Counseling Theories & Practice

PSYC 243

Start

January 21, 2025

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End

May 14, 2025

TABLE OF CONTENTS

CHAPTER 1

INTRODUCTION AND OVERVIEW

CHAPTER 2

THE COUNSELOR: PERSON AND PROFESSIONAL

2.0.1 Managing Your Personal Values

Personal therapy contributes to the therapist's professional work in 3 ways:

1. As part of the therapist's training, personal therapy offers a model of therapeutic practice in which the trainee observes a more experienced therapist.
2. A beneficial experience in personal therapy can further enhance a therapist's interpersonal skills, which are essential to skillful practicing therapy.
3. Successful personal therapy can contribute to a therapist's ability to deal with the ongoing stresses associated with clinical work.

- Therapists have a responsibility to be aware of their own values and set aside personal beliefs, so they do not "contaminate the counseling process" (aka, Bracketing).

2.0.2 Becoming an Effective Multicultural Counselor

- Acquiring Competencies in Multicultural Counseling
  - Diversity-competent practitioners
    - Beliefs and attitudes
    - Knowledge
    - Flexibility with Intervention Strategies

2.1 Maintaining Your Vitality as a Person and as a Professional or "Burnout Prevention"

- Therapeutic lifestyle changes (TLCs)
  - Physical activity
  - Diet and nutrition
  - Time in nature
  - Relationships
  - Recreation
  - Religious/spiritual involvement
  - Providing service to others

CHAPTER 3

ETHICAL ISSUES IN COUNSELING

3.1 Codes Versus Laws

3.1.1 Mandatory Codes

- Ethical functioning at the minimum level.

3.1.2 Aspirational Ethics

- Doing what is in the best interest of the clients.
- Going above and beyond the minimum requirements.
- Understanding the spirit of the code and the principles on which the code is based.

3.1.3 Steps for Ethical Decision-Making

- Identify the problem.
- Look at the relevant ethics codes and laws.
- Seek consultation.
- Brainstorm various possible courses of action.
- List consequences.
- Decide and document the reasons for your actions.
- To a degree, include the client in all phases of your ethical decision-making process.
- When clinicians are unsure of what action to take, they may contact their liability insurers to discuss the best plan of action to ensure ethical decision-making.

3.2 Informed Consent

- Clients must consent to treatment.
  - Uninformed consent –what problems could arise from this?
    - Patients could be under the impression that their treatment would be one way, but is actually another.
  - Informed consent are conditions that you disclose to the patient about the treatment they are about to receive.

- These conditions include:
  - The purpose of the treatment.
  - Potential risks and benefits.
  - Alternatives to the treatment.
  - Disclosure about the right to refuse treatment.
  - Any other information that the client may need to make an informed decision.

3.3 Confidentiality

Situations in which your therapist can legally break confidentiality:

- If the client is at risk of:
  - Harming themselves.
  - Harming others.
  - Being harmed by others.
- If there is child or elder abuse or neglect.
- If the client has a lawsuit against them (and the therapist is subpoenaed).
- The client can also sign a release of information form.
- Involuntary hospitalization.

3.4 Evidence-Based Practice

- Ethical treatment is effective treatment.
- How do you know that what you're doing is helping your clients?
  - You can use evidence-based practice.
    - Balancing treatment and relationship.
  - Outcome tracking.
  - Problems with relying on intuition.

3.5 Multiple Relationships

- These occur when the therapist has a relationship with the client outside the therapeutic relationship.
- Can be sexual or non-sexual.
- How could these cause ethical concerns for your clients?
- Prevention is key. Set healthy boundaries from the start.

CHAPTER 4

PSYCHOANALYTIC THERAPY

4.1 Sigmund Freud

4.1.1 Terms

- *Ego*
  - Executive mediating between id impulses and superego demands
  - Testing reality
  - Rational
  - Operates at the conscious level but also at the preconscious level.
- *Superego*
  - Ideals and morals
  - Striving for perfection
  - Incorporated from parents
  - becoming a person's conscience
  - Operates at the conscious level
- *Id*
  - Basic impulses (sex and aggression)
  - Seeking immediate gratification
  - Irrational and impulsive
  - Operates at the unconscious level
- **Unconscious Ego Defense Mechanisms**
  - *Repression*
    - Banishes anxiety-arousing wishes and feelings from consciousness.
    - Example: A child who is abused by a parent forms no memory of the abuse.
  - *Denial*
    - Refusing to believe or even perceive painful realities.
    - Example: A partner denies evidence of his spouse's affair.
  - *Reaction Formation*
    - Switching unacceptable impulses into their opposites.

