SAMPLE

Learning Specific Skills

Lesson Aim

Become aware of various methods of learning counselling, and identify essential counselling micro-skills.

WHAT IS COUNSELLING?

Many people go through times when they find their lives overwhelming or distressing. This may be due to bereavement, illness, family crisis, relationship breakdown and so on. They may find it hard to cope or not have the resources to deal with the problem. Counselling can help them to retain their self-sufficiency, build better relationships and help them to make and act on their choices. Before moving on to specific skills, it is important to just repeat what counselling is.

Counselling means different things to different people. It is not a get well quick option, offering quick answers, but is asking the person to engage in a process and an exploration. There are many definitions of counselling. A simple version is that counselling is a working relationship where the client is helped to manage what is happening in their life and to explore their life. It is a form of psychological or talking therapy that offers people the ability to change how they live and feel. The aim of counselling is to provide the client with a more satisfying experience of life. Everyone has different needs, so counselling can be concerned with many different aspects of a person's life.

Activity: Briefly make a list of all the different areas where you think a person might require counselling.

You may have listed things such as:

Resolving and addressing specific problems

Personal development issues

Decision making

Coping with a crisis

Developing personal insight and knowledge

Working through an inner conflict

Improving relationships with others

And so on……

The Counsellor's Role

The role of the counsellor is to facilitate the person's resolution of personal issues whilst respecting their values, personal resources, culture and capacity for choice. Counselling can provide people with a regular time and space to talk about their problems and explore difficult feelings in a confidential and dependable environment.

Counsellors do not usually offer advice, but instead give insight into the client's feelings and behaviour and help the client change their behaviour if necessary. They do this by listening to what the client has to say and commenting on it from a professional perspective. Counselling covers a wide spectrum from the highly trained counsellor to someone who uses counselling skills as part of their role, for example, a nurse or teacher.

Many people use counselling skills in their daily lives. However, sometimes it may be inappropriate for people to use their usual methods of support. They may not want to discuss their problems with a friend or family

member. They may feel that the person is too close, that they don't want them to know their confidential problems or the person they would usually confide in might be part of the problem. Counsellors are trained to be effective helpers in difficult or sensitive situations. They should be independent, neutral and professional, as well as respecting our privacy. Counselling can help people to clarify their problems, identify changes they would like to make, get a fresh perspective, consider other options and look at the impact that life events have made on their emotional wellbeing.

Counselling can help people to come to terms with specific issues. It works best if the client enters counselling of their own free will. Counselling is a specific arrangement between the counsellor and the client. It is not about making judgements.

There are five elements that must be in place for counselling to work. These include:

A contract between the counsellor and client

A warm and trusting, professional relationship

The focus is on the client

A space where the client feels safe

A place where the client is able to share difficult feelings in an accepting atmosphere

Counselling

Counsellors provide guidance for clients and a support system, rather than working with the deeper levels of the psyche. However, there are other therapists who work with people with difficulties. A *psychoanalyst* is someone who has been trained in the theory and techniques of psychoanalysis. Many have initially been trained in other caring professions such as physician, psychiatric social worker, or psychologist before pursuing psychoanalysis. Others come from a range of other professions. Part of their training involves undergoing personal analysis with another trained psychoanalyst. Psychoanalysis is the term first used to describe Freud's set of theories about human behaviour and the form of treatment of mental disorders he devised, although this field has developed considerably since Freud's time.

A **psychotherapist** is a practitioner of psychotherapy. They are usually a psychiatrist, a clinical psychologist or a psychiatric social worker, although once again people from other professions might enter into training programs in psychotherapy. Psychotherapy is the use of psychological techniques to treat psychological disturbances. The four main forms of psychotherapy are behavioural, cognitive, humanistic and psychoanalysis. There are many variations of the four approaches.

A **clinical psychologist** is a practitioner of clinical psychology. They may *also* be psychotherapists, but this is not essential. They may work in hospitals or clinics or may have a private practice. Clinical psychology is the branch of psychology concerned with the application of psychological theory and research to the treatment and diagnosis of mental, emotional and behavioural problems. Clinical psychology is based on psychology as a science. Therapies and assessment techniques are empirically tested. Psychologists also use a range of psychological tests and inventories to assess clients or patients with regards to personality, intelligence, and mental health.

