "Shake a hand and sing with me, Shake a hand now, 1, 2, 3. Shake a hand and sing with me, Won't you shake a hand." Change the lyrics to other forms of social interaction such as "Give a smile ... ," or "Pat a back" This song allows students to practice their social skills.

Adapt your activities to your students' physical abilities. For instance, you could have a class "rhythm band" in which each student plays an instrument together with the rest of the class. If a differently-abled student needs to work on fine motor skills, you might have him play the xylophone with a mallet. If the student cannot perform on a xylophone and needs to focus on gross motor skills instead, you might have him play the drum. Dance also helps students to work on physical skills and coordination. Encourage differently-abled students to express themselves creatively. Just as any student needs to be able to express emotions and ideas, differently-abled students

can benefit from creative musical activities as well. You might try song-writing activities, creative dance or improvised instrument playing (as in a drum circle in which each person takes a turn playing solo passages of rhythm). Use music to teach life-skills and educational concepts. A song about colors or numbers might help a differently-abled student to better grasp these concepts. A song about body parts (such as "Head, Shoulders, Knees, and Toes") might help some children to identify various body parts. You might even incorporate songs about personal hygiene, exercise and healthy eating habits in order to teach and reinforce these ideas.

Chronic illness

Euro symposium in 1957:- An impairment of bodily structure and or a function that necessitates a modification of the patient's normal life and has persisted over an extended period of time. The commission on chronic illness in the USA:- Chronic illness as comprising all impairments or deviations from normal, which have one or more of the following characteristics:-

- Permanent
- Residual disability (still there are some problems)
- Are caused by non-reversible pathological alterations
- Require special training of the patient for rehabilitation

- May be expected to require a long period of supervision, observation or care.
- Eg. Cardiovascular problem, renal, nervous, mental illness, blindness, diabetes etc.

Risk factors

- Smoking
- Alcohol abuse
- Failure or inability to obtain preventive health services eg. Hypertension control, early detection of cancer, management of diabetes etc.
- Lifestyle changes (dietary patterns, physical activity)
- Environmental risk factors eg. Occupational hazards, air and water pollution etc.
- Stress factors

Gaps in natural history

- The absence of a known agent- it makes both diagnosis and specific prevention difficult.
- Multifactorial causation- most chronic diseases are the result of multiple causes.
- Long latent period- it is difficult to find out the incubation period.
- Indefinite onset- most chronic diseases are slow in onset and development and the distinction between diseased and nondiseased states may be difficult to identify.

Eg. Diabetes, hypertension

Prevention

- Tertiary prevention is possible
- Identification of risk factors
- Health promotion activities (reduction of risk factors, modification of lifestyle patterns).
- Case finding through screening and health examination techniques.
- Application of improved methods of diagnosis.
- Treatment and rehabilitation
- Control of food, water, and air pollution.
- Reducing accidents
- Influencing patterns of human behavior.
- Lifestyles through intensive education
- Upgrading standards of institutional care.
- Developing and applying better methods of comprehensive medical care including primary health care.
- Political approaches are needed in the case of smoking control, alcohol control and drug abuse.
- Treatment and rehabilitation
- Control of food, water, and air pollution
- Reducing accidents
- Upgrading standards of institutional care and developing and applying better methods of comprehensive medical care including primary health care.

HIV/AIDS (slim disease)

INTRODUCTION

The Human Immuno Deficiency Virus/Acquired Immuno Deficiency Syndrome (HIV/AIDS) epidemic today has become not only a public health issue but also one that is seriously affecting the dynamics of social, cultural, economic and developmental pace of the society. Factors that were once considered to be the main causes of the disease and preventive measures prescribed have become superfluous in the face of HIV/AIDS mutating itself into society, in forms, such as poverty, crime, culture, religion, environment, commerce, traditional practices and discrimination and so on. The Human Immuno Deficiency Virus is a pandemic and poses a major challenge to health professionals, caregivers and families in undertaking its psychological, social and cultural aspects and in formulating specific and appropriate intervention programmes, for its management and prevention throughout the world. It is much truer in countries like India, with inadequate health related infrastructure and rehabilitation facilities. The Human Immuno Deficiency Virus is not a mere medical problem but is also a societal problem, which needs to be understood from a biological, psychosocial, social economical perspective, rather than from a purely biomedical perspective. Such a perspective integrates the biological, psychological and social influence into a complex system of interactions, which determine an individual's health vulnerability and coping reactions to disease, with implication for intervention and prevention.

Definition on HIV/AIDS

Acquired Immuno Deficiency Syndrome (AIDS) occurred in the USA in the early 1980s. A number of gay men in New York and California suddenly began to develop rare opportunistic infections and cancers that seemed stubbornly resistant to any treatment. At this time, AIDS did not yet have a name, but it quickly became obvious that all the men were suffering from a common syndrome.

The discovery of Human Immuno Deficiency Virus (HIV) was made soon after. Presently it has been proved that HIV cause Aids. By knowing the intensity of the problem our main concern at present is how developing countries like India will come up with this disease. As stated in a Medical journal in January 1986 (Ghosk T.K. 1986) “Unlike developed countries, India lacks the scientific laboratories, research facilities, equipment, and medical personnel to deal with an AIDS epidemic. In addition, factors such as cultural taboos against discussion of sexual practices, poor coordination between local health authorities and their communities, widespread poverty and malnutrition, and a lack of capacity to test and store blood would severely hinder the ability of the Government to control AIDS if the disease did become widespread.”

According to Simoes E.A.et al. (1987) India’s first cases of HIV were diagnosed among sex workers in Chennai, Tamil Nadu. It was noted that contact with foreign visitors had made

initial infections among sex workers, and as HIV screening centres were set up across the country there were calls for visitors to be screened for HIV. Gradually, these calls subsided as more attention was paid to ensuring that HIV screening was carried out in blood banks. (Kakar D.H. Kofan S.N. 2001). Kakar state that by this stage, cases of HIV infection had been reported in every state of the country(Baria, F. et al. (1997). Throughout the 1990s, it was clear that although individual states and cities had separate epidemics, HIV had spread to the general population. Increasingly, cases of infection were observed among people that had previously been seen as '*low-risk*', such as housewives and richer members of society.

In 1998, Nath L.M wrote "HIV infection is now common in India, exactly what the prevalence is, is not really known, but it can be stated without any fear of being wrong that infection is widespread it is spreading rapidly into those segments that society in India does not recognize as being at risk. AIDS is coming out of the closet. Current estimates by UNAIDS (2006) shows that there were 5.6 million people living with HIV in India, which indicated that there were more people with HIV in India than in any other country in the world.

However, National Aids Control Organization (NACO) disputed this estimate, and claimed that the actual figure was lower. In 2007, following the first survey of HIV among the general population, UNAIDS and NACO agreed on a new estimate – between 2 million and 3.1 million people living with HIV. The figure was confirmed to be 2.31 million in

2008. This puts India behind South Africa and Nigeria in numbers living with HIV which equates to a prevalence of 0.3%. While this may seem a low rate because India's population is so large, it is third in the world in terms of greatest number of people living with HIV. NACO released figures in 2008 suggesting that the number of people living with HIV has declined from 2.73 million in 2002 to 2.31 million in 2007, NACO (2008). Further NACO reported that there were 124,995 of which 29% were women, and 36% were under the age of 30. These figures are not accurate reflections of the actual situation though, as large numbers of AIDS cases go unreported. Overall, around 0.3% of India's population is living with HIV. While this may seem a low rate, India's population is vast, so the actual number of people living with HIV is remarkably high. There are so many people living in India that a mere 0.1% increase in HIV prevalence would increase the estimated number of people living with HIV by over half a million. NACO (2008)

Besides these, stigma and discrimination are other factors that are common to all Most-At-Risk groups. Any person has high risk of HIV infection if they have unprotected sex with a partner of unknown HIV status or if they inject drugs with shared needles and syringes. People may be at risk for many reasons: poor or incomplete information on HIV, being unable to negotiate safer sex, being unable to get hold of condoms, belief that HIV affects people who are richer/ poorer than themselves.

Initially, most HIV programmes aimed at reducing risk behaviors by targeting individuals and groups. For instance, they provided information and education, free condoms and clean syringes. However, this approach is not sufficient. People do not always act the way we expect them to act. For instance, an injecting drug user may share needles as a sign of solidarity with her/ his friend even if there is easy access to clean syringes. Similarly, a sex worker or MSM may use condoms with everyone except a special partner – they may perceive the use of condoms as a sign of lack of trust, or as an expression of love and confidence.

Vulnerability is the result of “societal factors that affect adversely one’s ability to exert control over one’s health” (UNAIDS, 1998). Vulnerability could be due to various factors: Personal factors such as sexual history, personal knowledge, and membership of specific social networks may increase vulnerability. Factors such as quality of services offered to individuals in need, geographical access, and cost will also increase or decrease vulnerability. Finally, there are societal factors such as cultural norms which influence a person’s behaviour. For instance, Indian men and women are expected to marry and have children. So it is almost impossible for men and women who have a sexual attraction for a person of their own sex to avoid getting married to a person of the opposite sex. Gender norms and poverty are other societal factors that increase vulnerability. Risks and vulnerability related to HIV infection are different for these various communities. Moreover, these are not isolated

communities. Instead they may overlap with other sub-groups. For instance, many drug users may also sell and buy sex. Men who have sex with men may also be married and have sexual relations with spouses and sometimes with female sex workers. It is not possible to put the behaviors of people into neat boxes.

HIV/AIDS is typically viewed by common people as a disease that affects “others,” that is people who are different from them, people whose lifestyles are seen as “perverted” and “immoral.” In the case, their behaviors and activities appear to be very different from what is familiar to general communities. Hence they are treated with rejection.

UNAIDS defines HIV-related stigma as a ‘process of devaluation’ of people either living with or associated with HIV and AIDS. Anyone who treats an individual unfairly and unjustly based on his or her real HIV status is guilty of practicing discrimination. Discrimination is the result of the social separation or devaluation. It is also sometimes called enacted stigma. We can think of stigma as attitudes and thoughts, and discrimination as the behavior based on stigmatizing attitudes and thoughts. HIV/AIDS stigma and discrimination violate human rights and arise from 3 factors: Lack of awareness of how stigma affects People Living with HIV/AIDS. Common fear of people of being infected from ordinary contact with people already infected with HIV – In this case, it is fear of being tainted/ damaged by associating with people whose sexual behaviors or drug-related behaviors

we cannot understand Linking all PLHIVs with behaviors that are immoral HIV/AIDS stigma and discrimination is one of the structural factors that create barriers for people in accessing health care and protective measures such as condoms.

HIV is a member of a family of viruses that causes disease slowly (animal lent viruses), and infects a wide range of mammals including monkeys, sheep, cattle and cats. Each virus is specific to one species - HIV is specific to humans and cannot be passed on to other animals in its present form. It has been discovered that HIV has descended from the Simian (Monkey) Immunodeficiency Virus (SIV), and that the two diverged about 140 million years ago.

Nature of HIV/AIDS

HIV stands for Human Immunodeficiency Virus. The HIV virus infects cells of the immune system. The immune system is what protects us from infections and disease.. In a healthy individual, infections are kept at bay by an army of defenders known as white blood cells (WBCs). These cells live in the bloodstream and make up one per cent of the total number of blood cells. WBCs recognize foreign invaders and attack them by producing specific *antibodies* that neutralize the infection. Each disease stimulates the production of antibodies *specific to itself*. HIV uses cells of the immune system to grow. When HIV has used one of these cells to grow, the cell can no longer do its job, leaving the body without a part of its immune

system. HIV targets the body's CD4 or T-helper cells. These are the cells that coordinate the body's fight against infections - in effect, the commanders of the army. After some time, the body is no longer able to defend itself against infections although, since HIV is slow acting, it can take some years for the infections to develop. HIV does not cause any symptoms by itself - it hides behind other infections that weaken the body on its behalf. HIV can also directly attack the brain, causing progressive deterioration in a person's physical or mental status.

Characteristics of HIV

The most common characteristics of HIV transmission from one person to another are;

- By having sexual intercourse (anal, Vaginal or oral sex) with an HIV-infected person by sharing needles or injection equipment with an injected drug user, from HIV-infected women to babies before or during birth or through breast-feeding after birth.
- HIV also can be transmitted through transfusion of infected blood or blood clotting factors
- In the health care setting, workers have been infected with HIV after being stuck with needles containing HIV-infected blood or less frequently, after infected blood gets into a worker's open cut or a mucous membrane (for example, the eyes or inside of the nose).
- The only way to determine for sure whether one is infected is to be tested for HIV infection.

- One cannot rely on symptoms to know whether or not one is infected with HIV. Many people who are infected with HIV do not have any symptoms at all for many years.
- The warning signs of infection with HIV Rapid weight loss, Dry cough, Recurring fever or profuse night sweat, Profound and unexplained fatigue, Swollen lymph glands in the armpits, groin or neck, Diarrhea that lasts for more than a week, White spots or unusual blemishes on the tongue, in the mouth or in the throat, Pneumonia, Red, brown, pink or purplish blotches on or under the skin or inside the mouth, nose or eyelids, Memory loss, depression and other neurological disorders. However, no one should assume they are infected if they have any of these symptoms. Each of these symptoms can be related to other illnesses. Again, the only way to determine whether one is infected is to be tested for HIV infection.

Difference between HIV and AIDS

The difference between the two can be said to be one of two things. The first is time. The second is an Opportunistic Infection (OI). A simple way $HIV+OI=AIDS$. TB (tuberculosis) is an OI and there are many others. There is no cure for HIV but there is for TB. In Western countries there are tablets that can delay the progression of HIV, but it still remains in the body. These drugs are too expensive for majority of the Indians. However, Indians can get TB

medications *free at* (some) government hospitals. HIV is confirmed by a blood test. An AIDS diagnosis, however, is a different matter. A physician, on the basis of the person having HIV and OI, (opportunistic infection) makes an AIDS diagnosis. There is a period of time that must pass before a person can have an HIV test, known as The Window Period. It is the time from when a person is infected to the time it takes the antibodies to the virus to develop in the bloodstream (three months). Thus, someone can have a definite positive or negative result only three months after their last high-risk behavior.

It is not high-risk groups that transmit the virus but certain defined behavior. HIV is not contagious; TB is contagious - you can catch it sitting next to someone on the bus. To contract HIV you have to engage in certain activities, which every group in society could, and does, engage in. It is not just confined to one or two social groups. People living with HIV/AIDS can live healthily for 8-12 years after infection, depending upon their lifestyle. Such things as a healthy diet, regular exercise, counseling and support can greatly increase the ability of someone to live with the virus for a long time. If, however, you live in a slum, it is unlikely that you will be able to live in such a fashion and your life expectancy with HIV/AIDS will be reduced unless support is given.