    - Example: A person who is angry with a friend acts overly kind.
  - *Projection*
    - Disguising one's own threatening impulses by attributing them to others.
    - Example: A person who is unfaithful accuses his partner of cheating.
  - *Displacement*
    - Shifting sexual or aggressive impulses toward a more acceptable or less threatening object or person.
    - Example: A person who is angry with his boss kicks his dog.
  - *Rationalization*
    - Offering self-justifying explanations in place of the real, more threatening unconscious reasons for one's actions.
    - Example: A person who drinks every day says he does so to be sociable.
  - *Sublimation*
    - Transferring of unacceptable impulses into socially valued motives.
    - Example: A person who has aggressive impulses becomes a soldier.
  - *Regression*
    - Retreating to a more infantile psychosexual stage, where some psychic energy remains fixated.
    - Example: A person who is under stress begins to suck his thumb.
  - *Introjection*
    - Taking in and swallowing the values and standards of others.
    - Example: A person who is abused by a parent becomes an abusive parent.
  - *Identification*
    - Bolstering self-esteem by forming an imaginary or real alliance with some person or group.
    - Example: A person who is insecure identifies with a famous person.
  - *Compensation*
    - Masking perceived weaknesses or developing certain positive traits to make up for limitations.
    - Example: A person who is not athletic becomes a scholar.

- **Psychosexual Stages**
  - *Oral*
    - *Oral Passive*: trusting, gullible, passive, and needy.
      - Forceful feeding.
      - Underfed
    - *Oral Aggressive*: sarcastic, aggressive, envious, and exploitative.

        - Overfed
    - *Anal*
        - *Anal Retentive*: stingy, orderly, rigid, and obsessive.
            - Harsh toilet training
        - *Anal Expulsive*: messy, wasteful, destructive, and hostile.
            - Lenient toilet training
    - *Phallic*
        - Abdnoral family set-up leading to unusual relationship with mother/father.
            - Vanity, self-obsession, sexual anxiety, inadequacy, inferiority, and envy.
    - *Latency*
        - After the torment of sexual impulses of the preceding years, this period is relatively quiescent. Sexual interests are replaced by interests in school, playmates, sports, and a range of new activities.
    - *Genital*
        - Old themes of the phallic stage are revived. The person seeks to establish a mature sexual relationship with a partner.

4.2 Erik Erikson

4.2.1 Psychodynamic Approach

- Also focused on unconscious influences.
- Increased emphasis on Ego instead of Id.
- More focused on present.

Approximate Age	**Psycho Social Crisis**
Infant (18 months)	Trust vs. Mistrust
18 months - 3 years	Autonomy vs. Shame and Doubt
3-5 Years	Initative vs. Guilt
5-13 Years	Industry vs. Inferiority
13-21 Years	Identity vs. Role Confusion
21-39 Years	Intimacy vs. Isolation
40-65 Years	Generativity vs. Stagnation
65 and Older	Ego Integrity vs. Dispair

Table 4.1: Erikson's Stages of Psychodynamic Development

CHAPTER 6

EXISTENTIAL THERAPY

6.1 Existentialism: The Origins

- Philosophical foundations in 19th/20th-century thinkers:
  - Søren Kierkegaard (subjective truth, anxiety, freedom)
  - Friedrich Nietzsche (will to power, "God is dead," self-creation)
  - Martin Heidegger (being-toward-death, *Dasein* [being-in-the-world])
  - Jean-Paul Sartre ("existence precedes essence," radical freedom)
- Later integrated into psychology by:
  - Rollo May (pioneer of existential psychology)
  - Irvin Yalom (four existential "ultimate concerns")

6.1.1 Key Existential Themes

- Confrontation with the "ultimate concerns" (Yalom):
  - Death: Awareness of mortality as a catalyst for authenticity.
  - Freedom: Responsibility for self-creation in a world without inherent meaning.
  - Isolation: Existential aloneness despite relationships.
  - Meaninglessness: The challenge to create meaning without guarantees.
- Existential anxiety vs. pathological anxiety:
  - Healthy anxiety: Motivates growth and authenticity.
  - Neurotic anxiety: Avoidance of freedom/responsibility.

