Learning Unit 4

Theories of psychological intervention[i]

Introduction

There is a vast array of theoretical perspectives and conceptual frameworks that guides the psychological intervention process that is embedded in togetherness. Most of these theories have major shortcomings in their applicability across different contexts. Given the decolonial emphasis of this module, you may wonder why there is a need to engage with the theoretical frameworks given their shortcomings. The reason being because there are convergences between indigenous psychology and Western psychology. For example, American psychology and Jungian psychology share a concern for the importance of dreams and dream work in the process of individual and cultural healing. In other words, we do not want to throw out the proverbial baby with the bathwater. Furthermore, if we are to be critical of Western psychology, we need to know and understand what we are critical of. Hence, in this learning unit, we cover four of the major theoretical frameworks that have dominated the field of psychological intervention. Each of these are discussed in terms of the following:

- *Background* – Historical information related to the development of the theoretical system and the individual(s) responsible for its development is.
- *Human nature* – A developmental perspective: the process of individual development over time, as defined by the theoretical perspective
- *Major constructs* – The structural components that constitute the theoretical perspective.
- *Goals of psychological intervention* – A description of desired client outcomes based on the tenets of the theory.
- *The process of change* – The factors within the theory that address what brings about change in the individual/system
- *Traditional intervention strategies* – Techniques for implementing the process of change.
- *Evaluation* – This section includes some of the current research studies that form the basis for continued use of this theoretical system and some of the factors that limit the use of the theoretical perspective.

Learning Outcomes

At the end of this learning unit, you should be able to:

- list the major western theoretical frameworks that have dominated psychological intervention
- identify the historical context and individuals responsible for the development of the major theoretical frameworks
- explain the major constructs that constitute the theoretical frameworks.
- define the goal of psychological intervention based on the tenants of the theoretical frameworks.
- describe processes and technique used within the theoretical framework to bring about change in individuals/systems.
- evaluate the strength and limitations of the theoretical frameworks.

Key concepts

Psychoanalytic theory Id, ego, superego, life and death instincts, defense mechanisms, transference, countertransference, resistance, posthypnotic suggestions, free association, dream analysis, person-centered theory, actualisation, emphatic understanding, congruence, active listening, cognitive behaviour theories (CBTs), cognitive therapy, therapeutic empathy, self-efficacy reinforcement, extinction, shaping, stimulus control, aversive control, all-or-nothing thinking, disqualifying the positive, catastrophising, family theory, family life cycle, family genogram, dyad, family boundaries, family system, triangulation, first-order change, second-order change, family interview

PSYCHOANALYTIC THEORY

Psychoanalytic theory is based on the concept that individuals are unaware of the many factors that cause their maladaptive behaviours and discomforting emotions. Psychoanalytic treatment is highly individualised, lengthy in duration, and seeks to show how early childhood experiences have affected the formative aspects of one's personality development.

The theory first emerged with the pioneering efforts of neuroscientists Josef Breuer and Jean-Martin Charcot, and the primary components of the theory were later adapted and popularised by Sigmund Freud. Throughout Freud's professional career, his articulated ideas regarding unconscious motivations and psychosexual development and his dynamic insights about coping mechanisms greatly influenced psychological and medical explanations of how the human mind works.

Psychoanalytic theory suggests that early life experiences shape one's social interactions and relationships in adulthood. Humans across cultures are conceptualised largely in terms of biological instincts and psychological drives, and maladaptive behaviours are symptomatic of a subconscious response to social interactions that the mind interprets as unsafe, thereby threatening the stability of the human personality structure. Within a psychoanalytic framework, culture is viewed as having defensive hierarchies that result in cultural patterns and ethnic characters. There is a commonality of defenses and conflicts that are both provided and facilitated by a particular culture, and concepts such as anxiety, depression, defense mechanisms, and dreams are present in people of all cultures. An assumption of this theory is that the modes of expression of these concepts may differ in diverse cultures (Lijtmaer, 2006).

Major Constructs

Id, ego, and superego – One of the most well-known constructs of psychoanalytic theory is that of an interactive system constituting the human personality. The instinctual and biological drives of the psyche are referred to as the id, the superego, and the ego. The id, the ego, and the superego are used to describe the structural model of the personality that drives and guides one's functions and behaviour.

The id constitutes the unorganised part of the personality structure that contains the basic drives. It is the only component of personality that is present from birth. This aspect of personality is entirely unconscious and includes the individual's instinctive drives and primitive behaviours. The id is the source of all psychic energy, making it the primary component of personality. The id functions on the pleasure principle, which emphasises wants and desires and instant self-gratification, and if not satisfied immediately, the result is a state of anxiety or tension (Pigman, 2014). For example, should an infant be hungry or uncomfortable, they will cry until the demands of the id are met.

The superego strives to act in a moral, socially appropriate manner and directly contradicts the instant self-gratification desire of the id. This component of personality consists of one's internalised ideals, morals, and ethics acquired from one's parents and from society (Cherry, 2010). This helps an individual conform to societal norms by encouraging them to behave in socially constructed moral and civilised ways. The superego is present in the conscious, preconscious, and unconscious. This is the last component of personality to develop, emerging around age 5. There are two parts to the superego: The first is the ego-ideal that includes the rules and standards for good behaviours.

These behaviours include those that are approved of by parental and other authority figures. Obeying these rules leads to feelings of pride, value, and accomplishment. The second part is the conscience, which includes information about things that are viewed as bad by parents and society. These behaviours are often forbidden and lead to bad consequences, punishments, or feelings of guilt and remorse (Cherry, 2010).

The ego is the largely unconscious part of the personality that mediates the demands of the id and the superego. The ego prevents individuals from acting on their basic urges (created by the id), but also works to achieve a balance with their moral and idealistic standards (created by the superego). The ego is the component of personality that is responsible for helping an individual cope with reality. According to Freud, the ego develops from the id and ensures that the impulses of the id can be expressed in a manner that is acceptable in the real world. Like the superego, the ego functions in the conscious, preconscious, and unconscious mind. The ego functions on the reality principle that strives to satisfy the id's desires in realistic and socially appropriate ways (Cherry, 2010). The reality principle weighs the costs and benefits of an action before deciding to act on or abandon impulses.

Self-assessment activity

Read the following situational descriptions and identify which of Freud's personality components are at work here.

Situation 1 – Tshepiso has been studying for the final exam in calculus for weeks. The test is Monday. On Friday afternoon her boyfriend, Thando, tells her that he has tickets for the Saturday and Sunday performances of the annual Shakespeare Festival. Tshepiso loves Shakespeare and would really like to spend time with Thando but feels guilty and anxious about it because she must continue to study for the exam. She eventually realises that she can tell Thando that she must study on Saturday but would love to go with him on Sunday.

Situation 2 – Tom has just gotten his driver's license. His parents allow him to drive to and from school, but nowhere else before or after. His friends want him to drive them to the video arcade on the way home, which is about 2 km out of his way. Tom feels nervous at first, and then starts thinking how mean his friends' suggestion is and that he should find new friends who won't ask him to break rules.