HIV/AIDS: Global Scenario

Within the South and South-East Asia Region, an estimated 7.4 million are people living with HIV/AIDS (PLHA) (as of December 2005). This region ranks second in HIV prevalence, after sub-Saharan Africa, and accounts for about 20% of new annual HIV infections globally. The epidemic in India is varied, with areas of generalized epidemic in the South and North-east, and with pockets of concentrated epidemics and highly vulnerable regions with low-levels of HIV infection. Half of HIV patients in Asia live in India: India houses half of Asia's HIV patients and is way ahead of China in disease burden. It also finds a place in the list of 22 countries prioritized for preventing mother to child transmission infection, according to the latest UN-AIDS report, drafted jointly with the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) About 48 lakh people were living with HIV in Asia in 2010 and nearly half of them 49 per cent to be precise are in India, say the report released on the eve of World AIDS Day. The Percentage of pregnant women who tested positive for HIV infection in India also raised from 2 percent in 2005 to 23 per cent in 2010. Seven Asian countries report an estimated 100,000 or more people living with HIV in 2009, collectively accounting for more than 90 per cent of people with HIV in the region. India tops the list followed by China, Thailand, Indonesia, Malaysia, Myanmar and Vietnam, through the highest prevalence rate, one per cent, was observed only in Thailand. In Asia, the rate of HIV transmission appears to be slowing

down. The estimated 3,60,000 people who were newly infected with HIV in Asia in 2010 were considerably fewer than the 4,50,000 estimated for 2001. (The Hindu, December1, 2011)

HIV/AIDS: Indian Scenario

In India, the Human Immuno Deficiency Virus/ Acquired Immuno Deficiency Syndrome (HIV/AIDS) epidemic is nearly two decades old. India reported its first known case of AIDS to the world health organization on 1986. It would be easy to underestimate the challenge of HIV/AIDS in India. India has a large population and population density, low literacy levels and consequently low levels of awareness, and HIV/AIDS is one of the most challenging public health problems ever faced by the country (UNPAN, 2003) At the end of 2004, 5.3 million Indians were estimated to be infected with HIV. A hundred and eleven districts in the country are classified as high HIV prevalence districts. Transmission of HIV is predominantly through the sexual route (86%). Other routes include injecting drug use (IDU) (2.4%), vertical transmission from mother to child (3.6%) and transfusion of blood and blood products (2%), and others (6%) as of July 2005. (UNAIDS and World Health Organization, 2005). The vast size of India makes it difficult to examine the effects of HIV on the country as a whole. The majority of states within India have a higher population than most African countries, so a more detailed picture of the crisis can be gained by looking at each state individually. The HIV prevalence data for most

states is established through testing pregnant women at antenatal clinics. While this means that the data are only directly relevant to sexually active women, they still provide a reasonable indication as to the overall HIV prevalence of each area. Data for six states are also available from a survey of the general population.

High prevalence: Maharashtra, Tamil Nadu, Manipur, Andhra Pradesh, Karnataka and Nagaland States which have HIV prevalence rates exceeding 5% among groups with high-risk behaviour and 1% among women attending antenatal clinics in public hospitals. (UNAIDS and World Health Organization, 2005)

Moderate epidemics: Gujarat, Pondicherry and Goa, where HIV prevalence rates among population with high risk behaviour has been found to be 5% or more, while HIV prevalence remains below 1% among women attending antenatal clinics. (UNAIDS and World Health Organization, 2005)

Low prevalence: *High vulnerable states:* these states are where migration was rampant, and where weak health infrastructure existed. HIV prevalence rates among vulnerable population are below 5 percent and less than 1 percent among women attending antenatal clinics. (UNAIDS and World Health Organization, 2005)

Vulnerable states: All other states and Union Territories fall into the low prevalence category. The following states have recorded the highest levels of HIV prevalence at antenatal and sexually transmitted disease (STD) clinics over recent years. (UNAIDS and World Health Organization, 2005)

Andhra Pradesh: Andhra Pradesh in the southeast of the country has a total population of around 76 million, of whom 6 million live in or around the city of Hyderabad. The HIV prevalence at antenatal clinics was 1.26% in 2005 - higher than in any other state - while the general population prevalence was 0.97% in 2005. The vast majority of infections in Andhra Pradesh are believed to result from sexual transmission. HIV prevalence at STD clinics was 24.4% in 2005. (UNAIDS and World Health Organization, 2005)

Goa: Goa is a very small state in the southwest of India, and is best known as a tourist destination. Tourism is so prominent that the number of tourists almost equals the resident population, which is about 1.3 million. The HIV prevalence at antenatal clinics was found to be 0.50% in 2005. Prevalence at STD clinics was 8.6% in 2005, indicating that Goa has a serious epidemic of HIV among sexually active people. (UNAIDS and World Health Organization, 2005)

Maharashtra: Mumbai (Bombay) is the capital city of Maharashtra state and is the most populous city in India, with around 20 million inhabitants. Maharashtra is a very large state of three hundred thousand square kilometres, with a total

population of around 97 million. The HIV prevalence at antenatal clinics in Maharashtra was 0.75% in 2005, and surveys of female sex workers have found around 20% to be infected. Similarly high rates are found among injecting drug users and men who have sex with men. The 2005 survey found an infection rate of 0.62% in the general population of Maharashtra. This state is home to around one in five of all people living with HIV in India. (UNAIDS and World Health Organization, 2005)

Tamil Nadu: When surveillance systems in the southern Indian state of Tamil Nadu, home to some 62 million people, showed that HIV infection rates among pregnant women were rising - tripling to 1.25% between 1995 and 1997 - the State Government acted decisively. Funding for the Tamil Nadu State AIDS Control Society (TANSACS), which had been set up in 1994, was significantly increased. Along with non-governmental organisations and other partners, TANSACS developed an active AIDS prevention campaign. This included hiring a leading international advertising agency to promote condom use for risky sex in a humorous way, without offending the many people who do not engage in risky behavior. The campaign also attacked the ignorance and stigma associated with HIV infection. The HIV prevalence at antenatal clinics in Tamil Nadu was 0.25% in 2005, though several districts still have much higher rates. The general population survey of 2005 found a rate of 0.34% across the state. Prevalence among injecting drug users was 24.20% in

2005- the highest of all states and union territories. (UNAIDS and World Health Organization, 2005)

Manipur: Manipur is a small state of some 2.2 million people in the northeast of India. The nearness of Manipur to Myanmar (Burma), and therefore to the Golden Triangle drug trail, has made it a major transit route for drug smuggling, with drugs easily available. HIV prevalence among injecting drug users is around 20%, and the virus is no longer confined to this group, but has spread further to the female sexual partners of drug users and their children. The HIV prevalence at antenatal clinics in Manipur has exceeded 1% in all recent years. The 2005 survey found that 1.13% of the general population was infected - the highest of all states surveyed. (UNAIDS and World Health Organization, 2005)

Mizoram: The small northeastern state of Mizoram has fewer than a million inhabitants. In 1998, an HIV epidemic took off quickly among the state's male injecting drug users, with some drug clinics registering HIV rates of more than 70% among their patients. In recent years the average prevalence among this group has been much lower, at around 3-7%. HIV prevalence at antenatal clinics was 1% in 2005.

Nagaland: Nagaland is another small northeastern state, with a population of two million, where injecting drug use has again been the driving force behind the spread of HIV. In 2005, the HIV prevalence at antenatal clinics was 0.93%, and the rate among female sex workers was 16.40%.

HIV and AIDS in Karnataka

Karnataka - a diverse state in the southwest of India - has a population of around 53 million. In Karnataka the average HIV prevalence at antenatal clinics has exceeded 1% in all recent years. Among the general population, 0.69% were found to be infected in 2005-2006. Districts with the highest prevalence tend to be located in and around Bangalore in the southern part of the state, or in northern Karnataka's "devadasi belt". Devadasi women are a group of women who have historically been dedicated to the service of gods. These days, this has evolved into sanctioned prostitution, and as a result many women from this part of the country are supplied to the sex trade in big cities such as Mumbai. The average HIV prevalence among female sex workers in Karnataka was 8.64% in 2006, and 19.20% of men who have sex with men were found to be infected. There are a number of factors that contribute to Karnataka's vulnerability to the HIV epidemic. It is bordered by three states that have well-established and growing HIV epidemics (Maharashtra, Tamil Nadu and Andhra Pradesh). Karnataka shares many demographic and economic ties to these neighbouring states. There is extensive migration to and from these states and there are major transportation routes connecting Karnataka to them.

There are also economic and social factors that contribute to Karnataka's vulnerability. Poverty levels are high, leading to economic pressures that promote commercial sex work. Furthermore, economic pressures result in migration and

social dislocation of labourers (primarily men) who are seeking work. This situation is particularly acute in northern Karnataka, which is drought-prone and suffers from substantial levels of poverty. The low levels of literacy, especially among women, pose challenges to design effective and widespread behaviour change communication. Furthermore, the low social status of women in many settings inhibits the adoption of safer sexual practices. There is growing evidence that the HIV epidemic is having a large impact in rural areas where prevention and care services availability is inadequate. That HIV and AIDS is already an important health issue in rural Karnataka is clear from a complete census survey that conducted in randomly selected villages and city wards in Bagalkot district. Recounting deaths within the last two years in the household, AIDS was reported as the single leading cause of death among those aged 15-49, accounting for 17% of deaths.

Current estimation

In 2006 UNAIDS estimated that there were 5.6 million people living with HIV in India, which indicated that there were more people with HIV in India than in any other country in the world. In 2007, following the first survey of HIV among the general population, UNAIDS and NACO agreed on a new estimate – between 2 million and 3.1 million people living with HIV. In 2008 the figure was estimated to be 2.31 million. In 2009 it was estimated that 2.4 million people were living with HIV in India, which equates to a prevalence of 0.3%.

While this may seem low, because India's population is so large, it is third in the world in terms of greatest number of people living with HIV. With a population of around a billion, a mere 0.1% increase in HIV prevalence would increase the estimated number of people living with HIV by over half a million.

Recent estimates agreed by United Nation AIDS (UNAIDS), the World Health Organisation (WHO) and NACO, India's government body responsible for HIV/ AIDS management, suggest that HIV prevalence among 15-49 years old in India is approximately 0.36 percent, which amounts to between 2 million and 3.1 million people living with HIV (NACO, 2010). This rate is relatively low in global terms or current global terms and is not typically considered as generalized epidemic, which would imply that the whole population was at risk and that prevention efforts should be targeted at society as a whole. The pattern of prevalence suggests that HIV is first of all predominantly affecting particularly vulnerable groups such as FSWs (Female Sex Workers), Injecting Drug Users (IDUs) and Men Who Have Sex With Men (MSM) and is likely to spread, initially to bridge populations (such as clients of sex workers) truck drivers, migrant labour (mobile population) and subsequently to the 'general population', (NACO, 2010). The single national prevalence figure masks a great range in prevalence between different geographical areas and social groups, with some groups in some areas severely affected (Becker et al., 2007).

Karnataka is the eight largest state in the country in terms of both geographical areas and a population of 52.8 million Karnataka Profile 2009 (2001 census). Presently, Karnataka is one of the sixth highest HIV-prevalence states in India. The number of HIV infected individuals in the state has seen a steady increase in the last ten years. The number of HIV infected women is also on the rise. Till 2005, a total number of 1, 11,608 AIDS cases were reported in India (NCAR and NACO 2004-2005). The first case of AIDS in Karnataka was identified in 1988 (Karnataka Profile 2009) Karnataka with other HIV high-prevalence states, clearly indicates that the prevalence rates in the attendees of Sexually Transmitted Diseases (STDs)

Causes of HIV/AIDS

HIV generally affects those who are sexually active. Broadly speaking, these are people aged 15-45, though it is acknowledged that people can have sex before the age of 15 and after the age of 45.

Sex Workers or Prostitutes: The HIV virus is primarily transmitted from one person to another through sexual activities. There are various categories of persons who are vulnerable to HIV infection through sexual contacts. In every culture, and society one does come across sex workers. They are mostly women who sell their bodies for a price (money). Some men may also involve in male prostitution. There are various forms of sex work:

- **Organized Sex Work:** In big cities and towns, they live in certain areas known as Red Light Areas or Red Light Districts. Women who practice prostitution live in groups in such areas. There are also sex workers who live in brothels. Brothel keepers may keep them in brothels by force. They have no freedom to go out of the brothel premises. Very often they have to provide sexual satisfaction to several men in a day.
- **Call Girls:** The second category is call girls. Call girls are those who live a more comfortable life. They usually serve customers in their homes or hotels and earn handsome amount.
- **Religious Traditions:** There is also another group of young girls who are called Devadadis. These are young girls usually from very poor families who are offered to temples. Almost always, these dancing girls are sexually exploited and they also become sex workers later in their lives. It is a common practice in northern parts of Karnataka and several other states in India.
- **Eunuchs:** Involvement of eunuchs in the flesh trade is not a new phenomenon in our country. They are a high-risk group in India today. They are estimated to be over one million in India. They run brothels that serve particularly the homosexuals and also cater to bisexuals.
- **Sperm Donors:** There are some documented cases from various parts of the world where HIV has been transmitted through artificial insemination. People who donate sperm can also pass on HIV if they are infected. There are several sperm banks located in various parts of

the country. The usual donors of the sperm in the country are poor laborers, beggars or street vendors who make a living out of it. Many drug addicts also donate sperms for a price to buy drugs.

Blood Transfusion

Of all the forms of exposure to HIV, blood transfusion is the most effective means of transmitting the virus from person to person. No barrier of any kind exists between the infected person and the individual who receives contaminated blood directly into the blood stream. Instruments like scalpels or suture needles, if contaminated with infected blood can transmit the infection. Similarly needles that have blood stains on them can transmit the infection. Sometimes injuries that occur with broken glass vials containing infected blood or serum can transmit the infection.

Intravenous drug use (IVDU)

Intravenous drug use acts as a source of transmission of HIV because drug users frequently share syringes and needles to inject drugs. These instruments are not sterilized before use. Small volumes of contaminated blood remains inside previously used needles and syringes thereby providing opportunities to transmit the virus via their blood contents. Since the disease was first seen among the homosexual males, it was believed that their behavior put them at a risk. It was felt that the immune system was being exhausted due to constant stimulation of immune system by various types of foreign proteins present in the semen. Similarly it was felt that

patients with hemophilia were exposed due to repeated transfusions. This concept did not explain the occurrence of the disease among IVD users. IVD users may have used drugs, which may have some toxic substances. It was thought that the immune deficiency was due to toxic reactions to these substances.

Organ transplantation

HIV can be transmitted through infected organs. HIV is found in the blood as well as the tissue of an infected organ. Before any organ is transplanted the donor has to be screened for HIV. In cadaver (removal of organs from brain dead patients) transplantation, the donor has to be checked. This route of transmission is very rare in practice. Since an infected person's body fluids contain HIV it is essential that screening for HIV is carried in cases of organ transplantation of any kind such as kidney, bone marrow, eyes, skin, semen etc.