A p**sychiatrist** is a person who studies medicine and then specialises in psychiatry. Psychiatry is the branch of medicine that covers mental illness. The subject matter of psychiatry overlaps to a great extent with clinical psychology, the main difference being in the training of the psychiatrist and the clinical psychologist. A psychiatrist has no training in psychology, other than psychopathology and uses the medical model to deal with mental disorders. The clinical psychologist is not medically trained, cannot prescribe drugs and tends to view normal and abnormal behaviour as on the same continuum.

SOME THEORIES OF COUNSELLING

Empathy

Empathy is the ability to understand someone else's point of view and to share their emotions, almost "to stand in their shoes". Empathy is a centrally important ingredient of any therapeutic situation. Without empathy, the client is unlikely to trust the therapist, and without trust, will be unlikely to explore deeper levels of problems and effect changes.

To practice empathy, a therapist must continually be in touch with the client's feelings and values, without intruding their own set of values. The therapist must in a sense imagine being in the "client's shoes". Part of empathy is the practice of **reflection**.

The therapist becomes like a mirror, constantly reflecting the client's attitudes back to him or her; for example:

Client:	*"He makes me mad. I just want to lash out at him."*
Therapist:	*"You feel angry and frustrated."*
Client:	*"Yes, and I don't know what to do -how to end it."*
Therapist:	*"It's confusing for you and you don't know how to end the frustration."*

One might ask why reflection can help a person -the therapist doesn't appear to be adding anything to the clients understanding. The client however, in this way learns to accept their feelings. They then find it easier to express their feelings. They are making sense of a confused world through verbal articulation. All of these factors form a basis for problem solving.

Transference

Although the concept of transference originated in psychoanalysis, it has been proved to be of profound relevance to any therapeutic situation.

Transference involves the **projection** of feelings towards people in your life, onto the therapist. If the client perceives her husband of being a cold aloof person, she brings this attitude into the therapeutic situation, and projects it onto the therapist. Thus she perceives the therapist as being cold and aloof. In this way the therapist acts as a sounding board for the clients feelings. Since people's problems are often about loved ones, clients often experience feelings of love and attachment toward their therapists. A good therapist will not encourage or suppress such feelings. Instead they will work with them during the therapy session to broaden the client's self-awareness. They help the client to realise that these feelings come from other relationships, for example:

Client:	*"I don't know what's wrong with you today. You're not listening to my silly problems. You're not even listening."*
Therapist:	*"You're mistaken about that. I'm listening very closely. I begin to feel that someone at home perhaps, hasn't been listening to you. Is that so?"*

Transference can be a positive key to finding out what the client's central hidden problems are.

For instance, a client cannot openly admit anger to her husband (who perhaps doesn't even know that she is angry) but she might project those feelings onto the therapist.

DIRECTIVENESS/NON-DIRECTIVENESS

The use of empathy or reflection might be referred to as a non-directive approach. Here the therapist is not actively leading the client to a solution. This is a necessary part of therapy as it guides the client to learn to express his/her hidden feelings.

Once the client's world is opened to the therapist willingly, and the client has trust in the therapist, then a more directive technique can be used.

Directive techniques include:

Introducing the client to open ended questions – these require a greater level of trust and honesty. For example, "Why do you stay with your husband when he hurts you so much?"

Introducing a level of interpretation - instead of merely reflecting the client's feelings, an element of interpretation is added. This is not to say that you will take wild guesses. Your interpretation of the client's verbalisation must be grounded in your knowledge of their feelings and attitudes.

Greater Intervention with regards to the direction of discussion - often when the client has revealed a greater part of his/her experiences in therapy, a new level of defensiveness sets in, and the client might experience mental blocks.

BEHAVIOUR THERAPIES

The basic assumption of behavioural therapy is that maladaptive behaviour is a learned way of coping with stress, and that these learned behaviours can be unlearned and replaced with more efficient forms of behaviour. According to the behaviourists, it is not enough to simply change a person's attitude in therapy, for even if one develops healthier mental attitudes, one's behaviour does not necessarily change. I might develop the attitude that violence and aggression are abhorrent and counterproductive ways of dealing with stress, yet as soon as I am stressed I might still automatically have violent outbursts.

