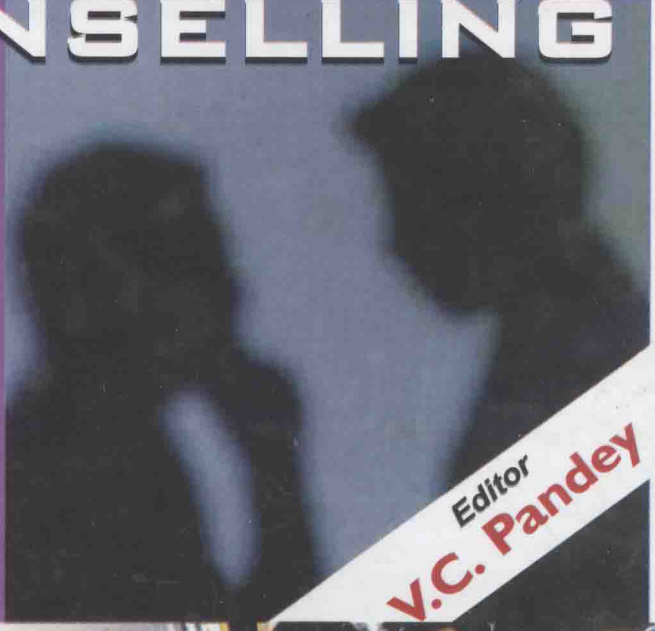
EDUCATIONAL GUIDANCE AND COUNSELLING



Editor
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PREFACE

Students are challenged daily to make decisions in an environment fraught with tension and uncertainty. Faced with social, economic, and cultural issues to a degree not experienced by previous generations, students must have proactive choices to nurture the potential they each have to become successful learners. Guidance and counselling programmes, as educational programmes, creates options for students to develop and emphasise strategies which enhance this potential.

Guidance and counselling programmes are integral part of each school's total educational program. It is developmental by design and includes sequential activities organised and implemented by certified school counsellors with the support of teachers, administrators, students, and parents. Generally a guidance and counselling programme include guidance curriculum, individual planning, responsive services and system support. Through counselling individuals may be facilitated in working towards living a more satisfying and enjoyable life.

The present book provides a vivid and in-depth description of all fundamental aspects related with educational guidance and counselling. The nature, purpose, techniques, procedures and scope of educational guidance and counselling programmes are covered comprehensively. The skills needed by counsellors, significance of carrier development, techniques of counselling students with special needs etc., are also described in detail. This book will assist guidance counsellors, guidance supervisors, teachers and parents.

Editor

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Understanding Guidance and Counselling

The Counselling Service aims to provide a professional and supportive service to the clients who are in need of help. The main activity of the Service is in providing individual counselling sessions to students within a confidential and supportive setting. The counsellors working for the service endeavour to conduct these counselling relationships in ways that respect the individual's values, rights and personal resources for coping. Through counselling individuals may be facilitated in working towards living a more satisfying and enjoyable life. Counselling offers an opportunity to talk with someone in a confidential and supportive setting. The counsellor will not advise the you about what you should think and feel in relation to their situation, or even what action you should take. Instead, they will facilitate you in exploring the issues that are concerning you and that you wish to address in counselling.

The purpose of counselling is not to tell you what to do. This is partly because it would stop you developing your own resourcefulness, but mostly because the counsellor cannot possibly know what is best for you in your particular situation. The emphasis, therefore, will be on offering you non-judgmental support and trying to understand, with you, what you are going through. It is hoped that by doing this you will be able to

develop your own answers and ways of overcoming your difficulties. People come for counselling for different reasons.

A particular event may have caused distress or a person may want to deal with something that has been going on for some time. In addition, the concerns that people bring to counselling vary enormously. These concerns can include: relationships (with friends, partners or family); self-harm; eating disorders; study problems; loneliness; depression; self-confidence; sexuality; bereavement; cultural issues; and self-esteem. There is also wide variation in the degree of distress that a person is experiencing when they come for counselling. Some people are aware that something is troubling them, although they're not experiencing too much difficulty, whereas others are already extremely distressed, perhaps feeling suicidal.

Therefore some people may be experiencing crisis, whereas others may feel their situation is not so urgent. But whatever the nature of your situation, you may find counselling to be of some help. The Counselling Service has a core staff team of professionally trained and qualified counsellors who are used to working with people experiencing a wide variety of difficulties.