Patients Suffering from Blood Disorders

Patients who suffer from various blood disorders like various types of anemia, especially Thalassemia or Leukemia require multiple transfusions. We have already discussed about bleeding disorders like Hemophilia. Patients may need multiple transfusions. They are at risk to contract the infection if untested blood is used. Measures that can reduce the need for transfusion in these patients can prevent the infection from spreading.

Hemophilia: Hemophiliacs are born with an inherited bleeding disorder and are exclusively males. This disorder is determined genetically, it results in poor clotting of blood, There is an absence of a single protein that is involved in coagulation. The theory did not explain the occurrence of the disease among the hemophiliac's and among children. As the disease was seen in various groups, it was postulated that an infectious agent might have caused the disease. Studies among gay men revealed that they had multiple sex partners. It strengthened the search for an infectious agent. It is easy to identify bacterial agents. Since bacteria were not identified, a viral agent was sought.

The infection is gradually spreading from urban to rural areas and from high risk groups to women who are mostly in monogamous marriages. Newman and Sarin (2006) have shown that having sex exclusively with one's husband was the only HIV risk factor for the majority of women. The presence of other sexually transmitted infections (STI's) and inflammation of the genital mucosa increase vulnerability to HIV infection in women through heterosexual vaginal intercourse (Fleming, et al, 1999). Women are frequently forced to tolerate abuse, violence and infidelity from their husbands (Soloman, et al, 2003). When they engage in sex, their lack of knowledge about their own sexual health, ignorance about their regular partner's and the continued culture of silence make them unable to negotiate safer sex practices. The NFHS - 3(2005-6) found that only 61 per cent of women ages 15 to 49 had heard of AIDS, compared with

84 per cent of men. Only smaller percentages (20 per cent of women and 36 per cent of men) had comprehensive and correct knowledge of HIV/AIDS. The prevalence of HIV among ever married women is higher than the national average (NACO, 2010). Since most HIV transmission in women in recent times takes place within marriage. AIDS is one of the extraordinary kinds of crisis of the humankind today. It can be understood that no region of the world has been out of this danger. AIDS killed almost three million people in a single year 2003. So far more than 20 million people died since the first cases of AIDS were identified in 1981. Throughout the world, the number of people living with HIV continues to grow from 35 million in 2001 to 38 million in 2003. AIDS is not only a physical disease, but it has multidimensional consequences. As Kofi Annan, previous UN General Secretary rightly mentions “AIDS is far more than health crises. It is threat to development itself”.

Affected population

The majority of the reported AIDS cases occurred in the sexually active and economically productive 15 - 49 year age group. Although HIV/AIDS is still largely concentrated in at risk populations, including commercial sex workers, injecting drug users, and truck drivers, the surveillance data suggests that the epidemic no longer confined, but is moving beyond these groups in some regions and into the general population through bridging population. It is also moving from urban to rural districts. The epidemic continues to shift towards women and young people. It has been estimated that 38% of adults

living with HIV/AIDS in India at the end of 2003 were women. In 2004, it was estimated that 22% of HIV cases in India were house wives with a single partner. The increasing HIV prevalence among women can consequently be seen in the form of increased mother to child transmission of HIV and pediatrics HIV cases.

According to the 1993, National Sample Survey in India, 24.7% of the population had migrated, either within India, to neighboring countries or overseas. Applying this percentage to the mid – 2003 population about 264 million Indians are mobile. Being mobile in itself, does not present a risk factor for HIV transmission. The migrants often live in unhygienic conditions in urban slums. Long working hours, relative isolation from the family, and geographical mobility may foster casual sexual relationships that make them highly vulnerable to STDs and HIV/AIDS. Migrant workers tend to have little access to HIV/STD information, voluntary counseling and testing, and health services. Regionalism, as well as cultural and language barriers cuts their access to such services. Returning or visiting migrants, many of who do not know their status, may infect their wives or other sexual partners in their home community.

India has one of the largest road networks in the world and an estimated 2 to 5 million long distance truck drivers and helpers are part of this network. The extended period of time that they spend away from their families placed them in close proximity to “high risk” sexual networks, and often results in

their increased number of sexual contacts. During their journeys the driver often stop at 'dhabas', roadside hotels that usually provide food, rest, sex workers, alcohol and drugs. They pick up the women, have sex with them and leave them at some other 'dhabas', where they encounter other drivers, get picked up and get used by other drivers and local youth. As a result truck drivers also play a crucial role in spreading STDs and HIV throughout the country. Women are more vulnerable because of their lack of access to health services, their lack of status within the family, their inability to talk or make decisions about sex. Additionally, the fact is that semen contains an extremely high concentration of HIV- far more than vaginal fluids - and because women frequently have undiagnosed episodes of STI's (Sexually Transmitted Infections), HIV can pass into the bloodstream more easily.

In India, where cultural constraints and social taboos impose great secrecy regarding sexuality, marital status is very closely related to HIV transmission in women. Women are vulnerable to HIV infection and their biological susceptibility at least two to four times greater than men's- is compounded by social, Cultural, economic and legal discrimination or inequalities. AIDS affects the poorest, the most vulnerable, and the most uneducated. And women often constitute the poorest of the poor, the most vulnerable due to their low status and more likely to be illiterate than men. Women depend on their partners for protection and to use of condoms. In a marriage, a woman can risk accusations of infidelity or even violence if she insists on using condoms. In a country like India, where

the woman's opinion is often ignored; neither her knowledge nor her awareness can offer her protection. 90 percent of female infections occur within marriage, women who stand up to their husbands risk violence-and those who get infected by their husbands are often shunned by their families. Lacking other skills, they may survive by selling sex - which, of course, spreads the disease further. According to the 2010 report of the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2010) sexual intercourse is the primary mode of HIV transmission in India, accounting for about 90 per cent of new HIV infections. More than 90 per cent of infected women acquired the virus from their husbands or intimate partners. In most cases, women are at an increased risk not due to their own sexual behavior, but because their partners are IDU's (Injecting drug users) or also having FSW's or MSM as other sex partners.

India is experiencing multiple epidemics. More than 100 districts have sentinel sites reporting sero prevalence of more than 1% among women visiting antenatal clinics. The epidemic is slowly moving beyond its initial focus among sex workers. Sub epidemics are evolving with potentially explosive spread among groups of injectable drug users (IDUs) and among Men having Sex with Men (MSM). It is now seen in all age group and sexual route is the major cause of transmission. The number of women is far on the increase.(UNAIDS, 2010).In Karnataka the mean prevalence among ANC's was 1.13 % in 2001 and 1.75% in 2002. In 2001 there were four districts with an ANC prevalence of 2 percent

or more, and these are located in the southern part of the state, in and around Bangalore, bordering with Tamil Nadu, or northern Karnataka's "*Devadasi* belt". *Devadasi* women are a group of women, who historically, have been dedicated to the service of gods. Over the years, this evolved into sanctioned prostitution – as a result many women from this part of the country are supplied to the sex trade in big cities such as Mumbai. (UNAIDS, 2010)

Biological, socio-cultural and economic- factors make women and young girls more vulnerable to HIV and AIDS. The HIV virus is more easily transmitted from men to women than from women to men. Male-to-female transmission during sex is about twice as likely as female to-male transmission. In India, the low status of women, poverty, early marriage, trafficking, sex-work, migration, lack of education and gender discrimination are some of the factors responsible for increasing the vulnerability of women and girls to HIV infection. Biologically, young women appear to be more susceptible to HIV infection than older women; gender inequality and poverty are responsible for the spread as well as disproportionate impact of HIV and AIDS on women.

Effects of HIV/AIDS

Fear and Shame: Fear and shame may prevent PWHIV (people with HIV) from confiding in others and gaining support; they may also be reluctant to seek help from AIDS organizations and the rehabilitation system. Fear can arise in

the infected person from the unpredictable nature of the disease. Fear can aggravate depression symptoms and lead to feelings of hopelessness, frustration and being overwhelmed. Fear can also ~rise in others, with fears of contagion or fears of a person's death, therefore leaving the person with HIV with a deep sense of isolation and loss. HIV has been called a Disease of Losses. Sadness is one outcome of experiencing repeated losses. People with HIV/AIDS may have to grieve the loss of deceased lovers, children and friends while at the same time mourning the loss of their own future. Losses can include loss of partner, family, friends, co-workers, mobility, strength, weight, appetite, and physical attractiveness.

Anger: The person with HIV disease may blame: themselves for getting infected and the resulting physical and mental loss: at family for not being able to do anything; at one's support system for lack of understanding, empathy or compassion; at society for their rejection; and the medical establishment, for failing to find a cure. The fluctuating nature of HIV disease and the interface with the health care delivery system can cause anger. The need to stay in control can sometimes produce behavior such as quarreling, arguing, complaining, or being demanding.

Depression: Feelings of depression can be expected and surface as feelings of discouragement, dejection, or helplessness. Signals that depression is being experienced, include disturbance in sleep, appetite changes, withdrawal from all activity, failure to find pleasure in favorite activities,

or difficulty in concentration. If depression is unresolved, a maladaptive coping strategy is; Substance abuse or attempted suicide. Psychological causes can include the anticipation of dying and death; the loss of friends, lovers, parents, or children; the possibility of becoming disabled; and the discomfort of becoming increasingly dependent on others.

Feelings of Dependency: Feeling of dependency can be experienced by people with disabilities arising from a loss of functional capacity in both physical and emotional areas. Being dependent on others brings on threats to autonomy, privacy, control, independence and feelings of helplessness and vulnerability that are often intolerable. This can have the effect of being unwilling to ask for accommodation- because of change in identity; feelings of shame, not wanting feel different or pitied.

Hope :Not all emotional responses to HIV/AIDS are negative. For people with HIV/AIDS, maintaining hope is not merely a virtue, but a primary task. It appears -that people actually live longer when they can hope for and plan future activities, achievements and relationships. Hope sustains them through the inevitable "bad days" and increases the capacity to appreciate periods of good health. Feelings of hope fluctuate daily, and sources of hope differ from person to person. Hope can be engendered by developing or maintaining spiritual practices such as organized religion and meditation. Hope is sustained by maintaining employment and relationships with co-workers; becoming involved in activist groups; cultivating

social and family ties, and finding meaning in new roles or new experiences. The most important factor in maintaining hope is active participation in decision-making. Any intervention that enables a person with HIV /AIDS to feel in greater control of their healthcare and activities strengthens their feelings of hope.

New lease on life for People with HIV: For those people whose lives are being lengthened by protease inhibitors, hope for living longer can be a two-edged sword. Along one edge, there is hope for extended life; along the other edge is that they now have to think about living, about going back to work (after having adapted to the idea they might never work again, let alone live), economic survival, insurance problems, and/or medical benefits' problems.

*HIV as Crises:*At any point along the HIV continuum, an individual can experience a crisis and the appearance of any symptom can trigger a crisis. Crisis disrupts the emotional homeostasis of an individual and challenges their ability to cope with the new stressors of each progressive stage. The majority of PWHIV are able to manage their emotional disequilibrium without excessive emotional, behavioral, or interpersonal disturbance. However, as many as 20 percent are less able to manage their distress. (Fishman & Crawford, 1996)

Those who become more emotionally distressed believe that they are extremely vulnerable and feel less equipped to cope

with the challenges they face. In addition, feelings of helplessness and hopelessness are present along with cognitive distortions, misinterpretations and a poor sense of personal control. Anxiety, depression and anger can easily escalate stress.

Social Withdrawal: Persons withdrawing from sexual and loving relationships to protect themselves from discrimination. This specific behavior took place because the PLWHA made the choice to withdraw and not because the community isolated them. The PLWHA isolate and keep to them or deny others access to their homes Greeff. Mimic et. al., (2008)

Self Exclusion: This dimension is defined as the process by which a person decides not to use services due to being HIV positive and fearing discrimination or attend community activities. The findings observed that this behaviour was seen in a social context by PLWHA not attending community activities but also excluding themselves from health services.

Fear of Disclosure : This refers to all behaviours related to revealing the HIV status of the person. This was the second highest subcategory verbalized by the respondents. They set many barriers to disclose that varied from denial, keeping it a secret, fear of the community's reaction as well as to whom, when and what to disclose, Risk is the “probability that a person may acquire HIV infection” (UNAIDS, 1998).

Epidemiological features:-

Agent factors-

- Agent – HIV virus (Human immune deficiency virus)
- Reservoir of infection- Once the person is infected the virus remains in the body life- long. The risk of developing AIDS increases with time. Since HIV infection can take years to manifest itself, the symptomless carrier can infect other people for years.
- Source of infection- The virus has been found in greatest concentration in blood, semen, CSF. Lower concentration in saliva, tears, breast milk and urine.

Host factors

Age – Most cases have occurred among sexually active persons aged 20-49. This group represents the most productive members of society.

Sex- Certain sexual practices increase the risk of infection more than others eg. homosexuals, bisexual men, anal intercourse, multiple sex partners.

High risk groups- homosexuals, heterosexual partners, intravenous drug abusers, blood and blood products , people with STD are the high risk groups.

Immunology- Those who are having immune system disorders associated with HIV infection

Mode of transmission

Sexual transmission- AIDS is first and foremost a sexually transmitted disease. Every single act of unprotected intercourse with an HIV infected person exposes the uninfected partner to the risk of infection. The size of the risk is affected by a number of factors including the presence of STD, the sex and age of the uninfected partner, the type of sexual act etc. Women are more vulnerable to HIV infection because more surface is exposed and semen contains higher concentration of HIV than vaginal or cervical fluid.

Blood contacts- AIDS is also transmitted by contaminated blood transfusion. The risk of getting an infection through contaminated needles, skin piercing instruments is very much lower than with transfusion.

Mother foetal transmission – HIV may pass from an infected mother to her foetus, through the placenta or during delivery or by breast feeding. The risk of infection transmission is higher if the mother is newly infected or she has already developed AIDS.

Incubation period:- The natural history of HIV infection is uncertain. The virus can be silent in the body for many years. It is estimated that 75 per cent of those infected with HIV will develop AIDS by the end of ten years.

Clinical symptoms:-

Major signs

- Weight loss more than ten per cent of the body weight

- Chronic diarrhoea for more than one month
- Prolonged fever for more than one month

Minor signs

- Persistent cough for more than one month
- History of herpes zoster – skin blisters
- Chronic skin inflammation
- Soreness and redness on the tongue, mouth and throat.
- Recurrent skin infections

Clinical manifestations:-Clinical features have been classified into 4 broad categories:

- Initial infection – Most HIV infected people have no symptoms for the first five years. Only mild infections like fever, sore throat, rashes etc. for few weeks after the initial infection with the virus.
- HIV antibodies usually take between 2 to 12 weeks to appear in the blood stream, sometimes 6 months or more than one year.
- The period before antibodies are produced is known as window period. Asymptomatic carrier state
- No symptoms. Not clear how long the asymptomatic carrier state lasts.