The behaviourist's main aim therefore is to modify behaviour through therapy. The therapist's technique of modifying the client's behaviour is largely based on learning theory, such as classical and operant conditioning

Systematic Desensitisation

This is a method used to eliminate fears and phobias. It involves systematically exposing the client to anxiety producing stimuli under relaxed conditions until eventually the main fear is overcome.

Relaxation Training

The individual is taught that they cannot be anxious and relaxed at the same time. Relaxation training is provided and then used by the client whenever they encounter stress.

Assertiveness Training

Since one cannot be anxious and assertive at the same time, the person is also taught how to assert themselves. The individual learns how to act assertively in situations which usually produce passivity and timidity in the client. For instance, a depressed person might be trained to overcome learned helplessness.

Both relaxation and assertive training are practiced in a therapeutic situation, and then the client is encouraged to employ the learned methods on his/her own, in real life situations. Role playing is a particularly important therapeutic tool in this respect (e.g. If a client is having problems with the boss at work; the therapist may pretend to be the boss in a work situation and ask the client to act out the situation in his own role as if he were at work).

POSITIVE REINFORCEMENT & EXTINCTION

These are other methods of behaviour modification used by behaviourists. Healthy behaviour is positively reinforced by the therapist or the client's own self. The client might develop a self-awareness system e.g. "For every three times I speak out at a meeting, I can buy myself a little gift"

Any therapist should always provide positive reinforcement in response to any psychological growth in a client e.g. "You have made excellent progress in regards to stating your needs to others".

Extinction involves the elimination of negative patterns of behaviour through withholding positive reinforcement

Behavioural therapy is largely geared towards helping individuals to regulate their own behaviour outside of the therapeutic situation. This is called *self-regulation.*

One way of doing this is to note the kinds of stimuli that produce negative and positive behaviour, thus avoiding situations that lead to negative responses and favouring situations that produce positive attitudes.

Goals of the Psychoanalytical Approach

Psychoanalysis seeks to make the unconscious conscious. It strives to probe into the deeper part of the psyche and get to those issues that were not resolved during cognitive development. It does not aim simply to uncover these issues, but rather to understand and experience them so that a change in character can occur.

This is based on the idea that psychological maladjustment is the result of unconscious conflicts. The individual uses defence mechanisms to keep these conflicts at bay. Sometimes the individuals maladjustment concerns an over reliance on defence mechanisms, leading to an alienation from their own emotions. We will discuss defence mechanisms shortly. At other times, stress is so great that all defences break down leading to irrational and disorganised behavioural patterns. The psychoanalyst's primary aim is to bring these conflicts into the individual's conscious awareness.

The therapist will typically not engage in much self-disclosure and will therefore consider that most of what the client discloses will be related to significant others from the past.

The relationship relies on transference and the client making projections onto the counsellor. They also seek to enable the client to deal with impulsive and irrational behaviour and to cope with anxiety, thus leading to a greater sense of self-awareness and hopefully more successful relationships.

The therapist also tunes in to the client's resistances and interprets dreams and free-associations to get an overall picture of what the client's problems may be. It is hoped that increasing the client's awareness will encourage them to change, though it is up to the client to want to change. The therapist's interpretation can therefore be seen as being not as important as the client's willingness to change.

Typically this form of therapy will last between 3 and 5 years, and the client will see the therapist several times a week. It is important that the therapist does not rush to interpret the information supplied by the client.

DEFENCE MECHANISMS

The most common ways of dealing with stress are by using *defence mechanisms,* such as those described by Freud. Freud claimed that we have an *id, ego and superego.* The id is our unconscious self, motivated by pleasure. The ego is our day-to-day self, responding to situations. It is our conscious self, whilst the superego is our moral self, almost our controller.

Repression

Memories that cause anxiety are kept out of our conscious awareness as a means of protecting ourselves. This is also called motivated forgetting. This involves repressing the chaotic desires of the id into the unconscious realm. Often these repressed desires will still find expression in dreams, slips of the tongue or psychopathological symptoms.

Displacement

This involves displacement of a disturbing emotion such as anger, from one person to another. Displacement reduces anxiety produced by the unacceptable wish, but at the same time it partially gratifies that wish. The basic emotion of irrational anger toward a parent (for example) cannot be removed. The individual will instead direct this anger toward another less important, less threatening person.