Life and death instincts – During Freud's self-analysis later in

life, he explored the purpose and motivations of human existence. Toward the turn of the century, psychoanalysis expanded to include a new class of drives in addition to those mentioned earlier. These drives are referred to as life instincts and death instincts. Life instincts are those that deal with basic survival, pleasure, and reproduction. Behaviours commonly associated with the life instinct include love, cooperation, and other prosocial actions. These instincts are important for sustaining the life of the individual as well as continuing the species. These are often called sexual instincts because the energy created by the life instincts is the psychosexual energy conceptualized as libido, but they also include such constructs as thirst, hunger, and pain avoidance. Conversely, death instincts emerge as self-destructive behaviour, self-harm, and self-sabotage. Death instincts are often expressed as aggression or violence and are tempered by the life instincts (Georgescu, 2011).

Defense Mechanisms – The concept of the defense mechanism can be observed daily across cultures and contexts, even among those who are not familiar with Freud or psychoanalytic theory. These mechanisms are a function of the ego that develops coping strategies to protect the individual from experiencing anxiety and guilt provoked by the discord between the id and superego. These mechanisms shield the mind against feelings and thoughts that are interpreted by the mind as inappropriate, unwanted, or uncomfortable. Psychoanalysis theory proposes several defense mechanisms (Corey, 2012):

- *Compartmentalisation* is a process of separating parts of the self from awareness of other parts and behaving as if one had separate sets of values.
- *Compensation* is a process of psychologically counterbalancing perceived weaknesses by emphasising strength in other areas.
- *Denial* is refusing to accept reality and acting as if a painful event, thought, or feeling did not exist. It is considered one of the most primitive of the defense mechanisms because it is characteristic of very early childhood development.
- *Displacement* is the redirecting of thoughts, feelings, and impulses from an object that gives rise to anxiety to a safer, more acceptable one.
- *Intellectualisation* is the use of a cognitive approach without the attendant emotions to suppress and attempt to gain mastery over the perceived disorderly and potentially overwhelming impulses.
- Projection is the attribution of one's undesired impulses to another.
- *Rationalisation* is the cognitive reframing of one's perceptions to protect the ego in the face of changing realities.

- *Reaction formation* is the converting of wishes or impulses that are perceived to be dangerous into their opposites.
- *Regression* is the return to an earlier stage of development in the face of unacceptable impulses.
- *Repression* is the blocking of unacceptable impulses from consciousness.
- *Sublimation* is the channelling of unacceptable impulses into more acceptable outlets.

A client may use any combination of these coping strategies at any one time. It is when these mechanisms fail to protect the individual at a certain point, however, that the individual will unconsciously experience an overwhelming sense of emotional discord, and it will most likely be at this time that he or she seeks counseling.

Transference and Countertransference – One of the most important concepts associated with psychoanalysis and still referred to today is the idea of transference, or the process of attributing one's feelings to another. Transference during a counseling session can be observed in many forms, including sexual attraction, rage, hatred, dependence, or mistrust (Etchegoyen, 2005). This concept is discernable from displacement or projection because the feelings are attributed primarily to the counselor. Countertransference is also used in counseling, especially when addressing issues of ethics and practice. Countertransference is the emotional reaction to a client based on the counselor's own unconscious conflicts that have been triggered by the client's dialogue. As a counseling tool, this concept can have both positive and negative effects on treatment. Awareness of this process by the counselor can provide important insight into the client's inner world and into the emotions and reactions the client often tends to induce in others.

Goals of psychological intervention

Psychoanalytic theory focuses on unconscious processes as they are manifested in the client's present behaviour. The general goals of psychodynamic counseling are client self-awareness and understanding of the influence of the past on present behaviour, and the correction of the client's distortions is often the primary focus of therapeutic treatment (Thomas, 2008). The primary goal of psychoanalysis is to bring the drives of the id into consciousness, allowing them to be understood and addressed directly, thus reducing the client's reliance on defense mechanisms to function in social contexts (Levenson, 2007). When symptoms are elucidated to bring the unconscious into consciousness or awareness, the ego is strengthened and the client

learns to express his or her needs and wants within a realistic paradigm, resulting in a greater balance between the id and superego.

Process of change

The primary method of psychoanalysis is the identification, analysis, and interpretation of the unconscious conflicts that interfere with the client's daily functioning. This is done using a variety of traditional strategies and techniques.

Intervention strategies

Analysis of transference – One of the most important tools of change for the counselor is the concept of transference. Assuming the position of a blank screen allows the counselor to maintain a neutral position in the therapeutic relationship. This encourages the client to transfer unconscious feelings onto the counselor. Within a psychoanalytic framework, the client experiencing the transference is unconsciously searching for a transformational meeting with another person, and in the case of a counseling relationship, the counselor becomes that person (Binder, 2004). The counselor, as the object of transference, assumes the position of an anonymous tool for the client to expose the unconscious issues driving the maladaptive behaviours and maintains an obscure presence during the process of transference with the goal of analysing the transferred material later.

Analysis of resistances – In addition to analysing transference, the counselor also analyses the resistances observed from the client during sessions with the intent to expose, or bring into consciousness, the underlying causes for those resistances. One of the most important tasks of the counselor–client alliance is to overcome resistance through remembering, reenacting events, and working through negative feelings. Resistance is interpreted as an instinctual reaction to uncomfortable situations in which the client attempts to keep hidden from themself and the counselor. It is a way of avoiding the expression of feelings, fantasies, and drives that the client's subconscious has learned over time to repress and defend.

Posthypnotic suggestions – Hypnosis is a mental state or set of attitudes usually induced by a procedure known as a hypnotic induction that is commonly composed of a series of preliminary instructions and suggestions. The use of hypnotism for therapeutic purposes is referred to as hypnotherapy. It features one or more suggestions made to a hypnotised client that specifies an action to be performed after awakening, often in response to a cue, with the aim of unconsciously redirecting the behaviour.

Hypnosis produces a highly focused, absorbed attentional state that minimises competing thoughts and sensations.

Free association – In free association, psychoanalytic clients are invited to relate whatever comes into their minds during the session without self-censorship. The counselor uses clarification and confrontation to help the client analyse unconscious or latent content in dreams, fantasies, or enactments that appear in the expressed content (Lothane, 2009). This technique is intended to help the client learn more about what he or she thinks and feels in a nonjudgmental, accepting atmosphere. Psychoanalysis assumes that people are often conflicted between their need to learn about themselves and their conscious or unconscious fears of and defenses against change and self-exposure. The method of free association is dynamic and unplanned; the client reveals intuitive links between thoughts and patterns that identify new personal insights and meanings. The goal of this technique is not to unearth specific answers or memories, but to instigate a journey of co-discovery that can enhance the client's integration of thought, feeling, agency, and selfhood.

Dream analysis – Traditional psychoanalysis places a strong emphasis on dreams as keys to the unconscious and wish fulfillments shown in the mind as symbols. The manifest content of the dream is the dream as it is recalled by the client, and the latent content is the actual meaning of the dream once analysed. In practice, this consists of analysing four aspects of dreams. 1. In condensation, one dream object stands for several associations and ideas. 2. In displacement, a dream object's emotional significance is separated from its real object or content and attached to an entirely different one. 3. Representation is a thought that is translated to visual images. 4. Meaningful symbols replace an action, person, or idea (Diena, 2014). These associations point to the inner conflicts and repressed drives of the client and are analysed throughout the course of treatment.