AIDS related complex-

- Unexplained diarrhoea for more than one month
- Loss of weight more than 10 per cent of the body weight
- Fever

- Night sweats
- AIDS
- It is the end stage of infection.
- Number of infections commonly occur.

TESTS:- ELISA- HIV enzyme linked immuno sorbent assay (screening test).And Western Blot- confirmatory test

Control of AIDS:-There are four basic approaches:

Prevention: Education – Enable people to make life saving choices (using condoms, avoid extra marital sex etc.). Educational material and guidelines for prevention should be made widely available. All mass media channels should be involved in educating the people on AIDS. And also the Prevention of blood borne HIV transmission.

Anti retroviral treatment-Antiviral chemotherapy suppress the HIV infection. It will prolonging the life.

Specific prophylaxis-Therapies will be to treat the manifestations of AIDS.

Primary health care- Mother and child health care.And Family planning and education.

Reasons for pre/post test counseling: Counseling provides an opportunity to educate people about the risk of transmission and to promote behavior change that will prevent further transmission of HIV.To help people to make considering the advantages and disadvantages of testing.

Post test counseling

- The main purpose is to give result.
- Help the patient to consider the implications for himself and others, in the immediate future and afterwards.
- It is important to convey some measure of hope and at the same time not to give false reassurance.
- Information about medical follow-up and treatments should be given. This helps to maintain feeling of hope.
- Health education- to discuss about preventing HIV transmission to others, protecting himself from acquiring new infections, the counselor should stress the importance of eating nutritious food and taking sufficient rest.
- After getting the result some patients seems to be very depressed and may have suicidal thoughts.
- To reassure the patient that there will be time for further discussion and continued contact. (follow up counseling)
- The counselor should summarise what has been discussed in the session and highlight important areas covered and need to be attended in future meetings.
- to arrange a future testing time or to discuss how to avoid high risk situation
- The counselor should communicate HIV cannot cure and provide more optimistic information about the successful treatment of many associated infections.

Terminal stage counseling

- Whether the cause of his death to be kept as confidential or disclose with others.
- Organizing and settling legal and financial matters.
- Resolution of past relationship, conflicts and difficulties.
- Dealing the dependency stage
- Talking about death
- Coming to terms with the death
- Feeling of hope and hopelessness
- Saying good bye.

Bereavement counseling

- Aim- to help the bereaved to reach a point in a comfortable way and plan for the future.
- The bereaved people can be helped to think about the changes and losses they are experiencing as a result of expired person.
- Information about the transmission of infection can be provided at this stage. Some bereaved people may have lack of knowledge about this or have unresolved fears.

Psychological reactions to AIDS

- Afraid
- Fear and anxieties-
- Losing their partners, families, friends and colleagues, fear of sexual contact, fear of infecting others
- Rejection and humiliation
- Being disabled and physically disfigured
- Losing control of one's mind and of one's life itself.

- Being known as a person dying of AIDS.
- Being denied medical and dental treatment and life insurance facilities.
- Losing jobs, promotion, and accommodation. As a result of fear and anxieties, depression sets in with anger against others and often the patient thinks of suicide.

Behavioral reactions to AIDS

- Denial – it helps the person not to be panic about the illness at least for some time.
- Helps the person to adjust himself.
- Revengeful attitude-
- They will recklessly engage in sexual activities with many partners.
- Such persons do not seek the assistance from professional people.

Counseling

- Instead of talking about AIDS, we could speak of HIV infection because many who have been infected with HIV have not yet moved into the full-blown AIDS.
- Instead of talking about persons dying of this viral infection we could speak of living with this infection.
- Instead of saying terminal illness we could speak of life-threatening illness. Since the term terminal speaks of the sickness in terms of finality without any hope which betrays our attitude towards this illness and death itself.

- Instead of speaking about risk group we could speak of risk activities since all the sexually active persons are at risk.
- The AIDS patients usually go through all the trauma of a dying person in ordinary circumstances and hence whatever skills of counseling we make use of for the dying person is really applicable to the AIDS patients too.

PART – V

Therapeutic Counseling in various areas

Counseling for Chemically dependent Clients

(Addiction Counseling): Addiction can be defined as any behavior or the use of any substance that is controlling a person's life. These include alcohol, drugs, sex, and eating disorders. Effective addiction counseling skills can help treat addictions.

Addiction Counseling Skills: Of all the addiction counseling skills, the most important is the ability to listen. But it's not as simple as it may seem. When talking with others, do you find yourself really listening, or do you immediately jump in with advice and/or your own stories? Are you able to listen to people without judging them, no matter what they say? As social and analytical beings, it takes practice and skill to become effective listeners. An addiction counselor should also have an enhanced sense of intuition and empathy. This follows the initial task of being a good listener. Intuition is needed to know where and when to probe a certain subject with a client; empathy is needed to fully understand where the client is coming from. Contrary to what some believe, intuition and empathy can be learned skills, if one is determined to work at it.

In general, duties of addictions counselors:

- work with clients from diverse cultures and lifestyles who have eating disorders or are addicted to alcohol, drugs, gambling, sex or tobacco
- assess client strengths, problem areas, the severity of dependence and readiness to change
- develop client treatment plans that are based on research, clinical experience, and client history
- provide information about addiction issues and about available services and programs and make appropriate referrals where necessary
- conduct information sessions and therapy groups as required
- counsel affected individuals and family members through all stages of recovery using appropriate intervention strategies and treatment approaches
- review, evaluate and document client progress
- provide aftercare and follow up as appropriate
- develop public education, prevention, and health promotion programs
- work with organizations, institutions, and communities to develop, implement and evaluate health and wellness programs.

Personal Characteristics : Addiction counselors need the following personal characteristics:

- emotional maturity and a balanced, healthy lifestyle
- patience
- tolerance for beliefs and values that are not their own

- the belief that individuals, families, and communities have the ability to make changes with support
- excellent communication and presentation skills
- the ability to manage time effectively.

Suicide prevention

Suicide prevention is an umbrella term for the collective efforts of local citizen organizations, mental health practitioners, and related professionals to reduce the incidence of suicide. Beyond just direct interventions to stop an impending suicide, methods also involve a) treating the psychological and psychophysiological symptoms of depression, b) improving the coping strategies of persons who would otherwise seriously consider suicide, c) reducing the prevalence of conditions believed to constitute risk factors for suicide, and d) giving people hope for a better life after current problems are resolved. General efforts have included preventive and proactive measures within the realms of medicine and mental health, as well as public health and other fields. Because protective factors such as social support and connectedness, as well as environmental risk factors such as access to lethal means, appear to play significant roles in the prevention of suicide, suicide should not be viewed solely as a medical or mental health issue.

Specific objectives :

- Promote awareness that suicide is a public health problem that is preventable
- Develop broad-based support for suicide prevention

- Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services
- Develop and implement community-based suicide prevention programs
- Promote efforts to reduce access to lethal means and methods of self-harm
- Implement training for recognition of at-risk behavior and delivery of effective treatment
- Develop and promote effective clinical and professional practices
- Increase access to and community linkages with mental health and substance abuse services
- Improve reporting and portrayals of suicidal behavior, mental illness and substance abuse in the entertainment and news media
- Promote and support research on suicide and suicide prevention
- Improve and expand surveillance systems

Specific strategies: Various specific suicide prevention strategies have been used:

- Selection and training of volunteer citizen groups offering confidential referral services.
- Promoting mental resilience through optimism and connectedness.
- Education about suicide, including risk factors, warning signs and the availability of help.

- Increasing the proficiency of health and welfare services at responding to people in need. This includes better training for health professionals and employing crisis counseling organizations.
- Reducing domestic violence and substance abuse are long-term strategies to reduce many mental health problems.
- Reducing access to convenient means of suicide (e.g. toxic substances, handguns).
- Reducing the number of dosages supplied in packages of non-prescription medicines e.g. aspirin.
- Interventions targeted at high-risk groups.
- Research.

It has also been suggested that news media can help prevent suicide by linking suicide with negative outcomes such as pain for the suicide and his survivors, conveying that the majority of people choose something other than suicide in order to solve their problems, avoiding mentioning suicide epidemics, and avoiding presenting authorities or sympathetic, ordinary people as spokespersons for the reasonableness of suicide.

Interventions: Many methods of intervention have been developed to intercede before suicide is attempted. The general methods include direct talks, screening for risks, and lethal means reduction. Each is explained in more detail below.

Direct talks: The World Health Organization has noted a very effective way to assess suicidal thoughts is to talk with a

person directly, to ask about depression, and assess suicide plans as to how and when it might be attempting. Contrary to popular misconceptions, talking with people about suicide does not plant the idea in their heads. However, such discussions and questions should be asked with care, concern and compassion. The tactic is to reduce sadness and provide assurance that other people care. The WHO advises to not say everything will be all right nor make the problem seem trivial, nor give false assurances about serious issues. However, some people who have talked about suicide have later attempted it, so the discussions should be gradual and specifically when the person is comfortable about discussing his or her feelings.

Screening: National Suicide Prevention Lifeline, a nationwide crisis line in the United States also available in Canada. The U.S. Surgeon General has suggested that screening to detect those at risk of suicide may be one of the most effective means of preventing suicide in children and adolescents. There are various screening tools in the form of self-report questionnaires to help identify those at risk such as the Beck Hopelessness Scale and Is Path Warm?. A number of these self-report questionnaires have been tested and found to be effective for use among adolescents and young adults. There is however a high rate of false-positive identification and those deemed to be at risk should ideally have a follow-up clinical interview. The predictive quality of these screening questionnaires has not been conclusively validated so it is not possible to determine if those identified at risk of suicide will actually commit suicide. Asking about or screening for suicide does not appear to increase the risk. In approximately

75 percent of completed suicides, the individuals had seen a physician within the year before their death, including 45 to 66 percent within the prior month. Approximately 33 to 41 percent of those who completed suicide had contact with mental health services in the prior year, including 20 percent within the prior month. These studies suggest an increased need for effective screening.

Lethal means reduction: Means reduction, reducing the odds that a suicide attempter will use highly lethal means, is an important component of suicide prevention. For years, researchers and health policy planners have theorized and demonstrated that restricting lethal means can help reduce suicide rates, as delaying action until depression passes. One of the most famous historical examples, of means reduction, is that of coal gas in the United Kingdom. Until the 1950s, the most common means of suicide in the UK was poisoning by gas inhalation. In 1958, natural gas (virtually free of carbon monoxide) was introduced, and over the next decade, comprised over 50% of gas used. As carbon monoxide in gas decreased, suicides also decreased. The decrease was driven entirely by dramatic decreases in the number of suicides by carbon monoxide poisoning. A photo illustration produced by the Defense Media Agency on suicide prevention. In the United States, numerous studies have concluded that firearm access is associated with increased suicide risk. Because guns are quick and more lethal than other suicide means (about 85% of attempts with a firearm are fatal, a much higher case fatality rate than for other methods), they are often a major driver of suicide rates.

Treatment: There are various treatment modalities to reduce the risk of suicide by addressing the underlying conditions causing suicidal ideation, including, depending on case history, medical pharmacological and psychotherapeutic talk therapies. The conservative estimate is that 10% of individuals with psychiatric disorders may have an undiagnosed medical condition causing their symptoms, upwards of 50% may have an undiagnosed medical condition which if not causing is exacerbating their psychiatric symptoms. Illegal drugs and prescribed medications may also produce psychiatric symptoms. Effective diagnosis and if necessary medical testing which may include neuroimaging to diagnose and treat any such medical conditions or medication side effects may reduce the risk of suicidal ideation as a result of psychiatric symptoms, most often including depression, which is present in up to 90-95% of cases.

Recent research has shown that Lithium has been effective with low. The risk of suicide in those with bipolar disorder to the same levels as the general population. Lithium has also proven effective in lowering the suicide risk in those with unipolar depression as well. There are multiple evidence-based psychotherapeutic talk therapies available to reduce suicidal ideation such as dialectical behavior therapy (DBT) for which multiple studies have reported varying degrees of clinical effectiveness in reducing suicidality. Benefits include a reduction in self-harm behaviors and suicidal ideations. Cognitive Behavior Therapy for Suicide Prevention (CBT-SP) is a form of DBT adapted for adolescents at high risk for repeated suicide attempts.

Respect of self-esteem: World Health Organization states that "worldwide, suicide is among the top five causes of mortality in the 15-to 19-years age group and in many countries it makes first or second as a cause of death among both boys and girls in this age group." and recommends "strengthening student's self-esteem" to protect children and adolescents against mental distress and dependency, and enables them to cope adequately with difficult and stressful life situations. and "prevention bullying and violence at school" that specific skills should be available in the education system to prevent bullying and violence in and around the school premises in order create a safe environment free of intolerance. and as well "to de-stigmatize mental illness"

Support groups: Many non-profit organizations exist, such as the American Foundation for Suicide Prevention in the United States, which serve as crisis hotlines. In addition, some groups such as To Write Love on Her Arms have been promoted using social media to reach more people.

Suicide Prevention: Suicide is the second leading cause of death among college students. In 2007 the suicide rate was 7.5 per 100,000 students; this translates into more than 1,000 completed suicides each year (National Institute of Mental Health, 2008). It is estimated that for every completed suicide there are 200-400 unsuccessful attempts. The American College Health Association's (2007) survey of college students found that 9.5% of students had seriously

contemplated suicide. With numbers like this, it is not 'if' an academic advisor will be faced with a student who has contemplated the option of suicide, it is 'when'. What sets the stage for a student to think suicide is an option is not always as clear as we would like. However, there are some patterns which can assist the advisor in more quickly identifying who might see self-destruction as an alternative. Twenge, et al (2009) report that all categories of mental illness are on the increase among college students with depression being called the 'royal road' to suicide. Furr, et al (2001) found that 53% of surveyed students reported they experience bouts of depression since entering college.