Rationalisation
This is when we pretend to have a socially acceptable reason for a form of behaviour that is actually rooted in irrational feelings.

Example: A person is angry with their mother and wants to avoid her. They then give a false reason for not going to visit her (e.g. It is too far away).

Projection
This is a particular form of rationalisation. It involves projecting our own undesirable characteristics onto someone else.

Example: You feel an irrational hatred toward someone else, and then you go around telling people that the person concerned hates you.

Reaction-Formulation
This involves unconsciously covering up what you really feel by behaving in the opposite manner, without realising it.

Example: A woman, who could not obtain an abortion, might harbour a lot of hatred towards her child, and unconsciously still want to get rid of it. Instead she behaves lovingly and over protective to the child, to an excessive degree.

Intellectualisation
This involves detaching oneself from deep emotions about an issue, by dealing with it in abstract and intellectual terms.

Denial
This involves simply denying that a situation or emotion is real. This is a defence mechanism often employed by a person who has lost a loved one - they go through a period of refusing to believe that it is true.

Sublimation
This involves establishing a secondary socially acceptable goal that can be satisfied; instead of satisfying the primary (original) goal.

Example: An excessively aggressive person might satisfy their desire to kill by joining the army where it can be socially acceptable to kill.

Defence mechanisms all play the role of distorting reality to a greater or lesser degree, in order to get rid of anxiety-producing feelings. Nevertheless, they are necessary to keep our psyches from being overloaded with the *id's* irrational feelings. They can however be overused by certain individuals so that reality becomes distorted to an unhealthy degree.

The use of defence mechanisms is inevitable and necessary; however an individual can rely on them too much; resulting in personality problems.

USE OF PSYCHOANALYTIC PSYCHOTHERAPY

Modern psychoanalytic psychotherapy differs from traditional psychoanalysis in several ways:

- There is less of a focus on dream and fantasy material, and more of a focus on practical elements of the client's life
- They tend not to use the traditional therapist's couch
- There are a lesser number of sessions
- The therapist is more active in terms of self-disclosure and the use of minimal responses
- There is less of an accent on restructuring personality and more of a focus on finite objectives

Psychoanalytic Techniques

The main techniques used by the psychoanalyst are "free association", "dream analysis" and "transference". There are a number of principles of this form of therapy as outlined below:

Analytic Framework

This refers to the maintenance of a set procedure in terms of the regularity of the meetings, the timing of the meetings, and trying to disrupt the parameters of the therapeutic process as little as possible. This includes such things as, minimizing vacations and avoiding changes to life conditions such as divorce.

Free Associations

This involves encouraging the client to speak freely and honestly about any thoughts that come to mind, without editing or censoring, or even trying to make sense of what is said. It is essential that the therapist conveys a sincere attitude of attentive listening and unconditional acceptance; to ensure that even the most irrational thoughts are not suppressed. Only after the client finishes speaking does the therapist intervene and encourage more free association. Thought and feelings that emerge during this process provide raw material for analysis and interpretation. The client can experience a great relief in being able to express old and disturbing emotions in a safe, non-judgmental environment.

During this process the client reels off whatever they think of no matter how disconnected, outrageous, silly, trivial, or otherwise they feel about it. In so doing the therapist is able to tap into the client's repressed fantasies, past conflicts, wishes, desires and so on.

If the client experiences psychological blocks in revealing information, then this can be viewed as a cue that they are dealing with anxiety-provoking material. What is not said is as significant as that which is vocalised.

Whilst the therapist offers interpretations of this material, the client needs to determine their own meanings.

Interpretation

This involves identification, clarification and translation of the client's information that arises during the therapeutic relationship.

This should only be offered with regard to material that is close to consciousness and with material that the client is going to be comfortable facing. It is acknowledged that in the case of repressed material which the client is resisting or defending, that the resistance should be drawn to the client's awareness before any revelations over what it is concealing are drawn to the client's attention.

Dream Analysis

Freud saw dreams as an expression of unconscious fears, needs and desires. Some of these motivations are seen as being too intolerable to the individual, and therefore are expressed in symbolic form.

> Latent content is viewed as the symbolic unconscious component.
>
> Manifest content is the way in which the latent content is disguised into a more acceptable form to the dreamer. It is therefore the actual dream as it is experienced.

Dream interpretations also shed light on the client's current life situation as well as past experiences and unresolved conflicts.