Overview

Psychoanalytic theory has been both acclaimed for its effectiveness and highly criticised for its limitations. Traditional psychoanalysis used structural, developmental, and motivational constructs to describe the complexity of human personality functioning. Many theorists and practitioners focus their criticisms on the lack of specific attention to the present and future, and in particular the lack of attention to cross-cultural applications and the potential for bias toward specific client populations. Other theorists favour the theory because of the dynamic foundation of development and structural components used to explain personality development and its contemporary

applications to present maladaptive functioning (Petrocelli, Glaser, Calhoun, & Campbell, 2001).

A primary limitation of traditional psychoanalysis is the lack of empirical research and evidence-based support for the efficacy of its techniques. Psychoanalysis has historically relied on the applications of case studies to demonstrate its usefulness, and this has limited its broad external validity. Traditional psychoanalysis is known to be a lengthy and costly therapeutic method. The treatment is prolonged and expensive, which makes it prohibitive to many. Another strong criticism of psychoanalytic theory is an oversimplification of cultural paradigms due to its strong focus on sexual development without consideration of the important contributions of class, race, sexuality, gender, and disability across all aspects of development.

Self-assessment activity

Identify the various defense mechanisms that you most often use in your life. After having done this, identify a situation in your life that exemplifies the use of these defense mechanisms and the purpose it serves. Share with the rest of the group on the discussion forum.

PERSON-CENTERED THEORY

The person-centered theory is associated with Carl R. Rogers whose perceptions of people and of how a supportive environment can assist in their development has had an immense impact on a wide variety of professions and on parenting. This approach was a major deviation from the psychoanalytic and behavioural models for working with people that were predominant in the early part of the 20th century. Person-centered theory offered a new way of looking at people and their development, as well as how people can be helped to change. From this frame of reference, people were viewed as fully in charge of their lives and inherently motivated to improve themselves. The responsibility for personal behaviours and the choice to change them were seen as belonging fully to the individual. Rogers believed that people saw the world from their own unique perspective, which is referred to as a phenomenological perspective. It was further assumed that no matter what that phenomenological view of the world was, all people were continually attempting to actualise their best and most productive selves.

The person-centered approach to counseling places confidence in each client. This confidence arises out of a belief that all people

have an innate motivation to grow in positive ways and the ability to carry out such a growth process. This highly positive view of human nature varies widely from other theories that view human nature as evil, negative, or a non-issue.

The person-centered perception of people is based on five key beliefs.

1. *People are trustworthy* – Person-centered therapists must treat their clients as trustworthy, From this point of view, words such as good, constructive, and trustworthy describe natural characteristics of human beings, although people also appear to take actions that demonstrate the opposite.

2. *Movement toward actualisation* – Human beings are viewed by the person-centered theorist as always striving to obtain the best of themselves. This is the driving force in the positive development of the individual. It clearly moves the individual away from control by others based on conditions of worth and toward autonomy and self-control.

3. *Inner resources* – The actualising tendency provides the motive for positive development in people. To carry out this motivation, people draw on inner resources that are available to everyone.

4. *An individually perceived world* – The person-centered view recognises that events will be perceived differently by different people. Cultural background and environmental factors play major parts in how individuals' perceptions and reactions can become very different.

5. *Interaction with external factors* – A person-centered view of human development gives attention to external factors that affect psychological development in addition to critical internal forces. Even as infants, people make choices that induce growth and actualise potential. They reject experiences that are perceived as contrary to their well-being. However, these naturalistic ways of making choices become confused as the developing person recognises that other individuals may provide or withhold love on the basis of how well the person assimilates values and behaviours set by others. This recognition can move individuals away from using their own best judgment to make personal choices and promote an alternative method that requires taking actions based on the presumed desires of others.

Major constructs

The following constructs guide a person-centered approach to psychological intervention:

No two people see the world exactly alike – Practitioners must recognise that whatever they personally believe reality to be, will be different from the client's perspective and that each client will have a unique perspective. Therefore, asking the client to believe or act in a way that "everyone knows is right" becomes the counselor's opinion, based on their own phenomenological view rather than some ultimate fact. Because helping someone from a person-centered approach emphasises this concept, it is imperative to understand the client's perspective as thoroughly as possible.

Empathic understanding – Empathic understanding is critical to the person-centered approach because it refers to understanding the client's world from the client's point of view. This is no easy task, because it is hard for counselors to set aside their biased views of the world in an attempt to see things through the client's eyes. All other actions that practitioners take will be inappropriate without empathy, because they would then be based on inaccurate perceptions of the client. This construct allows practitioners to respond effectively and assures clients that their confidence in the counselor is justified. Practitioners must accomplish two important tasks to make empathic understanding a useful construct: (a) understanding and (b) accurately conveying that understanding.

People make simple mistakes in judgment – People make simple mistakes in judgment all the time. They also make choices that appear to be right to them, but that are ineffective because they are made to match the perceived world of others rather than the individual's own best judgment. People are attempting to act in response to how they believe others would have them act (conditions of worth) rather than trusting their own positive, growth-oriented nature and their tendency to actualise. Such decisions only increase clients' beliefs that they cannot make their own effective choices and must instead look to others for what is best to do or not do.

Place confidence in the client – Person-centered practitioners place tremendous confidence in clients, even knowing that they will make mistakes in judgment along the way. This confidence is based on the belief that people are innately good and continually seeking a fully functioning experience in the world even as they make mistakes. People's tendency to actualise personal potential

in positive ways is the force that the person-centered practitioner recognises and seeks to free from self-induced constraints.

The perceived world of the client may not approximate the world sought – People seek psychological intervention because of difficulties evolving from the fact that the world they perceive is not close to the world they would naturally seek for themselves. The natural, growth-oriented, self-trusting nature of these people has been pushed into conflict with their chosen world, where they continually look outside their true selves for decisions. They act based on perceptions of what others think is right, and the results of their actions are not personally fulfilling or effective. This conflict is termed incongruence. It is a common occurrence, for example, to find that people who are abusive have also experienced an abusive environment.

Congruent individuals trust their worldview – Congruent individuals are those who trust their view of the world, trust their ability to act on their basic positive nature, and generally gain the acceptance they expect. They feel confident about reacting in the present moment because of a belief in their ability to discriminate between appropriate and inappropriate behaviours. Those around them then generally verify this self-trust because congruent individuals' actions tend to be beneficial both personally and socially. When human fallibility causes errors in reactions, congruent individuals also have a view of the world that allows the reactions of others to beevaluated and appropriate adaptive responses to be taken for the immediate and distant future. Congruent people are not infallible, but they do have the ability to recognise and use mistakes to grow without devaluing themselves or others.

Goals of psychological intervention

Moving from incongruence to congruence is the cornerstone person-centered goal for people who are having psychological difficulties. These people are attempting to more accurately perceive their own positive nature and learn to use it more effectively in their everyday lives. As this occurs, they will better accept both their strengths and weaknesses as legitimate and evolving parts of their positive nature. This acceptance reduces distortions in their view of the world and leads to greater accuracy in the match between how they see themselves and their interactions with people, ideas, and things. Reduced distortions and a greater trust in one's evolving positive nature, lead to other specific outcomes that practitioners often identify as goals of counseling. Successful clients generally become more flexible

and creative in their thoughts and actions as they free themselves from stereotypes and inappropriately imposed conditions of worth.

Process of change

The process of change is guided by the presence of three basic conditions: genuineness, acceptance and caring, and empathic understanding. Over the six decades since Rogers (1961) identified these conditions, their significance to the process of change has been integrated into virtually all schools of counseling (Joseph & Murphy, 2012).