6.1.2 Mental Health Effects of The Holocaust

- The horrors of the holocaust led to an increase of people struggling with existential crises.
- Frankl, a survivor of Auschwitz, developed a form of therapy called *logotherapy*. This therapy focuses on the search for meaning in life.

6.2 Goals of Existential Therapy

- Assisting clients in moving toward authenticity and learning to recognize when they are deceiving themselves.
- Helping clients face anxiety and engage in action that is based on creating a worthy existence.
- Helping clients to reclaim and re-own their lives; teaching them to listen to what they already know about themselves.
- Encouraging clients to confront existential "givens" (e.g., death, freedom) to live more fully.
- Facilitating acceptance of uncertainty and the courage to act despite it.

6.2.1 The Therapeutic Relationship

- Therapy is a journey taken by therapist and client
  - The person-to-person relationship is key.
  - The relationship demands that therapists be in contact with their own experience in the world.
- The core of the therapeutic relationship.
- Therapist as a *authentic companion*, not an authority:
  - Focus on the "here-and-now" interaction.
  - Use of self-disclosure to model authenticity.
- Emphasis on presence, deep listening, and phenomenological exploration (understanding the client's subjective world).

6.2.2 Techniques and Practices

- Less technique-driven; focuses on dialogue and process:
  - Phenomenological method: Unpacking the client's lived experience without judgment.
  - Existential reflection: Exploring choices, values, and responsibility.
  - Paradoxical intention (Frankl): Facing fears by exaggerating or embracing them.
- Applications: Effective for grief, identity crises, life transitions, and terminal illness.

6.2.3 Critiques and Limitations

- Challenges: Lack of structured techniques, abstract concepts.
- Criticisms: Overemphasis on individualism; less focus on systemic/social factors.

CHAPTER 7

PERSON-CENTERED THERAPY

7.1 Carl Rogers

- One of the founders of the Humanistic approach
- First person to conduct major studies on therapy using quantitative methods.
- Applied the Person-Centered Approach to topics areas outside of counseling including world peace, education, and politics.

7.2 Assumptions

- People are essentially good.
- People have a tendency to self-actualize under the right conditions.
- Clients are the expert of their own inner experience.

7.3 Role of the Therapist

- Three therapist attributes create a growth-promoting environment of clients:
  - Genuineness.
  - Unconditional positive regard.
  - Accurate Empathetic Understanding.
  - These are often called WEG (Warmth, Empathy, Genuineness).

7.4 Maslow's Humanistic Theory

- Hierarchy of Needs
  - Physiological needs.
    - Air, water, food, shelter, etc.
  - Safety needs.
    - Security, stability, freedom from fear.
  - Love and belongingness needs.
    - Affection, acceptance, friendship.
  - Esteem needs.

    - Self-respect, respect from others, competence, confidence.
- Self-actualization.
    - Realizing one's potential, self-fulfillment, seeking personal growth and peak experiences.

CHAPTER 8

GESTALT THERAPY

8.1 Fritz Perls

- Born in 1893 in Berlin, Germany
- After serving in WWI, Fritz studied medicine and provided treatment to soldiers with brain injuries.
- He fled Germany in 1933 and moved to South Africa.
- In 1946, he moved to New York City and began working with Karen Horney.
- Coauthored a book on Gestalt Therapy and founded the New York Institute for Gestalt Therapy.

8.2 Nature of Humanity

- Basic assumption about people is that they have the capacity to self-regulate when they are aware of what is happening around them.
- The view is rooted in existentialism and phenomenological theories.
- People need to "re-own" and unify all parts of themselves, including the parts they have disowned or denied.

8.3 Goals for Gestalt Therapy

- Focuses on the here and now.
- Clients need to gain awareness.
  - Defined as knowing the environment, themselves, accepting themselves, and being able to make contact (interact with others and nature without losing themselves).
  - Increased awareness itself is curative.

8.4 Role of the Therapist

- The work of therapy is done by the client.
- The therapists' job is to create a climate where clients can try new ways of being and behaving.