Depression: With depression a major factor in the development of suicidal options, the more advisors can be aware of the primary symptoms of depression, the more quickly appropriate actions can be implemented. A complicating factor is that the normal sadness which results from loss and transitions often looks much like depression. The primary difference is that the pain of depression is deeper, lasts longer, and impacts the individual's world in a more intense fashion. While counseling is certainly appropriate for those suffering from sadness, it is a must for those clinically depressed, especially since depression is an accurate predictor of suicidal thoughts and plans. The primary symptoms of sadness and depression include increasing emotionality. Women tend to exhibit their sadness more openly and clearly while men often show more irritation and frustration. The depressed find intellectual pursuits a

challenge as they have increased difficulty meeting the cognitive demands of an academic program and thus a lowering of motivation. The depressed student has problems taking in information and putting it out either verbally or in written form. Physically there is a sense of increased fatigue, changes in eating and sleeping patterns, and a reduction of sexual interest. Socially, depressed students have a tendency to withdraw from others. For the depressed who have difficulty intellectually, emotionally, and physically, it is doubly difficult to be around people. The few depressed who reach out ‘too’ much to others for assistance may find that friends and family push away because they are either overwhelmed by the student’s situation or do not know how to be of help. These symptoms tend to build up over time with an ebb and flow to their intensity. The depressed student often finds this confusing and not only difficult to cope with but quite difficult to explain to others. It can be difficult for the student to identify what exactly is the loss or change that has set the stage for these uncomfortable feelings. Students who experience the sadness or depression to a degree that their lives are in an uproar should be referred for counseling. For those students experiencing depression, counselors may suggest a visit to a physician for a medication evaluation.

Stress: Some students consider suicide because of the build-up of psychological stress. There are times of predictable stress for students such as the start of school, mid-terms, or final exams. Some are overwhelmed by unpredictable stress such as accidents, the death of a loved one, sickness of self or

others, or any other life situation which is troublesome. Probably the most common stress for college students is what can be called “exhaustion stress” when the student has experienced a number of life difficulties in a rather short period of time. Typically this student deals with each individual situation in a constructive manner, but gradually the reserves of emotional energy, cognitive strength, physical stamina, and social support become depleted. When the last event takes place, the student collapses in all areas because few internal or social supports remain to deal with the last situation. Ironically the “final straw” can seem quite minor to the student and others. Consequently, the student often feels doubly inadequate and confused. The open and accepting advisor can be of great assistance to the stress victim by being willing to help identify the stressors and offering an explanation as to why the last situation caused a serious break down of coping skills. As the total picture develops, the student will tend to understand the situation more clearly and not feel so emotionally discouraged. Consequently, the move into a suicidal position can be averted.

Characteristics of the suicidal student: Students contemplating suicide share some common personal characteristics including feeling

Helpless. This is probably the most common characteristic. The student has been experiencing deep pain and has been struggling to reduce that pain for some time but to no avail. He does not know what else to do. If this is true, then the

advisor must be willing to take an active, directive, supportive, and helpful stance.

Hopeless. Often the pain has been going on for so long with no relief, that the student is ready to give up on everything and everyone. From the student's perspective, there is little reason to live. Reasons to continue to live often require input from an outside resource. As an intervention, the advisor can help rebuild a student's sense of hope for life. Confused and having difficulty articulating what is happening: The student knows that something is amiss but is not able to clearly describe the internal processes taking place. Friends, family, and even instructors may find this confusion leads to them minimizing the seriousness of the situation. The advisor can help the student talk through the confusion.

Perfectionist: Acute perfectionism can set the stage for the student to see suicide as a viable resolution to pain experienced when his actions, or lack of action, fail to meet high standards. Since little or no action is taking place, the emotional pain continues to grow. Consequently, the advisor has an opportunity to help the student problem solve and see an alternative or more realistic solutions.

Isolated: Feeling helpless, hopeless, confused, and idealistic, the student contemplating suicide often has difficulty being with herself let alone seeing how others might want to be with her. It is common for the suicidal student to distance herself from others thus making it doubly difficult for others to be

supportive of her. The advisor can assist the student to reach out to others in a more realistic fashion and consequently re-create a helpful support system.

Ambivalence: This is a critical characteristic of all individuals who look at suicide as an option. In simple terms, self-inflicted death may be something thought about, planned for, and even attempted. However, there is also a life-sustaining element in operation for the suicidal; if someone is 100% suicidal he would already be dead. It is helpful during conversations to assist the student to talk about both sides of his ambivalence. The suicidal student needs the advisor to not minimize or deny the ‘death’ side; instead, he needs assistance in talking through reasons to stay alive. One could call this a pro/con discussion of the entire situation. From a practical perspective, conversations are never ended while the student is deeply connected with the ‘death’ option. Knowing that most students have these characteristics in one form or another provides advisors with a platform to guide difficult conversations. The characteristics also identify ways in which advisors can be constructively involved in assessing the risk of suicide. During the conversation, the advisor can offer help identifying the dominant source of pain, provide glimmers of hope that things can be changed or adjusted, assist in clarification of the situation so confusion is reduced, be realistic so expectations are not out of proportion, assist in improving connections with others thereby modifying the sense of isolation, and help the student see there are factors which support more life constructive actions.

Risk assessment: Advisors are not expected to function as therapists or counselors, however as a helping professional interacting with a student, there are some minimal standards for establishing how immediate is the risk for suicide (Paladino & Barrio Minton, 2008). Be willing to directly ask if the student is thinking about suicide. “I am wondering if you are in so much pain that you are thinking about suicide?” Don’t be afraid to be upfront with asking this question, it will not put the idea in a student’s head. If the student is thinking about suicide she may already be planning it. This question will not cause the ‘non-suicidal’ student to think that suicide is a solution to her problems. If the answer is “No”, the response can be “Good I am glad” and the conversation can then be directed back at some of the stressors which the student has identified. If the answer is “Yes”, then the counseling center should be called, the student walked to a counselor, or the campus suicide intervention plan should be triggered. (All academic advisors should be aware of their campus suicide prevention plan). Some students may make vague statements such as “My life is not worth living.” Or “I’m not sure there is any point anymore.” Here too it is important to ask “Are you thinking of killing yourself?” It is not unusual for a student to say “Things are so difficult that I have thought about it.” If the student is thinking that suicide is an option in the current situation then the actions prescribed by the campus suicide prevention plan should be implemented or a counselor called. It is not unusual for students who see suicide as a viable option to minimize the seriousness of their

thoughts or to reject counseling. The advisor must resist the temptation to go along with this hesitancy. It is critical that the advisor encourage the student to take positive steps to lessen the psychological pain at the base of any suicidal thoughts. For students resistant to taking action, the advisor must be willing to involve others. The student who is seriously at risk for suicide is not protected by confidentiality guidelines, so privacy should not be a factor in the advisor seeking consultation or making a counseling referral. Other viable actions for students who answer “yes” are to bring in the Dean of Students, a member of the institution’s Behavioral Assessment Team, or a campus security officer to mandate constructive action to protect the suicidal student from himself.

Successful referrals: As the conversation evolves the immediate risk of suicide will become clear. If there is a risk then the advisor must successfully refer the student to someone with psychological and/or counseling training. The more personalized the referral, the apter the student will follow up; when students meet counselors face-to-face then they are more apt to connect and follow through to work on the issues that caused the suicidal thoughts.

Counseling interventions: It is important to again highlight the fact that the typical academic advisor is not in a position to assume the role of counselor. However, it can be helpful when the advisor has a basic understanding of counseling interventions. The first goal of any intervention is to keep the

student safe. When counselors are brought in after a student has answered “yes” to the question “I am wondering if you are so much in pain that you are thinking about suicide?” the counselor most often will ask “I am wondering if you have plans for your suicidal thinking?” In many cases the answer to this question will be “No”. In these cases the response is usually “Good, I’m glad for that” but should be followed up with “I hope that if you ever do start making plans that you will stop and come to see me or someone else on campus.” In general, thinking about suicide as a problem solving option is quite common. Most who think of the option don’t have an action plan in place. Once it is established that a plan is not in place then the counselor can move the conversation to examining issues where the advisor can be of greater support. However, if the answer to “Do you have plans for suicide” is “Yes” then there is yet another line of questioning. When the answer is yes, as calmly as possible the counselor will state something like “I am interested in hearing the details of your plan” to better understand the risk. Again, it is important to understand that talking about it will NOT plant ideas in the student’s head. Typically the student is grateful that someone is not afraid to know the details of their suicidal option. When this happens the counselor pays careful attention to see if the student has planned for:

- Weapon (means) and its dangerousness
- Availability of the weapon
- When the act will take place.

This discussion will help the counselor understand the chance for rescue. If the student has a gun and plans to go off somewhere and use it, then the risk is high. If the student is going to take a handful of pills at home where others are present, the immediate risk is somewhat reduced. As this conversation proceeds the counselor will determine the intentionality of the student and will be able to better know how serious and how dangerous the threat to the student. The counselor will also find out if the student has previously attempted suicide and what were the outcomes any such incident. Additionally, the counselor will determine the level of alcohol or other chemical use as drug and alcohol use can increase impulsiveness. It is important to again highlight that most students will be appreciative of the counselor's willingness to ask these questions. Showing interest and remaining calm can increase the student's sense of hope and reduce his feelings of isolation. At this point the campus counselor may reach out to trained professionals beyond the campus community. This might mean in-patient hospitalization. Or it can mean finding friends or family to be with the student to insure personal safety. In some instances this requires that any weapon be removed from the student's access. For the student with intense depression and anxiety symptoms, medication may be prescribed as a part of any holistic treatment to reduce emotional pain. As the counseling progresses the student will learn coping skills, new ways to ask for help, and how to better cope with pain. As the student gains an increased sense of being heard, supported, and belonging, internal feelings of hope will result and suicide

becomes less likely. Counseling often focuses on increased understanding and personal insight. Changes in behavior reduce suicidal thinking and behavior.

Conclusion: Suicide on college campuses is a serious issue. Academic advisors by their very nature seek to establish warm, open, and supportive relationships with their advisees. As such advisors are often the first line of defense in identifying a student at risk for suicide and securing the help needed so that the student can confront and overcome these self-destructive thoughts. There is no expectation that counseling should be provided by advisors unlicensed in mental health counseling. However, as advisors become more aware of the underlying signs, symptoms and characteristics of suicidal students, it will be easier for the appropriate steps to be taken.

Definition of Health

The World Health Organization defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. It is the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs and, on the other hand,, to change or cope with the environment". Health as "a resource which gives people the ability to manage and even to change their surroundings...a basic and dynamic force in our daily lives, influenced by our circumstances, our beliefs, our culture and our social, economic and physical environments". This

active concept of health accords greater prominence than ever to the mental and social determinants of health. It also requires us to think of health as something experienced not only individually, but also collectively. Most significantly, this new understanding of health dwells less on people's traits as individuals and more on the nature of their interaction with the wider environment. "Environment" in this context is interpreted in its broadest sense and includes not only our physical surroundings, both natural and artificial but also the social, cultural, regulatory and economic conditions and influences that impinge on our everyday lives. In the past few decades,, there have been significant developments in our understanding of mental health. They have arisen from a growing community mental health movement and a body of social science research that places increasing importance on the ability of external forces and events to influence individual mental health. Social and economic situations, family and other relationships, the physical and organizational environment - all are plainly recognized as contributing factors. As a result, current concepts of mental health reflect a number of themes:

- psychological and social harmony and integration;
- quality of life and general well-being;
- self-actualization and growth;
- effective personal adaptation; and
- the mutual influences of the individual, the group, and the environment

The essential role of physiological processes (and, in particular, brain function) in all mental life has become more

and more evident. We now know that human biology and human experience interact continually in shaping mental life. Mental life embraces both inner experience and interpersonal group experience. Our interactions with others take place within a framework of societal values; therefore, any definition of mental health must necessarily reflect the kind of people we think we should be, the goals we consider desirable, and the type of society we aspire to live in. Social workers do not isolate ideas about mental health from such wider social values as the desire for equality among people, the free pursuit of legitimate individual and collective goals, and equitable distribution and exercise of power.

Definition of Mental Health: It is from this perspective that the following dynamic and interactive definition of mental health has been developed:

Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality. In this definition, mental health moves into the realm of the relationship between the individual, the group, and the environment. Mental health is no longer conceived of as an individual trait, such as physical fitness; rather it is regarded as a resource consisting of the energy, strengths, and abilities of the individual interacting effectively with those of the group and with opportunities and influences

in the environment. This conceptualization leads to certain conclusions about the factors that can enhance or weaken mental health. Whatever makes it difficult for the individual, the group and the environment to interact effectively and justly (for example, poverty, prejudice, discrimination, disadvantage, marginality or poor coordination of or access to resources) is a threat or barrier to mental health. A key feature of this new definition is that it does not define mental health in terms of the presence or absence of mental disorder, nor does it imply that mental health and mental disorder are simply opposite poles on a single continuum.

Mental Health

Health generally means sound condition or freedom from disease or freedom from mental disease. According to Hadfield, mental health is the full and harmonious functioning of the whole personality. It means the ability to balance feelings, desires, ideals and ambitions in one's daily living as well as the ability to face and accept the realities of life i.e. it has two aspects Individual and social.

Mental Health and Mental Hygiene: The modern concept of health extends beyond proper functions of the body. It includes a sound mind and controlled emotion. The expression mental health consists of two words.

The individual :The individual is internally adjusted, he is self confident, adequate and freed from internal conflict and tensions.

He adapts to the new situation. But he achieves this internal adjustment in a social set up. But the social forces are in a constant flux. Similarly the internal adjustment is also affected by various stresses. Thus mental health is a process of adjustment, which involves compromise, adaptation, growth and continuity. It can also be defined as the ability of the individual to make personal and social adjustments. Generally a, mentally healthy person has some insight into his motives and desires his weaknesses and strong points.

Mental hygiene: Just as physical health and hygiene are related so also mental health and mental hygiene are closely related. Mental hygiene is the branch of science which deals with the mental health of the individual. It consists of measures to reduce the incidents of mental illness through prevention and early treatment. As an organized program it has three main purpose.

- The prevention of mental disorder.
- Preservation and development of mental health.
- The removal of maladjustment.

Mental hygiene may be thus defined as the prevention of mental illness ,preservation of mental health and care of the mental illness.Mental hygiene is a means to an end and the end is mental health .(Cliford Beers ,The book that found itself)

Definitions: Karl Menninger (1947) defines mental health as "An adjustment of human beings to the world and to each other with a maximum of effectiveness and happiness". The American

Psychiatric Association (APA 1980) defines mental health as "Simultaneous success at working, loving and creating with the capacity for mature and flexible resolution of conflicts between instincts, conscience, important other people and reality". Thus mental health would include not only the absence of diagnostic labels such as schizophrenia and obsessive compulsive disorder, but also the ability to cope with the stressors of daily living, freedom from anxieties and generally a positive outlook towards life's vicissitudes and to cope with those.

Components of Mental Health: The components of mental health include:

The ability to accept self: A mentally healthy individual feels comfortable about himself. He feels reasonably secure and adequately accepts his shortcomings. In other words, he has self-respect.

The capacity to feel right towards others: An individual who enjoys good mental health is able to be sincerely interested in other's welfare. He has friendships that are satisfying and lasting. He is able to feel a part of a group without being submerged by it. He takes responsibility for his neighbors and his fellow members.

The ability to fulfill life's tasks: A mentally healthy person is able to think for himself, set reasonable goals and take his own decision. He does something about the problems as they arise. He shoulders his daily responsibilities, and is not bowled over by his own emotions of fear, anger, love or guilt.