Genuineness of the therapist – Clients thoughts, and beliefs that are not hidden behind facades. This genuine nature allows clients to trust that whatever specifics of the relationship emerge, they can be recognised as both personal and honest. It also allows the client to see that being open and genuine, which includes revealing one's fallibility, is not a condition competent human beings must shrink from. Most people's daily relationships are not always genuine but are instead controlled by facades and roles that cause other people to doubt the information they receive from them.

Acceptance and caring provided by the therapist – This allows clients to be less anxious about their perceived weaknesses and the prospect of taking risks. People try to hide their weaknesses, which often results in limited success, various degrees of embarrassment, and an accompanying tendency to work even harder at hiding them. Acceptance and caring consistently felt by the client (as unconditional positive regards) reduces the degree of stress caused by these fears in the relationship. This, in turn, will increase the chances that the client can recognise, discuss, and work on these problem areas rather than hide from them.

Empathic understanding of the client This deep recognition of the client's internal frame of reference must be successfully communicated to the client in order to be effective. Neither counselor nor client can ever fully understand the client, but the degree to which they effectively explore the client's world together to arrive at common understandings will improve the client's abilities to understand and therefore take positive actions in his or her life. Receiving attention and support from a genuine individual who can be trusted allows clients to explore themselves in areas and ways they cannot do in less therapeutic situations. Having another person listen closely and consistently helps clients begin observing and listening to themselves better. They begin to drop their masks as they recognise aspects of themselves

not being quite as bad as they thought they were. Self-recognition and self-acceptance are key first steps in the growth process. As individuals become open to their true experiences and more trusting of their own reflections, they begin to see the blocks to growth that have burdened them. An internal locus of control develops as clients direct their lives rather than follow the direction of others. A major part of the development process in clients is recognising that they are fallible human beings who are always in a growth process. This is very different from the belief that one must be perfect to be good or loved. Accepting this position allows clients to view themselves as continuing to learn and grow throughout their lives and to see success as regular improvement rather than perfection.

Intervention strategies

Person-centered theory is much more related to who counselors are rather than what techniques they use. Some specific behaviours that have consistently been identified as effective communication techniques are:

Active listening – Demonstrating empathy for the client requires highly attentive and interactive listening skills. Therapists must first demonstrate that they are paying attention. They accomplish this by things such as facing clients, leaning toward them, and making good eye contact. Combining this with the use of facial and body expressions that relate to clients' comments will, at least initially, put practitioners and clients in physical contact. Practitioners must then hear and see what is communicated by words and actions to turn the bits and pieces into a holistic picture.

Reflection of content and feelings – The first steps in the empathy exploration process tend to be the recognition and reflection of the actual words stated and the feelings that are most obvious. As client and counselor get to know each other better, an effective practitioner becomes better able to see behind these surface interactions to identify and convey feelings that the client does not even recognise that he or she is expressing. For example, a client may be distracted or become quieter periodically during the session. Initially, these reactions may appear to be related to the specific topic at hand. However, over time, the counselor may be able to tie these reactions to a theme that pulls what seemed to be very different discussion topics together in meaningful ways. Describing to the client what has been recognised can be very valuable, even when it is as little as extended listening, observing, and reflection of the client's world. At its most powerful, reflection can also bring together complex elements of the client's world that draw a much more accurate picture of the client as a

whole than the individual elements provide separately. Counselors who accurately reflect content and feelings act like a mirror by helping clients see what they are expressing so that clients can revise and expand perceptions of themselves based on counselor reflections.

Immediacy – Many of the most powerful interactions are those in which the content and feelings involved relate directly to the immediate situation between the client and the counselor, and when immediate feedback is provided. Immediacy provides a here-and-now approach to the relationship in general and to feelings in particular. Those feelings that both client and counselor are currently experiencing are often the most therapeutic ones available. A major reason for person-centered theory's emphasis on the here and now is that reactions between client and counselor can be verified, checked, and explored immediately by both participants. Statements or feelings from the past make use of only the client's perspective, thus reducing the practitioner's opportunity to be a vibrant part of the client's experience.

Genuineness and self-disclosure – To be genuine, counselors need to look closely at themselves before deciding how to be or what to do. People cannot be genuine and congruent by thinking, saying, or doing what someone else does. Knowing oneself, and being comfortable with that knowledge, is critical. Counselors must be more congruent than their clients, or they are likely to take more from the client than what is given. One clear way to deal with these issues is for practitioners to seek quality helpful relationships, including counseling, for themselves and to work as hard on their own continued growth as they ask their clients to work on theirs. Exploration of counselors' own values, beliefs, biases, and cultural norms and how they act on these is essential for the congruent communication necessary for clients to evaluate the counseling relationship as honest and trustworthy. Cross-cultural counseling requires even greater emphasis on such self-exploration, because when it is lacking, counselors will see clients' differences from themselves as being problems for correction rather than cultural differences in experiences, behaviours, and worldviews.

Personalised therapist actions – It should not be assumed that simplistic listening and reflecting is all the person-centered therapist does. True person-centered approaches will have a consistent foundation, but the full range of the relationship must build on the unique aspects of the counselor, the client, and their personalised relationship.

Overview

The person-centered movement brought about innovations in research and training as well as a new approach to counseling. Emphasising objectivity in the examination of client–practitioner relationships moved the profession forward in the evaluation of specific interaction variables in the therapeutic process. Many of the theory's principles have a solid evidence base, thus recognising that for any theory or technique to remain credible and become more effective, research is essential.

Unfortunately, this solid research background has not erased all concerns about the theory being considered simplistic when it is actually quite complex. It requires greater trust in the client than people are often able to offer and has few of the specific tactics for new therapists to fall back on that other theories provide. Assumptions about its simplicity makes it appear to be so simple to learn. The concepts are relatively few, there is not a long list of details to remember, and one does not need to recall a specific tactic for each diagnostic problem a client might have. The therapist can be lulled into a feeling of security by this apparent simplicity. For example, simple listening and reflecting words and surface feelings are usually beneficial at the very beginning of a session. However, continued surface-level interactions that do not attend to the many dimensions of both the client and the practitioner quickly become seen as repetitive, nondirectional, and trite.

The few basic concepts in person-centered theory have a virtually unlimited complexity because counselors must be fully aware of both their clients' and their own changing phenomenological worlds. They must respond to the interactions between these worlds in ways that are genuine.

This difficult task requires excellent understanding and continuing awareness of oneself and the client.

New counselors, in particular, have a difficult time with this complexity. Feeling the pressure to remember and do a new thing or a right thing naturally makes it more difficult to be genuine and aware of all that is happening around and within themselves and others. The supportive nature of person-centered theory is often misinterpreted to mean that one should not be confrontational with clients. Effectively functioning people confront themselves all of the time, and counselors must recognise that appropriate confrontation is a natural part of an effective helping relationship. Person-centered theory makes room for such confrontation, but it gives few specific guidelines as to where, when, and how it should occur. There are few techniques or activities to fall back

on if the counselor does not have or cannot act on a great deal of personal knowledge, understanding, and awareness in the helping relationship. Many other theories provide more activities or tactics that allow the practitioner to give the process a boost when the relationship is not all it could be.

Self-assessment activity

Watch the YouTube video on Person-Centered Therapy Role Play at https://www.youtube.com/watch?v=7PV9Yp34awQ. Identify the some of the central concepts of the Person-centered theory as portrayed in the YouTube video you have just watched.