HISTORY OF COUNSELLING AND PSYCHOTHERAPIES

Although psychological therapies trace their history back to the contributions of Freud, many modern approaches to counselling and psychotherapy are now much more firmly grounded in other bodies of thought. Modern psychological therapies trace their history back to the work of Sigmund Freud in Vienna in the 1880s. Trained as a neurologist, Freud entered private practice in 1886 and by 1896 had developed a method of working with hysterical patients which he called 'psychoanalysis'. Others such as Alfred Adler, Snador Ferenczi, Karl Abraham and Otto Rank were also analysed by Freud and had brief apprentice-type training from him before becoming psychoanalysts in their own right.

In the early 1900s, Ernest Jones and A.A. Brill, from the UK and US respectively, visited Freud in Vienna and returned to their own countries to promote Freud's methods; Freud himself began a lecture tour of North America in 1909. Gradually many such as Ferenczi, Adler, Rank, Stekel and Reich began to develop their own theories and approaches, which sometimes differed markedly from Freud's. Jung in particular, a close collaborator of Freud's from 1907-1913 who was in some sense 'groomed' as Freud's intellectual successor, eventually split from Freud and pursued the development of his own school of analytical psychology, drawing heavily on both Freud's and Adler's ideas. All these immediate descendants of Freud's approach are characterized by a focus on the dynamics of the relationships between different parts of the psyche and the external world; thus the term 'psychodynamics'.

A separate strand of psychological therapies developed later under the influence of psychology and learning theory and leading thinkers such as B.F. Skinner. Rejecting the notion of 'hidden' aspects of the psyche which cannot be examined empirically (such as Freud's rendition of the 'unconscious'), practitioners in the behavioural tradition began to focus on what could actually be observed in the outside world. Finally, under the influence of Adler and Rank, a 'third way' was pioneered by the US psychologist Carl Rogers.

Originally called 'client-centred' and later 'person-centred', Rogers's approach focuses on the experience of the person, neither adopting elaborate and empirically untestable theoretical constructs of the type common in psychodynamic traditions, nor neglecting the internal world of the client in the way of early behaviourists. Other approaches also developed under what came to be called the 'humanistic' branch of psychotherapy, including Gestalt therapy and the psychodrama of J.L. Moreno. The figure below illustrates some of the historical links between these three main strands which developed from Freud's original contributions.

Medical vs. Non-Medical Split

Freud strongly supported the idea of lay analysts without medical training, and he analysed several lay people who later went on to become leading psychoanalysts, including Oskar Pfister, Otto Rank and his own daughter Anna Freud. He published two staunch defenses of lay analysis in 1926 and 1927, arguing that medicine and the practice of analysis were two different things. When Ernest Jones brought psychoanalysis to the UK in 1913, he followed Freud's preferences in this area, and the tradition of lay involvement continues to this day in the UK, where most psychoanalysts, psychotherapists and counsellors have a lay background.

In the US, however, Freud's analysand A.A. Brill insisted that analysts should be medically qualified — even though there were already many lay analysts practising in the US who, like Brill, had trained with Freud in Vienna. Brill prevailed, however: in 1926 the state of New York made lay analysis illegal, and shortly thereafter the American Medical Association warned its members not to cooperate with lay analysts. To this day, almost all US psychoanalysts are medically qualified, and counsellors typically study psychology as undergraduates before becoming counsellors.

Counselling vs. Psychotherapy Divide

It was largely in response to the US prejudice against lay therapists that Carl Rogers adopted the word 'counseling', originally used by social activist Frank Parsons in 1908. As a psychologist, Rogers was not originally permitted by the psychiatry profession to call himself a 'psychotherapist'. Ironically, Rogers himself became renowned as one of the most influential empirical scientists in the fields of psychology and psychiatry, introducing rigorous scientific methods to psychology and psychotherapy that psychoanalysts themselves had long resisted (and, in the view of many, still largely resist today). He became a joint Professor in the Departments of Psychology

and Psychiatry at the University of Wisconsin as well as Head of the Psychotherapy Research Section of the Wisconsin Psychiatric Institute.

In the field as it now stands, the argument as to whether counselling differs significantly from psychotherapy is largely academic. Those from psychodynamic traditions sometimes equate 'psychoanalysis' and 'psychotherapy' — suggesting that only psychoanalysts are really psychotherapists — but this view is not common anywhere else.

Others use 'psychotherapy' to refer to longer-term work (even though some psychotherapists offer brief therapy) and 'counselling' to refer to shorter term work (even though some counsellors may work with clients for years). The two terms are commonly used interchangeably in the US, with the obvious exception of 'guidance counseling', which is often provided in educational settings and focuses on career and social issues.

Modern counselling and psychotherapy have benefited tremendously from the empirical tradition which was given such impetus by Carl Rogers, even though the research agendas of psychology and counselling have diverged greatly over the last half century. Additional work in cognitive psychology, learning theory and behaviour has informed many therapeutic approaches. The richness of the bodies of both empirical and theoretical work which are now available, coupled with the raw complexity of human beings, has led to a profusion of different approaches to the field.