Indicators of Mental Health: Jahoda (1958) has identified six indicators of mental health which include:

- **A positive attitude towards self:** This includes an objective view of self, including knowledge and acceptance of strengths and limitations. The individual feels a strong sense of personal identity and security within the environment.
- **Growth, development and the ability for self actualization:** This indicator correlates with whether the individual successfully achieves the tasks associated with each level of development.
- **Integration:** Integration includes the ability to adaptively respond to the environment and the development of a philosophy of life, both of which help the individual maintain anxiety at a manageable level in response to stressful situations.
- **Autonomy:** It refers to the individual's ability to perform in an independent self-directed manner; the individual makes choices and accepts responsibility for the outcomes.
- **Perception of reality:** This includes perception of the environment without distortion, as well as the capacity for empathy and social sensitivity—a respect and concern for the wants and needs of others.
- **Environmental mastery:** This indicator suggests that the individual has achieved a satisfactory role within the group, society or environment. He is able to love and accept the love of others.

Characteristics of a Mentally Healthy Person

- He has an ability to make adjustments.
- He has a sense of personal worth, feels worthwhile and important.
- He solves his problems largely by his own effort and makes his own decisions.
- He has a sense of personal security and feels secure in a group, shows understanding of other people's problems and motives.
- He has a sense of responsibility.
- He can give and accept love.
- He lives in a world of reality rather than fantasy.
- He shows emotional maturity in his behavior, and develops a capacity to tolerate frustration and disappointments in his daily life.
- He has developed a philosophy of life that gives meaning and purpose to his daily activities.
- He has a variety of interests and generally lives a well-balanced life of work, rest and recreation.

Mental Illness

Mental illness is maladjustment in living. It produces a disharmony in the person's ability to meet human needs comfortably or effectively and function within a culture. A mentally ill person loses his ability to respond according to the expectations he has for himself and the demands that society has for him.

In general an individual may be considered to be mentally ill if:

- The person's behavior is causing distress and suffering to self and/or others.

- The person's behavior is causing disturbance in his day-to-day activities, job and interpersonal relationships.

Definition: Mental and behavioral disorders are understood as clinically significant conditions characterized by alterations in thinking, mood (emotions) or behavior associated with personal distress and/ or impaired functioning. (WHO, 2001).

Characteristics of Mental Illness

- Changes in one's thinking, memory, perception, feeling and judgment resulting in changes in talk and behavior which appear to be deviant from previous personality or from the norms of community
- These changes in behavior cause distress and suffering to the individual or others or both
- Changes and the consequent distress cause disturbance in day-to-day activities, work and relationship with important others (social and vocational dysfunction).

Features of Mental Illness

The features of mental illness are classified under four headings

- Disturbances in bodily functions
- Disturbances in mental functions
- Changes in individual and social activities
- Somatic complaints

a. Disturbances in Bodily Functions

Sleep: Disturbed sleep throughout the night, or no sleep at all, or difficulty in falling asleep, or waking up in the middle of night and falling to fall asleep again. In addition, the individual may experience lethargy and lack of freshness in the morning.

Appetite and food intake: Increased appetite or decreased appetite, weight loss or weight gain, nausea, vomiting.

Bowel and bladder movement: Diarrhea or constipation, increased micturition, bed-wetting.

Sexual desire and activity: Decreased interest in sex, premature ejaculation, impotence or lack of sexual satisfaction. In some conditions there can be excessive sexual desire or lack of social inhibitions.

b. Disturbances in Mental Functions

Behavior: The patient may exhibit over activity, restlessness, irritability, may be abusive to others for trivial or no reasons at all, or The patient may become dull, withdrawn and not respond to external or internal cues. At times the patient may behave in a bizarre way which the family members may find irritating. Sometimes the patient's behavior can be dangerous to self or others.

Speech: Patient talks excessively and unnecessarily or talks very little or stays mute. The talk becomes irrelevant and un-understand-able (incoherent).

Thought: Patient expresses peculiar and wrong beliefs which others do not share.

Emotions: Patient may exhibit excessive emotions like excessive happiness, anger, fear or sadness. Sometimes emotions can be inappropriate to situations. He may laugh to self or weep without any reason.

Perception: The patient may perceive without any stimulus. There can be misinterpretation of perception. For example a mentally ill person can see things or hear sounds or feel objects which do not exist or which others do not see. This is known as hallucinations. A patient who is hallucinating is seen talking to self, laughing or weeping to self, wandering in the streets and behaving in a manner which others may find abnormal.

Attention and concentration: Patient may have decreased attention and concentration; he may get distracted easily, or have selective inattention.

Memory: Patient may lose his memory and start forgetting important matters.

Intelligence and judgment: In some mental illnesses, intelligence and the ability to take decisions deteriorate. Patient loses reasoning skills and abilities, may not be able to perform simple arithmetic, or commits mistakes in-routine work.

Level of consciousness: In some mental illnesses due to possible brain damage there may be changes in the level of consciousness. Patient fails to identify his “relatives. He can be disoriented to time and place. He may remain confused or become unconscious.

c. Changes in Individual and Social Activities

Patients may neglect their bodily needs and personal hygiene. The patient may also lose social sense. They behave in an inappropriate manner in social situations and embarrass others.

They behave strangely with their family members, friends, colleagues and others. They may insult, abuse/assault them.

d. Somatic Complaints

Patient may complain of aches and pains in different parts of the body, fatigue, weakness, involuntary movements, etc.

Common Signs and Symptoms of Mental illness

Disturbances in Motor Behaviour: Motor retardation, stupor, stereotypes, negativism, ambitendence, waxy flexibility, echopraxia, restlessness, agitation and excitement. Disorders of thought, language and communication Pressure of speech, poverty of speech, dysarthria, flight of ideas, circumstantiality, loosening of association, tangentiality, incoherence, perseveration, neologism, clang association, thought block, thought insertion, thought broadcasting, echo-lalia, delusions, obsessions and phobias.

Disorders of Perception

- Illusions, hallucinations, depersonalization, derealization.
- Disorders of emotion - Blunt affect, labile affect, elated mood, euphoria, ecstasy, dysphoric mood, depression, anhedonia.
- Disturbances of consciousness - Clouding of consciousness, delirium and coma.

- Disturbances in attention - Distractibility, selective inattention.
- Disturbances in orientation
- Disorientation of time, place or person.
- Disturbances of memory - Amnesia, confabulation.
- Impaired judgment
- Disturbances in biological function - Persistent deviations in temperature, pulse and respiration, nausea, vomiting, headache, loss of appetite, increased appetite, loss of weight, pain, fatigue, weight gain, insomnia, hypersomnia and sexual dysfunction.

Role of the social worker in mental health

Neurosis: The definitive symptom is anxiety. Neurotic tendencies are common and may manifest themselves as acute or chronic anxiety, depression, an obsessive-compulsive disorder, a phobia, or a personality disorder. Neurosis is a mental health problem best defined as a spectrum of personalities that have exceeded their natural inclination and temperament, giving way to an obsession with certain thought processes. Psychosis refers to a personality's break from reality. Symptoms: These may include palpitations, rapid heart rate, hyperventilation, muscle pain, abdominal pain, headache, numbness, and tingling. Symptoms of disorders that are considered a neurosis or neurotic disorder generally are severe enough to result in difficulties with interpersonal relationships. Neurotic disorders: Neurosis refers to a class of

functional mental disorder involving distress but not delusions or hallucinations, where behavior is not outside socially acceptable norms. It is also known as psychoneurosis or neurotic disorder. Neurosis, plural neuroses, also called psychoneurosis or plural psychoneuroses, a mental disorder that causes a sense of distress and deficit in functioning. Neuroses are characterized by anxiety, depression, or other feelings of unhappiness or distress that are out of proportion to the circumstances of a person's life.

A role for social workers in mental health was established early in Canada's history of service delivery in this field. Primary mental health care was institutionally based for the first half of the century, with a period of de-institutionalization beginning in the late sixties preceding the current emphasis on community-based care. Throughout these changes, the role of social work has developed from one of providing social histories and supervising community placements to that of interdisciplinary team member/independent practitioner. The field of mental health provides a unique opportunity for social workers to practice collaboratively with allied professionals and at the same time maintain the integrity of their knowledge and skill base. This document will define health and mental health; describe the current roles of social workers within the spectrum of mental health services; identify the necessary education and knowledge base, and consider future directions.

Social work role descriptions: Although formal mental health services are generally delivered through the public service in Canada, voluntary or private sector agencies, as well as private practitioners, also play major roles in most provinces. Social workers are involved at the micro, mezzo and macro levels in all sectors. "The social work profession promotes social change, problem-solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilizing theories of human behavior and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work." Many of the roles that social workers perform are common to all mental health disciplines. Specific to the domain of social work are roles of building partnerships among professionals, caregivers and families; collaborating with the community, usually with the goal of creating supportive environments for clients; advocating for adequate service, treatment models and resources; challenging and changing social policy to address issues of poverty, employment, housing and social justice; and supporting the development of preventive programs. Prevention occurs on many levels and includes a focus on early intervention, individual and public education, advocacy and improving access to services, resources and information.

Specific Roles: Mental health settings usually include services in three broad levels of health care application: prevention, treatment and rehabilitation. It is recognized that individual social workers may practice exclusively within one setting or

cross the boundaries of all three in response to diverse client, family and community needs.

Prevention : aims to reduce the incidence of disease or dysfunction in a population through modifying stressful environments and strengthening the ability of the individual to cope. Prevention involves the promotion and maintenance of good health through education, attention to adequate standards for basic needs and specific protection against known risks. In mental health settings, preventive activities include public and client education regarding emotional self-care and healthy relationships, building community knowledge and skills (community development), social action, and advocacy for social justice.

Treatment: aims to reduce the prevalence (number of existing cases) of a disorder or dysfunction and includes early diagnosis, intervention and treatment. In mental health settings, treatment activities are focused on individuals experiencing acute psychiatric symptoms, emotional trauma, relationship problems, stress, distress or crisis and include assessment, risk management, individual, couple, family and group counselling, intervention or therapy and advocacy. Social work uses relationship as the basis of all interventions.

Rehabilitation: aims at reducing the after effects of disorder or dysfunction, and involves the provision of services for re-training and rehabilitation to ensure maximum use of remaining capacities by the individual. In mental health

settings, rehabilitation activities focus on clients who are disabled by mental illness and may include individual, couple, family, and group interventions to build knowledge and skills, provision of specialized residential, vocational and leisure resources, and advocacy to ensure the development of needed services and to change community attitudes.

Specific to their employment setting, social workers in mental health deliver the following professional services:

- Direct Services to individuals, couples, families, and groups in the form of counseling, crisis intervention, therapy, advocacy, coordination of resources, etc.
- Case Management - coordinating inter-disciplinary services to a specified client, group or population.
- Community Development - working with communities to facilitate the identification of mental health issues and development of mental health resources from a community needs perspective.
- Supervision and Consultation- clinical supervision/consultation, maintaining quality and management audits and reviews of other social workers involved in mental health services.
- Program Management/Administration - overseeing a mental health program and/or service delivery system; organizational development
- Teaching - University and college level; workshops, conferences and professional in-services
- Program, Policy and Resource Development - analysis, planning, establishing standards

- Research and Evaluation
- Social Action

Since its inception, social work has focused on the social contributions to emotional well being and mental health. As healthcare moves towards a "population health" approach that emphasizes the importance of social and psychological determinants of health, social workers will continue to make a significant contribution to the healthcare/mental health team. Psychosis should be the concern of physicians in all clinical specialities. First, psychosis can be associated with diseases of every organ system and therefore may be a sign of an illness requiring medical rather than psychiatric treatment. Second, psychosis can be induced by pharmacologic treatments used in almost every area of medicine. It can also be caused by substances of abuse or by the withdrawal of a variety of drugs. Third, patients with psychosis often have concerns about their health and are likely to seek help from a family physician or an internist. Finally, individuals with psychiatric illnesses have the same health-care needs as the rest of the population and thus require the services of nonpsychiatrists. Consequently, an understanding of the nature of psychosis and a knowledge of its causes and treatment are fundamental to the practice of medicine.

Psychosis: Definitions: Psychosis is characterized by an adherence to fixed, false beliefs outside the normal range for a person's subculture, by a hallucinatory experience that is not recognized as such or by a formally defined disorder of thought. False beliefs that cause a person to suffer, that

produce conflict with others or that render a person unable to comfortably adapt to the demands of life are delusions if they are not relinquished when the person is presented with adequate evidence to the contrary. This definition allows for idiosyncrasy and for differences in the beliefs of a person's subculture from those of the majority of the population.

Organic vs. Functional Psychoses: Psychoses may be classified as organic or functional. In organic psychoses, structural or physiologic dysfunction directly or indirectly affecting the brain is known to cause the psychosis. In functional psychosis, behavior or experience is altered, but the cause of the pathologic state is not yet identifiable. Distinguishing organic from functional psychoses is essential. If the cause of psychosis is not recognized quickly, a patient may die because a potentially effective treatment is not given. For example, delirium, which is often accompanied by hallucinations and delusions, may be caused by a severe infection that is responsive to antibiotics.

Affective vs. Nonaffective Psychoses. Psychosis is a syndrome, and the predominant characteristics of the syndrome are used in determining its classification. The two major classes of psychosis are termed "affective" and "nonaffective." Both classes include organic and functional disorders. Affective psychoses are characterized by prominent disturbance of mood. Examples of the affective psychoses are major depression and mania with psychotic features. In contrast, schizophrenia is a nonaffective psychosis. Patients with schizophrenia may experience depression, but mood disturbance is not a core element in the clinical course of their

illness. Prescription agents and drugs of abuse may cause either effective or nonaffective psychoses. It may be very difficult to distinguish an effective psychosis from a nonaffective psychosis based on the signs and symptoms at the time of presentation. For example, schizophreniform disorder is a functional psychosis characterized by delusions, hallucinations, confusion and disorganization of thought processes for a period of less than six months. It may be very difficult, if not impossible, for astute clinicians to confidently distinguish schizophreniform disorder from mania based on the clinical features observed at the time of presentation. Knowledge of the course of the illness, the family history and the patient's previous response to treatment may be critical factors in determining treatment. For example, a manic episode is more likely in a patient who has in the past exhibited signs of mania (e.g., euphoric or irritable mood, pressured speech, flight of ideas, heightened level of energy, decreased need for sleep, indefatigability, increased involvement in goal-directed activity, increased self-esteem or delusions of grandeur), has a family history of affective illness or has a history of good response to lithium carbonate (Eskalith, Lithane, Lithobid), carbamazepine (Tegretol) or valproic acid (Depakene).