COGNITIVE BEHAVIOUR THEORIES

Cognitive behaviour theories (CBTs) are best conceptualised as a general category of theories, or a set of related theories, that have evolved from the theoretical writings, clinical experiences, and empirical studies of behavioural and cognitively oriented psychologists and other mental health workers. The term cognitive behaviour reflects the importance of both behavioural and cognitive approaches to understanding and helping human beings. To understand CBT, it is necessary to study the history of the development of behaviour theory, various cognitive models, and the union of these approaches into CBT.

John B. Watson and the beginnings of behaviour theory – Early behaviourism was based on learning theory; the development of clearly defined techniques; and systematic, well-designed research. John B. Watson is widely recognised as the most influential person in the development of behaviourism, which emerged as a reaction against the Freudian emphasis on the unconscious as the subject matter of psychology, and introspection as the method of its investigation. According to Watson, behaviour should be the sole subject matter of psychology and that it should be studied through observation.

B. F. Skinner – Skinner further developed the field of behaviourism by introducing the principles of reinforcement and operant conditioning. Skinner maintained an adamant denial of the importance of cognitions and affect in understanding human behaviour. He developed applied behaviour analysis, which is based on operant conditioning. In operant conditioning, reinforcers shape behaviour by being contingent on the response. Key interventions in applied behaviour analysis include reinforcement, punishment, extinction, and stimulus control, each of which involves a search for environmental variables that will lead to changes in behaviour. In operant conditioning,

reinforcement is used to increase behaviour. Examples of positive reinforcement include praise and money. Negative reinforcement, which also increases behaviour, involves the removal of a negative stimulus, such as an electric shock or a ringing bell. Punishment and extinction decrease behaviour through the addition of an aversive stimulus or the removal of a positive reinforcer. An example of punishment involves following cigarette smoking with electric shock. In extinction, a behaviour that has to be decreased is ignored; for example, a person who has the habit of interrupting conversation is ignored by friends when he or she interrupts, but friends listen when the comment is made in conversation without interrupting.

Major constructs

Cognitive therapy – The cognitive revolution brought forth by Aaron Beck, Albert Ellis and others who began as clinicians found that the available systems of therapy were not satisfactory. Aaron Beck (1976) was dissatisfied with psychoanalysis and behaviour therapy. Though trained as a psychoanalyst, Beck objected to the unconscious aspects of Sigmund Freud's theory (Rosner, 2012), asserting that people can be aware of factors that are responsible for emotional upsets and blurred thinking. At the same time, he found the radical behavioural explanation for human emotional disturbance to be too limited to adequately explain human emotional difficulties. For Beck (1976), psychological disturbances may have been the result of "faulty learning, making incorrect inferences on the basis of inadequate or incorrect information, and not distinguishing adequately between imagination and reality" (pp. 19–20). Beck's work in cognitive therapy has been extremely influential in the treatment of depression and has been expanded to other psychological problems.

There is an assumption that behaviour is learned. This applies equally to the explanations of how problem behaviours and adaptive behaviours are learned. Behaviour is assumed to be developed and maintained by external events or cues, by external reinforcers, or by internal processes such as cognition. Development is based on each individual's different learning history, experiences, and cognitive understanding of the world. Emphasis is placed on the present in understanding the presenting problems of a client.

Because CBTs are an amalgamation of behavioural and cognitive approaches, the cognitive–behavioral theoretical constructs contain aspects of both behaviour and cognitive theories. For behavioural interventions, purely behavioural terms such as *behavioural excesses* or *deficits, learning theory,* and *observed*

changes in behaviour are used. Cognitive interventions on the other hand, are based on purely cognitive terms such as *cognitive excesses or deficits, semantic interventions (cognitive),* and *changes in cognitions*. Cognitive–behavioural interventions are considered to encompass a range of approaches limited by the purer behavioural and cognitive interventions. Treatment targets range from behavioural excesses and deficits to cognitive excesses and deficits, and cognitive–behavioural interventions target both cognitive and behavioural excesses and deficits. The treatment interventions also range from an emphasis on behavioural interventions, to an emphasis on cognitive interventions with some behavioural strategies included, to a full integration of cognitive and behavioural strategies.

The importance of cognitions – The unifying characteristic of cognitive–behavioural interventions is the emphasis on the importance of cognitive workings as mediators of behavioural change (Dobson & Dozois, 2001). All cognitive behaviour therapies share these three fundamental propositions:

- Cognitive activity affects behaviour.
- Cognitive activity may be monitored and altered.
- Desired behaviour change may be affected through cognitive change (Dobson & Dozois, 2001, p. 4)

The importance of learning – CBTs assert that abnormal behaviour is learned and developed in the same way that normal behaviour is learned, and that cognitive–behavioural principles can be applied to change the behaviour. The importance of this statement lies in the focus on learning as the way that behaviour is acquired, rather than through underlying intrapsychic conflicts. It rejects the psychodynamic and quasi-disease models of development, which assume that underlying intrapsychic conflicts cause maladaptive behaviour.

The importance of operational definitions and functional analysis – In cognitive–behavioural approaches, problems are viewed operationally. The definition of the presenting problem must be concrete, specific, and observable whenever possible. It is assumed that problems are functionally related to internal and external antecedents and consequences. This assumption means that in order to understand behaviour, it is necessary to know the events that precede (antecedents) and follow (consequences) the behaviour. These events may be external and observable behaviours or internal thoughts and feelings. The functional relationship conceptualisation of problems necessitates a clear understanding of the internal and external antecedents that contribute to a problematic behaviour as well as the internal and external consequences that maintain behaviour. This also means

that the causes and treatments of problems should be multidimensional. Causes might include behaviours, environmental circumstances, thoughts, beliefs, or attitudes. Because there is rarely a single cause for a problem, treatments are comprehensive and designed to address multiple issues.

The importance of therapeutic empathy – Unfortunately descriptions of cognitive-behavioural interventions often emphasise the importance of techniques and theory at the expense of the relationship between the client and the therapist. The use of therapy manuals may restrict the therapist's ability to respond to the client's needs in the moment. Therapists cannot become so reliant on techniques that they forget that clients require a warm and supportive environment in the therapeutic process. Thus, it is important to be clear that although cognitive–behavioural treatment manuals focus on the specific treatment techniques, the helping relationship is also addressed. Beck (1976) described the importance of the relationship and included strategies for developing a therapeutic relationship in manuals. Burns and Auerbach (1996) highlighted the necessity of a warm, empathic therapeutic relationship in cognitive therapy. The efficacy of the intervention is dependent on a relationship that is characterised by counselor or therapist warmth, accurate empathy, and genuineness (Beck, Wright, Newman & Liese, 1993).

Goals of psychological intervention

Cognitive–behavioural interventions include various combinations of cognitive and behavioural techniques and are aimed at changing either cognitions, behaviour, or both. They are directive, structured, goal-directed, and time-limited treatments, and most types involve the client in a collaborative relationship with the therapist. The use of homework assignments and skills practice is common, along with a focus on problem-solving ability. Cognitive–behavioural interventions can be applied to counseling the culturally diverse. Providing culturally responsive cognitive behaviour therapy includes accepting the client's core cultural values and belief systems, validating potential experiences of disparity and oppression, understanding the client's cultural context, and highlighting culturally related strengths and supports.