- Working in the here and now with an "I/Thou" relationship.
- Fritz Perls methodology: The therapist is directive and confrontational.

8.5 Gestalt Therapy Overview

8.5.1 Evolution of the Approach

- From Fritz Perls' pioneering work emphasizing present-centered awareness and direct confrontation,
- to contemporary relational approaches that stress authentic dialogue and mutual influence.

8.5.2 Philosophy and Basic Assumptions

- Emphasizes wholeness, personal responsibility, and the integration of thoughts, feelings, and behaviors.

8.5.3 Key Concepts

- *Holism* – Viewing the person as an integrated whole.
- *Field Theory* – Understanding behavior in the context of the whole environment.
- *Figure-Formation Process* – How individuals perceive and organize experience.
- *Organismic Self-Regulation* – The innate drive toward growth and balance.

8.5.4 Trusting Relationship in Experiments

- A strong, trusting client–therapist relationship is central to engaging clients in experiential experiments that promote change.

8.5.5 Role of Confrontation

- Contemporary relational Gestalt therapy uses measured confrontation to challenge defensive patterns while maintaining support.

8.5.6 Standard Gestalt Therapy Interventions

- Internal Dialogue Exercise – Enhances self-awareness.
- Empty-Chair Technique – Facilitates expression of unresolved issues.
- Future Projection – Aids clients in envisioning change.

- Making the Rounds – Explores multiple perspectives.
- Reversal Exercise – Encourages viewing situations from an opposite angle.
- Rehearsal Exercise – Allows practice of new behaviors.
- Exaggeration Exercise – Amplifies actions for clarity.
- Staying with the Feeling – Supports acceptance of emotions.
- Dream Work – Interprets dreams as meaningful signals.

8.5.7 Application to Group Counseling

- Gestalt techniques foster group cohesion and authentic interaction, enabling members to experiment with new relational patterns.

8.5.8 Application in School Counseling

- Emphasizes experiential learning and self-awareness to improve student self-regulation and interpersonal skills.

8.5.9 Multicultural Perspective

- Stresses adaptation of interventions to be sensitive to diverse cultural values and worldviews.

8.5.10 Contributions, Strengths, and Limitations

- *Contributions*: Focus on present experience and relational authenticity.
- *Strengths*: Flexible, experiential methods that empower client insight.
- *Limitations*: Potential challenges in structure and cultural adaptability.

CHAPTER 9

BEHAVIOR THERAPY

9.1 Overview of Behavior Therapy

9.1.1 Key Figures in Behavior Therapy

- Ivan Pavlov – Classical conditioning.
- B.F. Skinner – Operant conditioning.
- Joseph Wolpe – Systematic desensitization.
- Albert Bandura – Social cognitive theory.
- Aaron Beck – Cognitive therapy.

9.1.2 Four Developmental Areas in Behavior Therapy

- *Classical Conditioning*: Learning through association.
- *Operant Conditioning*: Learning via consequences (reinforcement/punishment).
- *Social Cognitive Theory*: Learning by observing others and through self-efficacy.
- *Cognitive Behavior Therapy (CBT)*: Integration of cognitive restructuring with behavioral techniques.

9.1.3 Central Characteristics and Assumptions

- Emphasis on observable behavior and measurable outcomes.
- A functional analysis of behavior.
- Assumption that behavior is learned and can be unlearned or modified.
- Reliance on empirical evidence and systematic techniques.

9.1.4 Role of the Therapist

- Acts as a *coach* or *facilitator*.
- Provides structure using specific behavioral procedures.
- Encourages active client participation.

9.1.5 Client–Therapist Relationship

- Collaborative and goal-oriented.
- Built on trust and mutual respect.
- Essential for tailoring behavioral interventions.

9.1.6 Behavioral Techniques and Evidence-Based Practice

- Use of reinforcement, punishment, modeling, exposure, and systematic desensitization.
- Integration with cognitive restructuring and self-monitoring.
- Techniques are empirically validated within the evidence-based movement.

9.1.7 EMDR (Eye Movement Desensitization and Reprocessing)

- Uses *bilateral stimulation* (often eye movements) to reprocess traumatic memories.
- Mainly applied to posttraumatic stress disorder (PTSD) and trauma-related conditions.
- Supported by research showing its effectiveness in reducing distress.