Delusions: Certain types of delusions are characteristic of psychosis in the context of affective illness. These are referred to as mood-congruent delusions. A person's belief that he or she has committed an egregious act for which condemnation to hell is deserved, even though his or her religious beliefs do not support this conclusion, is a typical mood-congruent

delusion. This is a delusion of guilt. Since the time of Hippocrates, irrational feelings of guilt have been recognized as characteristic of depressive illness. Guilt is included among the many items on standardized instruments used to quantify the severity of depression, such as the rating scales developed by Carroll and associates and by Hamilton. A person's belief that his or her thoughts are controlled by an external force is a classic example of a mood-incongruent delusion. Although patients with affective psychosis sometimes have mood-incongruent delusions, delusions of this type are much more common in nonaffective psychoses.

Hallucinations

Hallucinations are auditory, visual, tactile, olfactory or gustatory experiences that occur in the absence of a stimulus. While nonauditory hallucinations are more characteristic of organic psychoses, they may also occur in functional psychoses (Table 2). The occurrence of a hallucination does not necessarily indicate that a person is psychotic. For example, a person with a migraine headache may have a visual hallucination, but if the person recognizes that the hallucination is the product of a neurologic disorder, he or she is not psychotic. A person who is psychotic fails to appreciate that a perception occurs despite the absence of an adequate stimulus. Hallucinations must be distinguished from illusions. An illusion is a perception that occurs in response to a stimulus, but the person reaches an erroneous conclusion about the cause of the perception. For example, a person may glance at wind ruffled foliage and perceive a deer running

through the forest. Although illusions are normal experiences, they may occur with a high degree of frequency in some psychotic individuals. Illusions are particularly common in patients with dementia and delirium.

Thought Disorders: Distinct patterns of cognitive impairment occur in organic and functional psychoses. The technical phrase for this type of cognitive impairment is formal thought disorder." Characteristics of this type of disorder include speech that cannot be understood because of inadequate connections between words ("word salad") or phrases and sentences (loose associations); the use of illogical meaningless language; the creation of useless novel terms (neologisms); the failure to complete sentences or phrases (thought blocking); the intrusion of irrelevancies into conversation; abrupt changes in subject matter; distorted grammar or syntax; the idiosyncratic use of words, or the use of empty, stereotyped or obscure phrases. Formal thought disorder is an autonomous, independent attribute of psychosis. By definition, it cannot be caused by extreme psychomotor retardation (which can create the appearance of thought blocking), hallucinations or delusions. Treatment of Functional Psychoses It is critical to making a preliminary decision about whether a patient has an affective or no affective psychosis since the type of psychosis determines the pharmacologic agents to be used. Many patients with affective psychoses can be treated without antipsychotic agents.

Psychiatric Social Worker: Job Description, Duties and Requirements

Learn about the education and preparation needed to become a psychiatric social worker. Get a quick view of the requirements as well as details about degree programs, job duties and licensure to find out if this is the career for you. Psychiatric social workers typically conduct interviews in order to determine the appropriate services to offer mental health patients and their families. They develop care plans that include counselling, support services, treatment methods and referrals, as well as periodically review their patient and patient family situations and make changes to the care plans as necessary. Typical job duties include explaining treatment plans to patients and their families, maintaining patient records, preparing reports, monitoring progress toward treatment goals and conducting annual reviews of active treatment plans. Psychiatric social workers may also offer individual and group therapy sessions to patients, instruct other mental health staff in therapeutic techniques, provide crisis interventions, arrange for services from referral agencies and help patients ease back into the community after leaving inpatient programs.

In general, the core functions of a Medical Social Worker are:

1. Psychosocial Assessment, to assess strength and resilience of the patient, family, social support systems to help the individual functions within the community,

2. Family Education and Mediation, to educate the family on the physical and psychosocial needs of its members and how they can access to internal and external resources; to meditate on the conflicts so as to strengthen their family relationship and aid in problem solving,
3. Counselling for individual, couple and family, to provide counseling to clients presented with poor mental health issues (such as depression and anxiety) due to relationship problems and financial stress; clients facing adjustment difficulty due to illness and disability and clients with caregiving issues,
4. Risk assessment, to assess and manage risk due to self-harm and harm to others,
5. Financial assessment, to administer Medifund Assistance, identify and refer cases of financial hardship, administer other financial assistance,
6. Discharge planning, to work with the MDT in formulating discharge plan and
7. Information and referral services, to link patients and caregivers to necessary community resources.

In the mental health field, the social worker not only has to perform the core functions but often has to incorporate other roles to adequately meet the needs of someone affected by mental illness. The social worker needs to manage the psychiatric condition of the person by assessing the mental stability of the illness, monitoring the medication regime, providing psychosocial rehabilitation and working on improving PMI functioning in the community. In the National

Mental Health Blueprint, there are three community outreach teams. Each team deals with the unique needs of the targeted client across the human lifespan of Singaporeans. Firstly, the Response Early intervention and Assessment in Community Mental Health (REACH) focuses on the needs of school going children. The Community Mental Health Team (CMHT) provides psychosocial rehabilitation of adult population with a mental disorder. The Aged Psychiatry Community Assessment & Treatment Service (APCATS) is a community-oriented psychogeriatric outreach service.

Role of Medical Social Workers in REACH: The GP-school network was proposed by the Institute of Mental Health (Department of Child and Adolescent Psychiatry) where mobile multi-disciplinary clinical teams (i.e. REACH) were set up to provide mental health support for children and adolescents in the community involving schools, general practitioners (i.e. family doctors and community paediatricians) and voluntary welfare organisations. The REACH team comprises of Medical Social Workers, Doctors, Psychologists and Nurses.

The key objectives of this project are to:

- Improve the mental health of children and adolescents in schools
- Provide early interventions, support and training to school counsellors on mental health disorders
- Develop a mental health network for children and adolescents in the community involving

- The role of the Medical Social Worker in the REACH team is to provide support and training to the school counsellors, general practitioners and staff from the voluntary welfare organisations on ways to identify and assess children with mental health problems.

This is done by providing:

- A helpline to consult and seek advice on strategies to help children with emotional, behavioural and/or developmental disorders,
- Assessment, intervention and psychiatric treatment for children with mental health disorders when needed,
- Case conferences, talks or workshops,
- Individual and family therapy,
- Group therapy,
- Formulation and development of care management plans for referred students in collaboration with school counsellors and the other community partners,
- Appropriate referral and liaison with other healthcare professional and agencies and
- A network of resources and information for dissemination to the referred student/ caregiver and FTSC.

The six main roles of a Medical Social Worker in CMHT are:

- To provide social work and psychosocial rehabilitation assessment and interventions to support the main case managers,

- To provide care coordination by taking on the role of a case manager,
- To provide a clinical opinion in a multidisciplinary team,
- To spearhead networking efforts of CMHT,
- To provide training to community partners and
- To provide crisis interventions in a mobile crisis team

APCATS Medical Social Worker's Scope of Work Include:

1. Respond to inquiries on the referral to APCATS,
2. Conduct home visit after liaison and discussion with team members,
3. Establish rapport and build therapeutic alliance with client and family members,
4. Identify client's/family's need(s), formulate and develop appropriate individualised service plan in collaboration with other team members,
5. Case-manage patients that require more social work input,
6. Provide social and/ family support for caregivers within the boundaries of patient care,
7. Conduct bio-psycho-social assessment of clients including monitoring signs of relapse and caregiver stress (eg. administering the ZARIT Burden Scale with caregiver) (Generic skill),
8. Conduct social and family assessment for clients when necessary and to provide clinical services in terms of supportive counselling, family work, caregiver support, information and referral for services required, as well as

work with and support family members in implementation of therapeutic care plans (Specific skill),

9. Provide psycho-education to client and family in response to needs assessment,
10. Provide assessment of patient's financial status via means testing and render the necessary assistance if they meet the criteria,
11. Participate in APCATS multidisciplinary meetings and
12. Carry out duties as assigned by the Programme Director.

In conclusion, the roles of a Medical Social Worker may change over time depending on the needs of client and organisation. The training and education of social workers should equip entry social workers with a broad-based knowledge and skills. In addition, for social workers who are interested to work with PMI, they must be further trained to function to meet the unique roles of Medical Social Workers in the mental health field.

The Need and Importance of Counselling in Industry

Workplace counselling is an employee support intervention that is usually short-term in nature and provides an independent, specialist resource for people working across all sectors and in all working environments. Giving all employees access to a free, confidential, workplace

counselling service can potentially be viewed as part of an employer's duty of care.

Responsibilities and skills: The counselling process is about providing a sounding board for an employee, giving them a safe place to talk about issues that trouble them, and allowing counsellors to help them find their own solutions to problems or develop better ways to manage issues. It is not about giving advice, but about providing a non-judgmental, empathic and accessible means to allow an employee to find a way forward. Workplace counsellors have a specialist viewpoint and skill set, as they essentially have two clients – the employee in front of them and the organisation, as a peripheral client. Workplace counsellors are mindful of the context in which the employees work and have a crucial understanding of the environment to which the employees will be returning. As workplace counselling is short-term (up to eight one-hour sessions), practitioners are commonly “integrative”, meaning they have trained in a core therapeutic approach and built other disciplines into this. Counsellors may be person-centred or have skills in cognitive behavioural therapy (CBT), transitional analysis, gestalt therapy, solution-focused therapy, or one of several other disciplines. The choice of the approach used by the counsellor usually matters less than the quality of the counsellor-client relationship, with trust and openness helping to maximise success.

Employers and clients: Workplace counsellors offer support to people in organisations across all sectors, locations and sizes. While counselling is available on the NHS, the long

waiting times, lack of specialist insight and inflexibility of appointment times and locations make workplace counselling a more attractive option for many employers. Some organisations pay for counselling by recruiting a workplace counsellor either full time or part time, or on an ad hoc basis, depending on the size of the workforce. Other companies choose to invest in an employee assistance programme (EAP). EAPs are standalone packages that include counselling support provision, often from a nationwide pool of vetted affiliate counsellors.

Several factors, primarily the size of the organisation and the funds available, dictate how counselling is provided by an organisation. More important than the type of service used is the understanding that counselling must be confidential and voluntary, so it should not be used as a conditional requirement or as part of a disciplinary process. Organisations sometimes think that the counselling provision they are paying for should only be used to address issues directly relating to the employee's work life. While work-related issues, including stress, overwork, bullying and difficult colleagues, can of course directly impact an employee's performance, personal issues can have a similar negative impact. We all experience life-crisis issues at different stages in our lives. Experiences such as bereavement and loss, relationship and family difficulties, substance misuse (including alcohol issues) and stresses at home can all preoccupy someone's thinking and distract them from work. In certain safety-sensitive industries, this can also be a major risk. Workplace counselling often helps employees who are

absent from work, and there is evidence that counselling support can accelerate the rehabilitation of an absent employee, saving the organisation money in the long run. In short, everyone who works in an organisation is a potential client.

Counsellors in collaboration: Workplace counsellors now enjoy a long-established relationship with allied professionals, often working closely with HR representatives, trade unions, health and safety practitioners, and those working in the areas of people management and people development.

Skills training: Increasingly, many HR practitioners are choosing to learn counselling skills. This can help them better engage with employees with problems, develop skills in empathy, demonstrate a more open and transparent manner, and build a close trusting relationship with the staff member. However, it is important to remember that receiving introductory counselling training does not equip someone with sufficient knowledge to provide an employee with full counselling. A person with some counselling skills may think they can support or counsel a depressed employee, but what if that employee goes on to reveal a history of childhood sexual abuse, alcohol dependency, or discloses that they are considering suicide? The greatest advantage of staff having workplace counselling skills is that they can help to better identify when it is time to refer an employee to a specialist workplace counsellor and can provide the crucial “bridge” into such a referral. This continuity contribution often encourages those with counselling skills to take the next step

and train to be a counsellor by going on a diploma course, registered by the British Association for

Counselling & Psychotherapy (BACP): Managers have found counselling skills training to be hugely helpful in terms of how they manage people. Poor people management skills are often cited in dysfunctional workplace relationships. While those in HR and OH often already have a skill set that enables them to understand, connect and engage with people, managers are often recruited to their roles because of the functional job capabilities, rather than because they are good at managing people.

Political and regulatory factors: The Government has conducted several consultations on the issue of absence and made clear recommendations for counselling to be offered by organisations for their employees, although this has yet to be made a legal requirement. However, employment legislation requires organisations to provide a safe working environment and exhibit a duty of care, so it makes financial and common sense to provide access to a counselling service. Workplace counsellors should have a sound counselling diploma as a prerequisite, but how they gain their experience of working in organisations can be varied. Many come from HR roles, retrain and are then able to utilise their understanding of how organisations function to inform ways to offer and deliver counselling. The members have additional areas of expertise, skills and knowledge, on top of their original training. In order to retain their accredited status they are required to keep up to date with training and continuing professional development,

and as such, they are widely recognised as the “gold standard” within the profession.

Future developments: Workplace counselling will always remain an important resource for organisations. It offers employees a safe, confidential place to talk about anything that may be confusing, painful or uncomfortable, and allows them to talk with someone who is trained to listen attentively and to help them improve the situation. It is an invaluable resource for managers, who can refer employees to counselling when they feel unable to help with a more complex or personal problem that an employee is facing. Workplace counselling appears to work best in a face-to-face context, where the employee meets and is treated at the professional premises of the counsellor. However, for some people, a telephone option can provide a more immediate opportunity, as well as a measure of anonymity. Some counsellors are embracing new technologies and offer email, instant messaging and online counselling. This can help employees in more remote settings, or those who travel frequently as part of their job.

Counselling in Industry: Employee counselling can be explained as providing help and support to the employees to face and sail through the difficult times in life. At many points of time in life or career, people come across some problems either in their work or personal life when it starts influencing and affecting their performance and, increasing the stress levels of the individual. Counselling is guiding, consoling, advising and sharing and helping to resolve their problems

whenever the need arises. Technically, Psychological Counselling, a form of counselling is used by the experts to analyze the work-related performance and behaviour of the employees to help them cope with it, resolve the conflicts and tribulations and re-enforce the desired results.

Ingredients of counselling: Counselling of staff is becoming an essential function of the managers. The organisation can either take the help of experienced employees or expert, professional counsellor to take up the counselling activities. Increasing complexities in the lives of the employees need to address various aspects like:

Performance counselling: Ideally, the need for employee counselling arises when the employee shows signs of declining performance, being stressed in office-hours, bad decision-making etc. In such situations, counselling is one of the best ways to deal with them. It should cover all the aspects related to the employee performance like the targets, employee's responsibilities, problems faced, employee aspirations, inter-personal relationships at the workplace, et al.

Personal and Family Wellbeing: Families and friends are an important and inseparable part of the employee's life. Many times, employees carry the baggage of personal problems to their workplaces, which in turn affects their performance adversely. Therefore, the counsellor needs to strike a comfort level with the employees and, counselling sessions involving their families can help to resolve their problems and getting them back to work- all fresh and enthusiastic.