By some accounts, the different strands of counselling and psychotherapy now number in the hundreds. Mainstream approaches, however, are much fewer in number, and over time it is likely that many of the less well-grounded schools of thought will fade away, while more new ones will emerge to take their place. While the main approaches continue to develop, and others appear and then fade away, clients are left to choose for themselves what might be best for them.

TYPES OF PSYCHOTHERAPY

Psychotherapy is a method of talking with a psychotherapist, psychiatrist, psychologist or professional counselor. Many forms of psychotherapy can help people having difficulty in life, those who wish to make some kind of change in their personal or professional life, or people suffering from depression, anxiety or other serious mental health problems. The recovery success rate for those with depression who combine psychotherapy with medication to control symptoms is more than 80 percent, according to some studies. Although best in person, therapy is also provided on the phone, via e-mail, and online. Therapy can be held in one-on-one sessions, family or couple sessions, or in a group led by a trained counselor:

Family therapy or couples therapy

Family therapy includes discussion and problem-solving sessions with every member of the family. Some sessions are done as a group, in couples, or one on one. Family or couples therapy is helpful when one of the family member's physical or mental health is directly affecting family dynamics or the well-being of significant relationships. In therapy, interpersonal relationships shared among family members are examined and communication is strengthened. If a family member suffers from depression, the roles played by various family members in reinforcing the depression often are examined.

Group therapy

In group therapy, a small group of people meet regularly to discuss individual issues and help each other with problems with the guidance of a trained therapist.

DIFFERENT APPROACHES TO PSYCHOTHERAPY

Much psychotherapy is not limited to a particular type or technique. Many therapists are trained in several different

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approaches. They then combine techniques from these various approaches that fit their own style and personality and the needs of the patient. Medication may be used with psychotherapy. For many people, this is the best approach to treatment. People with moderate-to-severe depression typically do best with a combination of antidepressants and some form of psychotherapy. The following are the common types of therapy available:

Behavior therapy

Behavior therapy, also called behavior modification or behaviorism, sets up rewards and punishments to change thinking patterns and shape behavior. Behavioral therapy can involve relaxation training, stress management, biofeedback and desensitization of phobias. Behavioral therapists help patients learn how to get more satisfaction and rewards through their own actions and how to unlearn the behavioral patterns that contribute to, or result from, their problems.

Cognitive therapy

Cognitive therapy seeks to identify and correct thinking patterns that can lead to troublesome feelings and behaviors. Beliefs and expectations are explored to identify how they shape a person's experiences. If a thought or belief is too rigid and causes problems, the therapist helps the client to modify his or her belief so that it is less extreme.

Cognitive-behavioral therapy

Cognitive-behavioral therapy (CBT) helps a person to recognize his or her own negative thought patterns and behaviors and to replace them with positive ones. Used both with and without medication, cognitive-behavioral therapy is the most popular and commonly used therapy for the treatment of depression. A major aim of CBT is to reduce anxiety and depression by

eliminating beliefs or behaviors that help to maintain problematic emotions. CBT generally lasts about 12 weeks and may be conducted individually or in a group. There is evidence that the beneficial effects of CBT last longer than those of medication for people with panic disorder, obsessive-compulsive disorder, posttraumatic stress syndrome and social phobia.

Interpersonal therapy

Interpersonal therapy (IPT) is a short-term therapy often used to treat depression. This treatment approach focuses on an individual's social relationships and how to improve social support. IPT therapy seeks to improve a person's relationship skills, working on communication more effectively, expressing emotions appropriately and being properly assertive in social and work situations. In depression, IPT helps patients learn how to deal more effectively with others to reduce conflict and gain support from family and friends. It is usually conducted, like cognitive-behavioral therapy, on an individual basis but also can be used in a group therapy setting.

Movement/dance/art/music therapy

These methods include the use of movement, art or music to express emotions. This type of therapy is effective for those who have difficulty expressing feelings.

Phototherapy (light therapy)

People who suffer from seasonal affective disorder (SAD), a form of depression that is related to the change of the seasons within their geographic location, may benefit from bright light phototherapy. Phototherapy uses special light bulbs, which are much brighter than ordinary lights and made for this purpose. A physician or therapist instructs the patient in how to use these high-intensity lights to improve symptoms of seasonal depression.

Psychoanalysis

Also called psychodynamic or psychoanalytic therapy, this type of treatment helps a person look inside himself or herself to discover and understand emotional conflicts that may be contributing to emotional problems. The therapist (psychoanalyst) helps the client "uncover" unconscious motivations, unresolved problems from childhood and early patterns to resolve issues and to become aware of how those motivations influence present actions and feelings. This is a lengthy process, typically taking several years.