9.1.8 Social Skills Training

- Involves modeling and role play.
- Provides feedback and reinforcement.
- Aims to improve interpersonal communication and assertiveness.

9.1.9 Self-Management Programs

- Steps include self-monitoring, goal setting, self-reinforcement, and regular evaluation.
- Enhances clients' independence in managing their behavior.

9.1.10 Mindfulness and Acceptance-Based Therapies

- Four approaches include *mindfulness-based stress reduction*, *acceptance and commitment therapy (ACT)*, *dialectical behavior therapy (DBT)*, and *mindfulness-based cognitive therapy (MBCT)*.
- Emphasize present moment awareness, acceptance, cognitive defusion, and clarification of personal values.

9.1.11 Brief Interventions and Group Counseling

- Brief interventions use focused, time-limited strategies.
- Group counseling employs behavioral techniques within a supportive group dynamic.

9.1.12 Behavior Therapy in School Counseling

- Application in classroom management and behavioral modification programs.
- Focus on reinforcing positive behaviors and reducing disruptive behavior.

9.1.13 Working with Culturally Diverse Clients

- *Advantages*: Empirical basis, structure, and clear behavioral goals.
- *Shortcomings*: May require adaptation to respect cultural nuances and values.

9.1.14 Evaluation of Contemporary Behavior Therapy

- Ongoing integration of cognitive, acceptance-based, and mindfulness strategies.
- Continual empirical testing to validate techniques.
- Recognition of both strengths (structured, measurable) and limitations (potential cultural biases, narrow focus) within diverse settings.

9.1.15 ABC Analysis Model

- *Antecedents* – Events that "activates" our behavior (prompts, instructions, signals).
- *Behavior* – Any action on the part of the person.
- *Consequences* – Events that follow the behavior (reinforcement, punishment).

CHAPTER 10

COGNITIVE BEHAVIORAL THERAPY

10.1 REBT and CT: Cognitive Behavior Approaches

- REBT and CT were devloped around th esame time, independently of each other.
- Therapists with backgrounds from either approach now call themselves cognitive-behavioral therapists.
- Both approaches consider mental health problems to stem (at least in part) from maladaptive thinking.
- Both address problematic thinking patterns and help clients develop healthier views about themselves, the world, and the future.
- *Thoughts, emotions, and behaviors interact* significantly and have reciprocal cause-and-effect relationships.

10.1.1 Albert Ellis' Rational Emotive Behavior Therapy (REBT)

- Originally trained as a psychoanalyst, Ellis developed REBT in the 1950s.
- He was frustrated with slow client process.
- Noticed that clients appeared to make progress when they *changed how they thought* about themselves and their problems.
- Basic Assumption of REBT: People **contribute to their own psychological problems** and symptoms due to rigid and extreme beliefs they hold.
- Clients must learn to fully accept themselves.

10.1.2 Aaron Beck's Cognitive Therapy (CT)

- Developed by Aaron Beck based on his research.
- CT is shown to effectively treat a wide range of mental health disorders.
- Posits that the cognitive triad causes the maintenance of depressive symptoms, regardless of initial cause (negative thoughts about oneself, the world, and the future).
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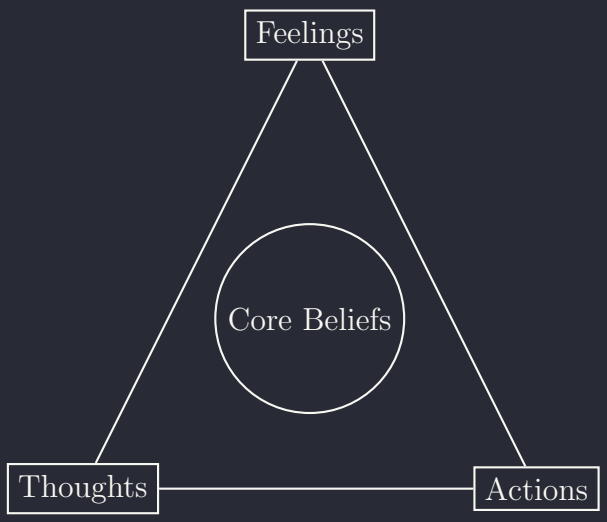