Case conceptualization – a therapist with a CBT orientation begins the intervention by developing a conceptualisation, or understanding, of the case. In CBT, the case formulation has five components: problem list, diagnosis, working hypothesis, strengths and assets, and treatment plan (Persons & Davidson, 2001).

The problem list is a comprehensive list of the difficulties stated in concrete behavioural terms. Usually, five to eight problems are identified in a variety of areas, such as psychological symptoms, interpersonal relationships, occupational problems, financial difficulties, medical diagnoses, lack of adequate housing, or legal issues (Persons & Davidson, 2001). Relationships between the problems may become clear when all of the issues are listed in this way. It is also useful to see a list of all of the issues so that prioritisation of issues can be used when preparing the treatment plan. A comprehensive problem list requires a detailed assessment and involves asking clients about areas that they may not have initially discussed. An important issue that clients may not report is substance abuse.

Another component in the case formulation plan is diagnosis, which is done on the basis of the Diagnostic and Statistical Manual of Mental Disorders method of presenting information along five axes. Diagnosis is not always included in CBT conceptualisations, but it is important because it provides a link to the type of treatment that may be selected.

The working hypothesis is considered the most critical part of the case conceptualisation and entails the presentation of the connections between the issues on the problem list. It consists of subsections, including schemata, precipitating or activating situations, and origins. The schemata section concerns the core beliefs held by the client. Core beliefs refer to those thoughts that are central to the problem, and these beliefs may cause or maintain the problems. Usually, they are clients' negative thoughts about themselves, the world, others, or the future. Precipitating or activating situations refers to the specific external events that produce the symptoms or problems. They are things that may have happened just before the problem began. Origins refers to early history that might be related to the problems. Origins might explain how the client learned the schemata that maintain the current situation.

Strengths and assets refer to the positive aspects of a person's current situation. For example, a client may have good social skills, the ability to work collaboratively, a sense of humour, a good job, financial resources, a good support network, a regular exercise routine, intelligence, personal attractiveness, and/or a stable lifestyle (Persons & Davidson, 2001).

These strengths can be used when developing the treatment plan. The treatment plan is the outcome of the case conceptualisation. It must be related to the problem list and working hypothesis. The

treatment plan talks about the goals of the psychological intervention. Treatment plans are also complex and require attention to goals and obstacles as well as modality, frequency, interventions, and adjunct therapies. The goals of treatment must be reviewed with the client, and both counselor or therapist and client must agree on these goals. It is also important to know how progress in counseling or psychotherapy can be measured and monitored.

Process of change

The process of change is concerned with understanding how a theory explains the mechanisms for therapeutic change. This is particularly important in the cognitive–behavioural arena because there are many different theories and many different interventions.

Self-Efficacy – The self-efficacy theory of Albert Bandura (1986) has been used to provide a cognitive–behavioural theoretical explanation for how people change. Self-efficacy theory asserts that individuals develop expectations for their success in performing specific behaviours and that these expectations influence their decision to try new behaviours and maintain behaviour changes (Bandura, 1986). Self-efficacy may be thought of as a sense of personal competence or feelings of mastery. Thus, cognitive behaviour therapy may work through increasing the self-efficacy of clients. Bandura (1986) described four mechanisms through which self-efficacy can be developed: enactive attainments, vicarious experiences, verbal persuasion, and recognition of physiological states.

Enactive attainments refer to an individual's own experience with achieving a goal. Vicarious experiences refer to observing others as they succeed or fail. Verbal persuasion is a less powerful way to influence self-efficacy. Physiological states refer to the emotional arousal or degree of apprehension one feels. Feelings of fear may lead to decreased performance, whereas a moderate amount of anxiety may be helpful when performing a new task. These sources of self-efficacy can be applied to teach clients assertiveness skills. When clients are taught assertiveness skills, they practice making appropriate assertive comments. Enactive attainments are experiences of success that lead clients to feeling able to repeat the assertive behaviour. It is important to recognise that all four sources of self-efficacy are involved in how cognitive therapy and other cognitive–behavioural interventions work.

Does changing beliefs lead to a change in behaviour? Addressing the question of how people change, Beck (1976) asserted that

behaviour and affective change are hypothesised to occur through the change in cognitions. The assumption is clearly that changing beliefs is the key to helping people. Research has demonstrated that cognitive therapy does indeed change thoughts and that there are reductions in psychological disturbances.

Intervention strategies

Cognitive–behavioural interventions include aspects of both behavioural and cognitive interventions.

Behavioural interventions

Behavioural interventions focus primarily on changing specific behaviours. Examples of purely behavioural interventions include reinforcement, extinction, shaping, stimulus control, and aversive control.

Reinforcement is a well-known behavioural strategy. Positive reinforcement is a procedure in which some specific behaviour is increased by following it with something rewarding. For example, children who clean their room are given praise and attention, a gold star, or a new toy. Negative reinforcement is the removal of something aversive to increase behaviour. The buzz most cars make when the key is put in the ignition is a negative reinforcer designed to increase seatbelt use. Both positive and negative reinforcement increase behaviour and can be applied when clients want to increase a behaviour.

Extinction is a behavioural intervention designed to decrease a problematic behaviour. In this case, a reinforcer that followed the behaviour in the past is removed, and the problem behaviour decreases. For example, think about a child who repeatedly gets out of his or her seat in a classroom. When the teacher notices and asks the child to sit down, the child may return to the seat. However, the attention of the teacher is reinforcing, and the problem of out-of-seat behaviour usually continues. Extinction is the procedure in which the teacher ignores the behaviour until it stops.

Shaping is a behavioural intervention used to gradually increase the quality of a behaviour. Often used to teach a new skill, shaping works by reinforcing the behaviour as it gets closer to the final goal. Shaping is used when there is a clearly identified behaviour to be changed and when differential reinforcement (reinforcing the behaviour that gets closer and closer to the target while ignoring the other behaviour) can be applied to successive approximations of the behaviour.

In *stimulus control*, some event in the environment is used to cue behaviour. When a stimulus leads to behaviour that is desirable and will be reinforced, the cue is called a discriminative stimulus. For example, seeing exercise shoes in the living room may act as a cue to use an exercise tape to do aerobics. The exercise shoes are a discriminative stimulus for exercise.

One example of aversive control is *punishment*, which is defined as the addition of an unpleasant event following a negative behaviour to decrease the occurrence of that behaviour. Punishment is not used often by behaviourists, but it has been used to eliminate dangerous behaviours, such as head banging or other self-mutilative behaviours in severely emotionally disturbed children.

Cognitive interventions

Cognitive interventions focus on the role of cognitions in the lives of clients and how cognitive distortions can be identified and changed through the process of cognitive therapy. Some types of cognitive distortions include all-or-nothing thinking, disqualifying the positive, and catastrophising (Burns, 1999).

All-or-nothing thinking is characterised by assuming that things are either 100% perfect or absolutely terrible; there is no gray area. Because few things are perfect, all-or-nothing thinking usually leads to depression, as everything is viewed as terrible.

Disqualifying the positive is defined as rejecting any positive experiences (i.e., compliments) and assuming that these positive events do not really count for some reason. The person using this type of distortion may say, "I only received an A because the test was so easy" or "She is only complimenting me because she wants a ride in my new car."