There are different types of psychoanalysis, each with a different focus. Freudian psychoanalysis has been criticized because of its tendency to create long-term dependent relationships between the therapist and the client. Recent types of psychoanalytically oriented therapy have become popular, such as Jungian therapy. Jungian therapy sessions focus more on the immediate situation and life problems than on the root of the problem to help individuals develop greater self-realization.

COUNSELLOR-CLIENT RELATIONSHIP

As a general rule, counsellors working for the Service will not inform a third party of any details relating to your attendance for counselling. This includes any information that is disclosed within the counselling relationship as well as details about whether or not you have used the Service. Confidentiality is contained within the Counselling Service, so that certain client information may be discussed within the counselling staff team. Issues relating to clients are often discussed amongst the counsellors in an attempt to monitor and improve their work; where necessary, matters may be discussed in detail with the Head of Counselling Service.

The Director of Employability and Student Support may also be consulted in exceptional circumstances. In addition, each counsellor has regular contact with a supervisor in order to

further monitor their work. However, there are certain circumstances where a counsellor may feel it necessary or be bound by law to break confidentiality with a client, liaising with an appropriate third party (other than their supervisor) outside the Counselling Service. It should be stressed that in such circumstances an attempt would usually be made to discuss the matter with the client first, hopefully working towards some kind of agreement that would not involve breaking confidentiality against the client's wishes. There are certain circumstances, however, where this may not be possible.

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Working with self-harming and suicidal clients

The counsellors work with many clients who harm themselves through cutting or eating habits, or who are indeed suicidal or have attempted suicide. However, it is not the policy of the Counselling Service to break confidentiality as a matter of course when working with clients of this nature. Where such a client does not wish for a third party to be involved the client's wish will usually be respected. In any situation where there is client suicidal intent, however, the counsellor will ensure that the client

is aware of other relevant sources of support, such as the Samaritans and their GP, in case they wish to access them.

When working with self-harming or suicidal clients, though, there are still circumstances (as with all clients) in which confidentiality may be broken, even if it goes against the client's wishes. In addition to these circumstances the Service has a clear policy where the client actually attempts to commit suicide in the presence of the counsellor (or another staff member of the Counselling Service), or informs the member of staff that they have taken an overdose of pills or some other substance that is intended to kill themselves.

In this situation the counsellor (or another staff member of the Counselling Service) will automatically call for an ambulance, letting the client know that they have done so. If there is any uncertainty as to whether the client's life is in danger, the member of staff will still call for an ambulance. The client will not be prevented from leaving the building if the client does not want to wait for an ambulance to arrive. Where the client telephones the Counselling Service and expresses a similar intent, an ambulance will be called if the client's location is known.

On first using the Counselling Service, you will be asked to complete a form giving basic details about how you can be contacted, your gender, date of birth, whether you are a part or full-time student, etc. Statistics are collected from the data on yours and other clients' forms and held anonymously (by reference number) on a database. This database also includes a list of the dates you came for counselling, the broad category of concern you were experiencing and the extent to which you were struggling with this concern (indicated by a number on an eight-point scale). The forms are kept securely at the Counselling Service and will be destroyed four academic years after the date you last attended counselling.

The counsellors working for the Counselling Service usually make notes about the counselling sessions they provide. These

notes are identified by a reference number, do not contain your name and are kept securely, separate from your details form. Along with any correspondence relating to you having counselling here, these notes form a paper-based file.

The counsellors will provide a supporting statement on a client's extenuating circumstances form where this is appropriate. However, counsellors cannot comment on a student's wellbeing prior to meeting them. Counsellors can only confirm the dates of the student's sessions and that the student was experiencing difficulties during the period they had been attending counselling. Occasionally, where a student has submitted an extenuating circumstances claim form but it has not been seen or signed by a counsellor, the student's subject department contacts the Counselling Service requesting confirmation of the dates the student attended counselling. If possible, the Counselling Service will check with the student first that it is all right to confirm this information. But if the Service cannot reach the student, and where it is clear that they have indicated on the form they have been a counselling client, the Service will usually confirm their attendance.

Correspondence and telephone calls

Any correspondence that is sent to you by post in relation to your counselling will be clearly marked as private and confidential. The subject matter of any correspondence will be limited to the purpose of writing and will not include any unnecessary personal information. (Where a counsellor and their client have entered into a joint correspondence as part of their therapeutic relationship, there will obviously be much greater openness in what is written.) Correspondence by email will only be conducted if you have given your permission to be contacted this way on your form. This is due to the potential lack of security of the email system.

If you choose to discuss personal information over email, the counsellor cannot be held responsible for a breach in

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