Freud regarded the dream as the "royal road to the unconscious". Psychoanalysts can often use dream analysis as a way of gaining a deeper awareness of unconscious conflicts that might not emerge during conscious speech.

Dreams have both a manifest & latent content. The manifest content is the set of images and events which the person experiences while dreaming. The latent content is made up of unconscious impulses and repressed memories upon which the dream is based. Not all repressed material is expressed in dream imagery. Much of it is censored and distorted before it is translated into the manifest dream images. The client and therapist work together in order to unravel these distortions, in order to arrive at the latent content, which tells the story of

major conflicts in the unconscious. Usually the client focuses on each particular dream image, and makes free associations about that image to aide access to the latent content.

Example: A house fails to resemble a place that is familiar to the dreamer.

After free associating on particular images of furniture for instance, the dreamer might realise that the house is an amalgamation of several different places where they have felt alienated or unloved.

Resistance

This is any action, thought, feeling or whatever that impedes the therapeutic process and hinders change. It is considered to be unconscious and a method of avoiding anxiety-provoking thoughts and feelings. By drawing resistance to a client's awareness it is hoped that they will then be able to deal the cause of the resistance.

Transference

Through awareness of transference the client can re-experience those issues that have been discarded into their unconscious and in so doing, hopefully alter their behaviour. Transference is the key in the relationship between the therapist and the client. Transference involves the **projection** of feelings towards people in your life, onto the therapist. This concept originated in Freudian theory, but has been useful for therapists of various orientations.

During the relationship the client uses transference to project their feelings and emotions toward significant others from their past onto the therapist. The therapist therefore acts as a replacement for these significant others and their client may project a whole range of feelings onto the therapist ranging from love to hate.

In order for the client to change they need to work through the unconscious material and defences that come to light during the therapy. In order for the client to achieve independence they need to free themselves from motivations that arose in their childhood.

Even during long-term therapy, not all childhood needs and traumas will be eradicated. Counter-transference also occurs whereby the therapist becomes aware of their own unresolved conflicts. It also occurs when a therapist's reactions within the relationship interferes with the therapeutic process, disrupting the therapist's objectivity. Counter-transference can be incorporated into the process and be used as another means of helping the client.

HUMANISTIC THERAPY

Humanistic therapy is based upon an interactive explanation of behaviour (unlike behavioural therapy or psychoanalysis which are based on a developmental approach to behaviour).

A *developmental explanation* of behaviour emphasises influencers from the past or present behaviour, for example, genetic history, past environmental influences, past psychological traumas.

An *interactive explanation* of behaviour focuses on present trends in the individual's life, which together exert influences on their behaviour; for example, present fears and goals, present environmental conditions.

Both explanations of behaviour are valid and necessary. Depending upon the individual's predicament, one approach may be more appropriate than another.

Example: If we are counselling a newly divorced woman, we may probably tend to explain her behaviour in terms of present influences such as social isolation and lack of self-esteem.

On the other hand: imagine if a friend suffers from a nervous breakdown "out of the blue", so to speak. During the last five years, we have known her, and her life appeared to run smoothly. It may be appropriate then to investigate her past history, to determine any causes of anxiety or tension.

The most popular branch of humanistic therapy is "client centred therapy", as formulated by Carl Rogers. We will come on to this again later. The basic assumptions of client centred therapy are:

1. That the client is the best equipped person for understanding and solving their own problems.

2. That behaviour is less a product of external stimuli than a product of subjective reality.

3. That psychological conflict is the result of a conflict between the individual's self-concept and actual experience.

The aim of the client centred therapist is to provide the client with a relationship and therapeutic atmosphere which facilitates growth, understanding and self-acceptance. This helps the client overcome the incongruity between self-concept and actual experience. One's self concept is usually based on a defined set of values. If the individual has an experience which contradicts this set of values, stress and anxiety are experienced.

Client centred therapists are not as directive as behaviourists or psychoanalysts in their techniques. They do not aim to modify or interpret the client's behaviour. Instead, they play the role of facilitator. This therapist provides conditions such as warmth, empathy, genuineness and unconditional positive regard.

Eclectic Approach

Most contemporary psychologists don't adhere strictly to only one particular theoretical orientation. Instead, they take what is useful from the different approaches and use them according to the situation they find themselves in. This is called the eclectic approach.