Catastrophising is exaggerating a negative event so that it has much more impact than it deserves. Making a mistake at work or receiving a B on a quiz may be catastrophised into losing the job or failing the course.

Cognitive therapy works through using many kinds of procedures, including thought stopping and positive self-statements, to change these negative or maladaptive kinds of thoughts.

Thought stopping is a cognitive self-control skill used to help the client cope with negative cognitions that cause distress, are untrue, or are counterproductive (Bakker, 2009). It is designed to

interfere with thoughts that run through the mind of the client and make it difficult to change behaviour. In this procedure, the client imagines the troublesome thought running through his or her mind and the counselor or therapist shouts “Stop!” Although the client may be a bit surprised, the shout does usually stop the thought. The client can then replace the thought with a more adaptive one like, “I can handle this situation.”

The use of *positive self-statements* can go along with thought stopping. Statements such as, “My opinion is important” or “I am an assertive person” can be practised over and over. It is normal that these thoughts may not feel quite right at first. The important point is that what clients tell themselves influences their feelings and behaviour. The counselor or therapist may use the self-statements as a way to cue assertive behaviour by saying, “If it were true that your opinion was important, how might you behave?” The client might be encouraged to try acting as if the statements were true.

Overview

There is a tremendous amount of research literature on the effectiveness of various cognitive–behavioural interventions for different types of disorders. The most recent studies have focused on diverse groups. The whole continuously developing body of work on empirically supported treatments is indicative of research that demonstrates the efficacy of cognitive behaviour therapy for a variety of problems. Most notably, the use of CBT for the treatment of depression. Beck’s cognitive therapy, developed for the treatment of depression, has been the subject of numerous treatment outcome studies. Research findings indicated that cognitive therapy is as effective as medication in the treatment of depression, even in cases of severe depression (Beck, Hollon, Young, Bedrosian & Budenz, 1985), and that a combination of cognitive therapy and drug treatment for depression is better than drug treatment alone (DeRubeis, Gelfand, Tang & Simons, 1999).

The union of cognitive and behavioural therapy into cognitive-behaviour therapy has been able to overcome many of the limitations of either type of therapy alone. However, those individuals who are more inclined toward psychodynamic interpretations continue to object to the lack of attention to unconscious factors in determining behaviour. Others are critical of the lack of attention CBT gives to the role of thoughts and feelings, ignoring the historical context of the present problems, and allowing the therapist too much power to manipulate the client.

Self-assessment activity

What is cognitive restructuring (also referred to as cognitive reappraisal)? Come up with a real-life example of the technique and share it on the discussion forum.

FAMILY THEORY

Up to this point, we have focused on psychological intervention modalities that focus on the individual. In this last section of the learning unit, we shift our attention to modalities that have the family system as the prime focus. This will give us a sense of how, in the context of psychological intervention, the scope can be enlarged from individuals to families and the larger sociocultural contexts that make up an individual's environment. Family therapy can help you look at the patterns of communication and relationships that connect people to one another and to their social

and physical environments.

Gregory Bateson – Bateson is widely acknowledged as the pioneer in applying cybernetic systems thinking to human interaction (Imber-Black, 2004). He saw that cybernetics provided a powerful alternative language for explaining behaviour – specifically, a language that did not resort to instinct or descriptions of the internal workings of the mind (Segal, 1991). Bateson began to use these ideas to understand social interaction and considered pattern, process, and communication as the fundamental elements of description and explanation. He believed that by observing human systems, he could formulate the rules governing human interaction.

The Palo Alto Group – In 1952, while based in Palo Alto, California, Bateson received a grant from the Rockefeller Foundation to investigate the general nature of communication. He was joined on this project by Jay Haley, John Weakland, William Fry and Don D. Jackson. This research team defined the family as a cybernetic, homeostatic system whose parts (i.e., family members) co-vary with one another to maintain equilibrium by means of error-activated negative feedback loops (Jackson, 1957). For example, whenever deviation-amplifying information is introduced (e.g., an argument between two family members or the challenge of a new stage in the family life cycle), a designated family member initiates a counter-deviation action (e.g., the family member exhibits symptomatic behaviour) so that the family's existing equilibrium is restored (i.e., threatened changes are defeated). The emphasis on homeostasis prevailed in family therapy theory into the 1980s. The recognition of the

symptomatic double bind as a homeostatic maneuver regulating family patterns of relationship is considered the definitive contribution of the Palo Alto Group.

As with individual development, a family system can be seen as a developmental process that evolves over time. Developmental models of family life include the family life cycle and the family genogram.

The Family Life Cycle – Jay Haley (1993) offered the first detailed description of a family life cycle. He identified six developmental stages stretching from courtship to old age. Haley was interested in understanding the strengths families have and the challenges they face as they move through the life cycle. He hypothesised that symptoms and dysfunction appeared when there was a dislocation or disruption in the anticipated natural unfolding of the life cycle: "The symptom is a signal that a family has difficulty in getting past a stage in the life cycle" (p. 42). Over time, tension inevitably emerges in families because of the developmental changes they encounter (Smith & Schwebel, 1995).

Family stress is most intense at those points when family members must negotiate a transition to the next stage of the family life cycle (Carter, Preto & McGoldrick, 2016). On one level, this stress may be viewed as part of the family's response to the challenges and changes of life in its passage through time — for example, a couple may encounter tension while making the transition to parenthood with the birth of their first child. On another level, pressures may emerge from the multigenerational legacies that define the family's attitudes, taboos, expectations, labels, and loaded issues — for example, over several generations, a rule that men cannot be trusted to handle the money may impose stress when the female is absent. When stress occurs on both levels, the whole family may experience acute crisis. Family therapists can find it difficult to determine the exact sources of stress on a family.

The family genogram – Genograms give family therapists another useful way to conceptualise family development. Typically, genograms are used to chart the progression of a particular family through the life cycle over at least three generations. They are like a family tree that includes information about birth order, family members, family members' communications, and issues of relationships. The work of Monica McGoldrick provides an excellent resource for clinicians unfamiliar with the use of genograms (see McGoldrick, Gerson & Petry, 2008). Genograms

often provide the basis for clinical hypotheses in family work and offer a culturally sensitive method for understanding individual or family clients. For example, Magnuson, Norem and Skinner (1995) recommended mapping the relationship dynamics in the families of gay or lesbian clients. They pointed out the importance of mapping the relationship markers of gay or lesbian couples that are not recognised by general society. A number of researchers have described the effective use of a genogram intervention with families of colour (Lim & Nakamoto, 2008).

Self-assessment

Construct a genogram of your family. Using the principles of family therapy, how would you describe your family and why?

Major constructs

Family theory has done much to expand our psychological intervention vocabulary. Some of its major theoretical constructs are outlined and briefly explained here.

Family – This term applies to two or more people who consider themselves family. These persons generally share a common residence and assume the obligations, functions, and responsibilities generally essential to healthy family life, such as economic support (Barker, 2003).

Dyad – This term denotes a two-person system (McGoldrick & Carter, 2001).

Family boundaries – This term denotes the explicit and implicit rules within a family system that govern how family members are expected to relate to one another and to non-family members (Barker, 2003).

Family homeostasis – This term is used to describe a family system's tendency to maintain predictable interactional processes. When such processes are operating, the family system is said to be in equilibrium (Sauber, L'Abate, Weeks & Buchanan, 1993).