10.2 Main Questions Points from the Reading

- **Common Attributes of Cognitive Behavior Approaches:**
  - Emphasis on the interaction between thoughts, feelings, and behaviors.
  - Focus on identifying and modifying cognitive distortions or maladaptive thought patterns.
  - Utilization of structured, goal-oriented, and present-focused interventions.
  - Incorporation of self-monitoring and skills training to facilitate change.
- **The ABC Model: Understanding Feelings, Thoughts, and Behavior:**
  - **A (Activating Event):** The situation or trigger that initiates a reaction.
  - **B (Beliefs):** The thoughts or interpretations about the event.
  - **C (Consequences):** The emotional and behavioral responses resulting from the beliefs.
  - This model helps individuals identify and alter irrational beliefs to change emotional and behavioral outcomes.
- **Applying Cognitive Methods to Change Thinking and Behavior:**
  - Use of cognitive restructuring to challenge and modify negative thoughts.
  - Incorporation of behavioral experiments and exposure tasks to test and revise beliefs.
  - Development of problem-solving and coping strategies.
  - Implementation of self-monitoring techniques to increase awareness of thought patterns.
- **Application of REBT in School Counseling:**

- Helping students identify and dispute irrational beliefs that lead to emotional distress.
- Teaching rational thinking to manage academic pressures and social challenges.
- Structuring interventions that promote adaptive coping and resilience.

- **Aaron Beck's Unique Contributions to Cognitive Therapy:**
  - Pioneering the development of cognitive therapy for depression.
  - Introducing the concept of cognitive distortions and their role in emotional disorders.
  - Establishing empirical methods for assessing and modifying dysfunctional thought patterns.
  - Integrating cognitive techniques with behavioral interventions to enhance therapeutic outcomes.
- **Basic Principles of Cognitive Therapy:**
  - The idea that thoughts, rather than external events, determine feelings and behaviors.
  - Identification and correction of cognitive distortions.
  - Collaborative and active therapist-client relationship.
  - Emphasis on skills acquisition and self-help strategies to promote long-term change.
- **Application of the Cognitive Behavior Approach in School Counseling:**
  - Addressing academic stress and performance anxiety.
  - Enhancing students' problem-solving and coping skills.
  - Promoting self-efficacy and adaptive thinking.
  - Utilizing both individual and group counseling modalities.
- **Basic Principles of Strengths-Based CBT:**
  - Focus on identifying and leveraging individual strengths and resources.
  - Emphasis on building resilience and fostering self-efficacy.
  - Balancing recognition of challenges with the reinforcement of positive attributes.
  - Collaborative goal-setting that empowers clients to capitalize on their strengths.
- **Meichenbaum's Three-Phase Process of Behavior Change:**
  - **Conceptualization:** Understanding the problem through self-talk analysis.
  - **Skill Acquisition:** Learning and practicing new coping and self-instructional strategies.

- **Application and Practice:** Implementing the acquired skills in real-life situations with reinforcement.

- **Key Concepts and Phases of Meichenbaum's Stress Inoculation Training:**
  - **Conceptualization:** Identification of stressors and personal responses.
  - **Skills Acquisition and Rehearsal:** Training in coping techniques and stress management.
  - **Application and Follow-Through:** Practicing skills in both simulated and actual stressful situations.

- **Strengths and Limitations of CBT from a Multicultural Perspective:**
  - **Strengths:**
    - Empirically supported, structured, and adaptable to diverse issues.
    - Focus on empowerment and skill development.
  - **Limitations:**
    - Potential to overlook cultural values and contextual factors.
    - Need for adaptations to ensure cultural relevance and sensitivity.

- **Differentiating REBT from Cognitive Therapy Regarding Faulty Beliefs:**
  - **REBT (Ellis):** Directly challenges and disputes irrational beliefs using a more confrontational and philosophical approach.
  - **Cognitive Therapy (Beck):** Employs a collaborative approach to identify and modify cognitive distortions with structured interventions.

- **Differences Among Ellis, Beck, Padesky, and Meichenbaum in CBT Practice:**
  - **Ellis (REBT):** Emphasizes disputing irrational beliefs with a philosophical underpinning.
  - **Beck:** Developed cognitive therapy focusing on depression and identifying cognitive distortions.
  - **Padesky:** Advocates for collaborative empiricism and structured case formulation.
  - **Meichenbaum:** Known for stress inoculation training and self-instructional methods.