Other Problems: Other problems can range from work-life balance to health problems. Counselling helps to identify the problem and help him/her to deal with the situation in a better way.

Need of counselling at workplace: Apart from their personal problems, there are various reasons which can create stress for the employees at the workplace like unrealistic targets or work-load, constant pressure to meet the deadlines, career problems, responsibility and accountability, conflicts or bad inter-personal relations with superiors and subordinates, problems in adjusting to the organizational culture. Counselling helps the employee to share and look at his problems from a new perspective, help himself and to face and deal with the problems in a better way. Counselling at the workplace is a way of the organisation to care about its employees.

Objectives: Counselling helps a person overcome emotional problems and weaknesses relating to performance. According to Eisenberg & Delaney, the aims of Counselling are as follows:

Understanding self: Making impersonal decisions; Setting achievable goals which enhance growth; Planning in the present to bring about desired future; Effective solutions to personal and interpersonal problems; Coping with difficult situations; Controlling self defeating emotions; Acquiring effective transaction skills; Acquiring 'positive self-regard' and a sense of optimism about one's own ability to satisfy one's basic needs.

Need for Counselling: Apart from their personal problems, there are various reasons which can create stress for the employees at the workplace like unrealistic targets or workload, constant pressure to meet the deadlines, career problems, responsibility and accountability, conflicts or bad interpersonal relations with superiors and subordinates, problems in adjusting to the organizational culture. Counselling helps the employee to share and look at his problems from a new perspective, help himself and to face and deal with the problems in a better way. Counselling at the workplace is a way of the organisation to care about its employees.

Functions of Counselling: The main objective of Counselling is to help the employee attain a better mental, emotional and physical health. A counsellor is the one who can help a person realize a better tomorrow by the attainment of self-confidence, self-development, patience and self-growth. The objectives of counselling are achieved through the counselling functions. The counselling functions are the activities that can be done by counselling. The functions are:

Advice: Advice-giving is not desired for counselling, as its a process of self- growth which advising would hamper. But many a time's counsellors do have to advise so as to show/ guide the counselled towards a path of action.

Reassurance: Counselling has to provide reassurance to the employee that he or she is progressing well and moving towards achieving the desired goal. Reassurance here can be meant as an encouragement also. This is mostly in the case of the mid-career managers where a counsellor can only reassure

that everything will work out Employees' Counselling fine and also encourage him or her to work as the desired goal is within reach.

Communication: Counselling is mostly about proper communication. A proper communication is required to pass the employee problems to the management and also to air the views of the management to the employees. Communication skills such as listening, providing feedback and so on are required for an effective counselling session.

The release of Emotional Tension: Counselling gives a scope to the employees to release their emotional tension. Emotional outbursts help the employee to release one's anger and frustration to a sympathetic listener, which in turn helps in subsiding the tension.

Clarified Thinking: Discussing one's problem with someone helps the person to see those points and facts which have been overlooked earlier due to emotional involvement with the problem. The counsellor is not required to guide the person in such a case, as only listening to the outpouring will help. Once the counselled person starts speaking very soon many facts are clarified as the counselled starts thinking aloud which in turn results in rational and logical thinking and helps in solving the problems, real or imaginary.

Reorientation: Reorientation is a result of clear thinking which helps an employee to assess oneself - one's potential and limitation and in accordance with them set new goals and values. Reorientation leads a person to have a better self-

image and it also helps to treat the patients with depression. A clear self-image leads to be a more confident person and also a more effective worker.

Types of Counselling: Counselling session depends upon the counsellor to give it a direction. The type of direction the counsellor gives to the session differentiates it into three types of counselling:

Directive Counselling: In this type of counselling the counsellor gives the full direction. The counsellor leads the session completely and this type of counselling fulfils the criteria of the counsellor giving advice and reassurance. The counsellor listens to the counselled and decides on behalf of the counselled as to what should be done. It also helps in releasing the emotional tension. But this form of counselling does not equip the counselled person to handle similar situations in future as no self - growth has taken place. The self - growth can be achieved when a Development person tries to look for the answers himself or herself with some help from someone; else. But, as stated earlier, in this case, a person will always have to look towards someone else to advice and 'sort out the problems in future. All said and done, one should remember that in many cases advice acts as reassurance. In adverse conditions, advice and reassurances act as morale boosters and in the long nm help on taking a course of action to resolve the difficult situation.

Non-Directive Counselling: This type of counselling is counselee oriented. This means that the counsellor focuses on

the counselee and his or her problems without any sort of interference. The counsellor does not act as an advisor; rather the counsellor only listens to the counselee, understands the problem but does not offers any solutions. The counselee here has to the find the solution on his or her own. This type of counselling helps in employee orientation as the employees are given a chance to find their own solution. Thus they are prepared to handle at least similar kinds of problems in future on their own.

Co-operative/Participative Counselling: This is a compromise between the above two extreme types of counselling. It is a mutual contribution for diagnosing a problem, analyzing the problem and then looking for a solution. It is a mutual counsellor - counselee relationship where both participate to find a solution. Here an exchange of ideas takes place between the two. Both the participants provide a bit of knowledge, experience and insight and thus it is a case of balanced compromise. In general, it provides four counselling functions, i.e. of reassurance, communication, emotional release and clarified thinking

Methods of Counselling: Effectiveness of counselling largely depends on the methods and techniques as well as the skills used by the counsellor. Methods and techniques of counselling change from person to person and from situation to situation. Normally employee counseling involves the following methods:

Desensitization: According to Desensitization, once an animal has been shocked in a particular situation, it will

continue to avoid it indefinitely. This is quite true in respect of human beings also. Once an individual is shocked in a particular situation, he gives himself no chance for the situation to recur. This method can be used to overcome avoidance reactions, so as to improve the emotional weak spots. If an employee is once shocked by the behavior, approach or action of his superior, he would continue to avoid that superior. It is difficult for such superiors to be effective counselors, unless such superiors prove otherwise through their behavior or action on the contrary. Similarly, once an employee is shocked by a particular situation, he can be brought back to that situation only if he will be convinced through desensitization that the shock will not take place further. Counselor can make use of desensitization in such situations.

Catharsis: Discharge of emotional tensions can be called catharsis. Emotional tensions can be discharged by talking them out or by relieving of the painful experience which engendered them. It is an important technique as a means of reducing the tensions associated with anxiety, fear, hostility, or guilt. Catharsis helps to gain insight into the ways an emotional trauma has been affecting the behaviour.

Insight: With the help of insight one may find that he has devalued himself unnecessarily, or his aspirations were unrealistic, or that his childish interpretation of an event was inaccurate. Then he can overcome his weakness.

Developing the new patterns: It is necessary when other methods to deal with weak spots remain ineffective, in order

to develop new, more satisfying emotional reactions, the individual needs to expose himself to situations where he can experience positive feelings. The manager who deals with such individuals may motivate or instigate them to put themselves into such situations, so that their self-confidence may increase. Every counsellor must concentrate his full attention on two aspects viz., using of assessment tools, and utilizing counselling methods, choice of which differs from person to person, situation to situation, and from case to case.

The Process of Counselling

The counselling process has three phases: rapport building, exploration and action.

Rapport Building: In the rapport building phase, a good counsellor attempts to establish a climate of acceptance, warmth, support, openness and mutuality. This phase involves generating confidence in the employee to open up frankly, share his perceptions, problems, concerns, feelings etc. The subordinate must be made to feel wanted and that his superior is genuinely interested in his development.

Exploration: In this phase, the counsellor should attempt to help the employee understand and appreciate his strengths and weaknesses. He should also understand his own situation, problems and needs. Questions should be asked which help the employee focus on his problem. For example, if an employee feels that his problem is that others do not co-operate with him, the counsellor may ask questions to narrow down the problem to the employee's relationship with a few

individuals. Then the superior may ask questions to help the employee understand what he does (or says) to his colleagues that is making it difficult for him to win their co-operation. Problem identification is a critical step in planning for improvement. To help the employee make a correct diagnosis of the problem, open-ended questions may be asked.

Action Planning: Counseling interviews should end with specific plans of action for the development of the employee. The main contribution of the superior in this phase is in helping the employee think of alternative ways of dealing with a problem. For example, in case of an employee whose relationships with colleagues are poor, the superior may suggest “What three things can you do in the coming week to improve your relationship with X?” After helping the employee brainstorm, the superior may also add more alternatives to the solutions already generated. Finally the superior may render some assistance in helping the employee implement the agreed upon action plan. Often good counselling sessions fail to produce effective results due to lack of following/

Effective Counseling: Counselling is an art. It requires serious effort on the part of the counselee to learn from each situation and stand on his own. The counsellor is there to lend a helping hand, clarify things, enable the counselee look at the picture himself clearly, show the alternative paths and suggest action plans for improvement.

Basic requisites for employee counselling: Employee Counselling needs to be tackled carefully, both on the part of

the organisation and the counsellor. The counselling can turn into a sensitive series of events for the employee and the organisation; therefore, the counsellor should be either a professional or an experienced, mature employee. The counsellor should be flexible in his approach and a patient listener. He should have the warmth required to win the trust of the employee so that he can share his thoughts and problems with him without any inhibitions. Active and effective listening is one of the most important aspects of the employee counselling. Time should not be a constraint in the process. The counsellor should be able to identify the problem and offer concrete advice.

Problems in Counselling: A manager has to deal with various types of problems in dealing with his subordinates, employees and particularly problem employees. Basically, no employee is a problem employee, except hereditary and inborn perversions, criminal tendencies, addictions, and nervous and psychological breakdowns. Once an employee turns out to be a problem employee, the employer has mainly two options viz., repair and recover, or replace. For the purpose of repairing and recovering and rehabilitating, employee counselling has an important role to play.

Problems are generally associated with the causes like;

Inferiority and Low Self-Esteem: Inferiority feeling of an employee may play great havoc in individual life and work. Though a mild form of inferiority in certain persons may help

them to work hard and overcome the inferiority. But very often, inferiority complex may lead a person to utter disappointment and depression leading to withdrawal perversion, absenteeism and even psychosomatic and psychotic problems.

Injustice or Ill-treatment: Very often injustice or ill-treatment makes a considerable impact in their minds resulting in behavioural problems, inferiority and low self-esteem. Depriving an employee of adequate wages, leave, or any perks, giving him an arrogant treatment, depriving a legitimate promotion, promoting somebody overlooking the legitimate candidate; may such incidents take place in organizations very often which may result in inferiority feeling or feeling of low self-esteem and low morale affecting the efficiency of the aggrieved employee.

Premarital Anxieties and Sexual Perversions: Premarital anxieties are common in many young employees. Once the marriage is arranged and the person is engaged, his anxiety increases. Two people of different family backgrounds, different cultures, different environments, etc., are bound to have anxieties before they come together. If one happens to wait unmarried after a particular age too, one's anxiety is bound to increase. Similarly, there are possibilities for sexual perversions in not only young employees but even in married employees. Such people can be spiritually motivated, educated, kept under the close contact of an influential group, and so on.

Alcoholism: Alcoholism is, perhaps, the largest threat to the human element of the organization. In fact, alcoholism is a serious social, moral and health problem. It ruins careers, disrupts families, affects productivity and efficiency, destroys bodies, and leads to untold human misery. Many traffic accidents are caused by alcohol abuse.

The problem of Addictions: Another important employee problem which deserves counselling is addictions. Addiction is a very dangerous problem which torments the social and work environment of today. Drug addiction has gone beyond proportions among youngsters nowadays. Not only drug addiction, many people are addicted to alcohol, pornographic materials, television, sexual immorality, and smoking, compulsive spending, overeating, and gambling, and so on. There are some people who are addicted to earning money and amassing wealth by hook or by crook. There are workaholics who have an addiction to work, due to which there are many broken families in the urban society.

Inadequate parental care: Broken family atmosphere; Bad company; Peer or other social influence; Feeling of emptiness in life; depression or stresses; Low self-esteem and deception; and Psychological problems. Both drug addiction and alcohol abuse involve behaviour change, physical deterioration, family stresses, financial problems, career destruction, increasing psychological disintegration, lawlessness and so on.

Mental Conflict in Union Rivalries: In recent times, there are many employees who lose their confidence, mental peace, job satisfaction and productivity due to union rivalries. Much right thinking and unattached employees become the victims of such rivalries. Some militant trade union leaders and their henchmen even manhandle assault and ill-treat such employees. Their legitimate promotions and claims are blocked by such trade unionists.

The breakdown in Interpersonal Relationships: Breakdown in interpersonal relationships is another important problem which creates low morale and depression in work-life which deserves timely intervention and counselling. There are many stressful situations in one's work life. Organizational cause of stress is occupational demands, role conflict, role ambiguity (stress from uncertainty), stresses from overload and under load, responsibility for others, stresses from evaluation, poor working conditions, unwanted changes, and such other factors lead to personal stresses. Interpersonal stresses make more impact in work life..

Low Job Satisfaction and Morale: Another important cause which affects the human behaviour in an organization is low job satisfaction backed by low morale. Low job satisfaction leads to low morale and vice-versa. Morale and job satisfaction are closely tied to the basic concepts of attitudes and motivation. Wages have been found to be the basic determinant of job satisfaction. However, once the monetary

needs are considerably met by the wages, other aspects like self-actualization, fulfilment, working conditions, security of employment, prestige, agreeability of the job, group cohesiveness, expertise, etc., also determine the job satisfaction. Some researchers have thrown light on the positive relationship between occupational level and job satisfaction.

The breakdown in Family Life: Every individual, rich or poor, has to face many family problems, some of which can seriously affect the peace of mind, happiness, achievement motivation and efficiency. Those who have broken family lives and serious family problems may possibly become unsuccessful in their work life too. Very often problem which affects the family life can convert a good employee into a problem employee. Studies have already proved that some alcoholics and drug addicts are the products of broken families. In fact, a breakdown in family life very often affects the work life. Hence, if such employees are provided with ways to release their tension, their efficiency can be improved. Counselling is of great importance in such cases once such employees can be brought to proper track with the help of counselling, their personality, behaviour and performance can be improved with the help of exposure in training, T-group formation, etc. so that better sense of cohesion and commitment to the organization can be ensured.

Conclusion: Counselling can go a long way in helping the employees to have better control over their lives, take their

decisions wisely and better charge of their responsibilities; reduce the level of stress and anxiety. Counselling of employees can have desirable consequences for the organisation. It helps the organisation when the employees know that the organization cares for them, and build a sense of commitment to it. It can prove to be of significant help to modify the behaviour of the employees and more so to re-enforce the desired behaviour and improve and increase the employee productivity.

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(An International Publisher for Academic
& Scientific Journals and Book)

Srinivas University,
A. Shama Rao Foundation,
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