Family system – A family system is a social system built by the repeated interaction of family members. These interactions establish patterns of how, when, and to whom family members relate (Sauber et al., 1993).

Family therapy – This is an umbrella term for therapeutic approaches for which the whole family is the unit of treatment.

This term is theoretically neutral, as one can conduct family therapy using a variety of frameworks (Reber, 2002).

Triangulation – This term describes the process of a third person or thing being added to a dyad to divert anxiety away from the relationship of the twosome (McGoldrick & Carter, 2001).

Goals of psychological intervention

Family therapy represented a watershed in the history of counseling or therapy. Before family therapy, the focus of counselors or therapists had been solely on the individual. The goal of counseling or therapy was always to change some cognitive, affective, or behavioural component of an individual. In contrast, family therapists aim to change systems within which individuals reside (Becvar & Becvar, 2013).

Process of change

Family therapists use cybernetics to understand change – specifically, the cybernetic control processes involving information and feedback. Information in the form of feedback precipitates shifts that either amplify or counteract the direction of change. Family therapists differentiate between first-order change and second-order change.

First-order change – First-order change occurs when a family modifies problem behaviours yet maintains its present structure. An example of a first-order change intervention is a family therapist instructing parents when they can fight with their son over bedtime. Through this intervention, the family therapist hopes to give the family relief from its problem behaviour; radical change of the present family system is not a goal. Family therapists call the process of bringing about this type of change negative feedback.

Second-order change – In contrast to first-order change, second-order change refers to transformations in either the structure or the internal order of a system. Family therapists often seek to generate or amplify change processes that will alter the basic structure of a family system (Nichols, 2012). This goal embodies second-order change. An example of a second-order change intervention is a family therapist directing the more passive parent to take over bedtime compliance responsibility with the goal of changing the power dynamics in the marital dyad. Family therapists call the process of bringing about second-order change positive feedback.

Intervention strategies

Specific Versus Nonspecific Factors – A strong current trend in individual-focused psychological intervention research is an examination of the specific and nonspecific factors involved in treatment outcomes. Specific factors are those intervention activities that are specific to a particular approach – for example, the use of free association in psychoanalysis. Nonspecific factors are those change-producing elements present in an intervention regardless of theoretical orientation. Many nonspecific factors have been proposed, but few have withstood empirical testing. One exception is the working alliance, the measure of which is the best known predictor of counseling or therapy outcomes (Horvath, 1994). According to Bordin (1994), there were three components of a working alliance: task, goal, and bond. He conceptualised these three components as follows:

- *Task* refers to the in-therapy activities that form the substance of the intervention process. In a well-functioning relationship, both parties must perceive these tasks as relevant and effective. Furthermore, each must accept the responsibility to perform these acts.
- *Goal* refers to the therapist and the client mutually endorsing and valuing the aims (outcomes) that are the target of the intervention.
- *Bond* embraces the complex network of positive personal attachments between client and therapist, including issues such as mutual trust, acceptance, and confidence (Horvath, 1994).

Overall, Bordin's working alliance model emphasised "the role of the client's collaboration with the therapist against the common foe of the client's pain and self-defeating behavior" (Horvath, 1994, p. 110). Given the effectiveness of the working alliance concerning treatment outcomes, persons practising family therapy would be wise to attend carefully to such alliances. At the same time, it needs to be emphasised that committing to building strong working alliances with a client family does not mean that you have to dismiss technique. Rather, it means acknowledging that techniques should not be separated from the interpersonal and cultural contexts in which they occur (Coady, 1992).

The Family Interview – From the start, Haley (1991) advocated brevity and clarity in counseling or therapy work with families. He stated, "If therapy is to end properly, it must begin properly – by negotiating a solvable problem and discovering the social situation that makes the problem necessary" (p. 8). To help family therapists start on a good note, Haley outlined a structured family interview for use during an initial session. The five stages of this structured family interview are as follows:

- *Social* – The interviewer greets the family and helps family members feel comfortable.
- *Problem* – The interviewer invites each person present to define the problem.
- *Interaction* – The interviewer directs all members present to talk together about the problem while the interviewer watches and listens.
- *Goal setting* – Family members are invited to speak about what changes everyone wants from the therapy.
- *Ending* – Directives (if any) are given, and the next appointment is scheduled.

The information gained from the first interview helps the family therapist form hypotheses about the function of the problem within its relational context. Moreover, this information can help the family therapist generate directives to influence change. For Haley, "the first obligation of a therapist is to change the presenting problem offered. If that is not accomplished, the therapy is a failure" (p. 135).

Overview

While solid research evidence for the efficacy of family therapy for treating a wide range of issues now exists (Vilaça & Relvas, 2014), therapists have been slow to adopt this practice in their work. We also need to recognise that family is a culturally determined phenomenon. For example, in the white western context, family refers to the intact nuclear family unit. In black culture, family refers to a wide network of kin and community. Thus, an effective family therapist must possess a high degree of cultural competence with diverse populations (McDowell, 2004). Otherwise, marginalisation and colonisation enter into and poison the family therapy process (McDowell, 2015). In a review of the literature on cultural competence and family interventions, Celano and Kaslow (2000) noted that family therapists can be efficacious and culturally competent only when they do the following:

- Recognise the effects of their own culture(s) on the therapy.
- Acknowledge that family therapies, theories, and techniques reflect the culture in which they were developed.
- Attend to the dynamic interplay of the cultural influences that affect the individual's and family's functioning.
- Devise and implement problem resolution strategies that are culturally acceptable.

One of the main criticisms against family therapy has been that the early language chosen for describing family systems was "combative and bellicose, often suggesting willful opposition:

double bind, identified patient, family scapegoat, binder, victim, and so on" (Nichols, 1987, pp. 18–19). The choice of language emphasised the destructive power of families and contributed to an assault on the family by several pioneers in family therapy (Cooper, 1970). This assault has continued to the present because many family therapy educators and practitioners have overread this language and adopted a directive, manipulative approach to treatment. This overreading has led to unfortunate consequences. For example, Patterson and Forgatch (1985) uncovered, in their study of families in treatment, a direct relationship between client resistance and frequency of counselor or therapist directives. Second, family therapists have ignored the different socialisation processes operating for men and women. Thus, family therapists have not adequately considered how these socialisation processes have disadvantaged women (Friedlander, Wildman, Heatherington & Skowron, 1994). Walters, Carter, Papp and Silverstein (1988) called for family therapists to review all family therapy concepts through the lens of gender socialisation to eliminate the dominance of male assumptions. Their hope was that such a review would promote the "recognition of the basic principle that no intervention is gender-free and that every intervention will have a different and special meaning for each sex" (p. 29).

Self-assessment

Do a Google search and compare and contrast the different approaches to family therapy.

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[i] The material in this chapter has been adapted from the following chapters in Capuzzi, D. & Stauffer, M.D. (eds) (2015). Counseling and psychotherapy: Theories and interventions. 6th Edition. Alexandria, VA: American Counseling Association (ACA).

- Adrianne L. Johnson - Psychoanalytic Theory - Chapter 3 (pp. 73-96)
- Richard J. Hazler - Person-Centered Theory - Chapter 7 (pp. 169-193)
- Yurandol O. Powers and Cynthia R. Kalodner - Cognitive Behavior Theories - Chapter 9 (pp. 227-252)
- Cass Dykeman - Family Theory - Chapter 13 – (pp. 339-366)