Evaluating the Effectiveness of Therapies and Counsellors

There is clear evidence that counselling and psychotherapy are effective, but it can be difficult to pin down exactly why. Subjective client reports and objective measures indicate counselling and psychotherapy are effective, in the short and long term. For some kinds of psychological distress, such as depression, there is evidence that counselling can have a positive interaction with medications such as anti-depressants. So counselling and medication together can offer better results than counselling or medication alone. Different types of conditions have also been found to respond better to certain approaches. For example, people with panic disorders seem to respond well to cognitive behaviour therapy.

No one type of therapy stands out alone as having overall effectiveness, but individual counsellors obviously do. Within certain approaches, research has shown significant variation between individual counsellors. There is evidence that the abilities of individual therapies can be a significant factor in determining the outcome of the counselling. So there are better and worse therapists!

Research has not yet been able to determine any particular accreditation or training which will definitely show a better or worse counsellor. But to become an effective counsellor, it is important to pick up effective counselling skills and continue to learn and develop throughout your career.

CASE STUDY – EXAMPLES OF DIFFERENT TYPES OF THERAPY IN THE TREATMENT OF PTSD

Treatment of PTSD - A National Centre for PTSD Fact Sheet

(This leaflet is reproduced with the kind permission of the National Centre for PTSD: Website www.ncptsd.va.gov)

This fact sheet describes elements common to many treatment modalities for PTSD, including education, exposure, exploration of feelings and beliefs, and coping-skills training. Additionally, the most common treatment modalities are discussed, including cognitive-behavioural therapy, pharmacotherapy, EMDR, group treatment, and psychodynamic treatment.

Common Components of PTSD Treatment

Treatments for PTSD typically begin with a detailed evaluation and the development of a treatment plan that meets the unique needs of the survivor. Generally, PTSD-specific treatment is begun only after the survivor has been safely removed from a crisis situation. If a survivor is still being exposed to trauma (such as ongoing domestic or community violence, abuse, or homelessness), is severely depressed or suicidal, is experiencing extreme panic or disorganized thinking, or is in need of drug or alcohol detoxification, it is important to address these crisis problems as a part of the first phase of treatment.

It is important that the first phase of treatment include educating trauma survivors and their families about how persons get PTSD, how PTSD affects survivors and their loved ones, and other problems that commonly come along with PTSD symptoms. Understanding that PTSD is a medically recognized anxiety disorder that occurs in normal individuals under extremely stressful conditions is essential for effective treatment.

Exposure to the event via imagery allows the survivor to re-experience the event in a safe, controlled environment, while also carefully examining his or her reactions and beliefs in relation to that event.

One aspect of the first treatment phase is to have the survivor examine and resolve strong feelings such as anger, shame, or guilt, which are common among survivors of trauma.

Another step in the first phase is to teach the survivor to cope with posttraumatic memories, reminders, reactions, and feelings without becoming overwhelmed or emotionally numb. Trauma memories usually do not go away entirely as a result of therapy but become manageable with the mastery of new coping skills.

Therapeutic Approaches Commonly Used to Treat PTSD

Cognitive-behavioural therapy (CBT) involves working with cognitions to change emotions, thoughts, and behaviours. *Exposure therapy* is one form of CBT that is unique to trauma treatment. It uses careful, repeated, detailed imagining of the trauma (exposure) in a safe, controlled context to help the survivor face and gain control of the fear and distress that was overwhelming during the trauma. In some cases, trauma memories or reminders can be confronted all at once ("flooding"). For other individuals or traumas, it is preferable to work up to the most severe trauma gradually by using relaxation techniques and by starting with less upsetting life stresses or by taking the trauma one piece at a time ("desensitization").

Along with exposure, CBT for trauma includes:

1) Learning skills for coping with anxiety (such as breathing retraining or biofeedback) and negative thoughts ("cognitive restructuring")

2) Managing anger

3) Preparing for stress reactions ("stress inoculation")

4) Handling future trauma symptoms

5) Addressing urges to use alcohol or drugs when trauma symptoms occur ("relapse prevention")

6) Communicating and relating effectively with people (social skills or marital therapy)

Pharmacotherapy (medication) can reduce the anxiety, depression, and insomnia often experienced with PTSD, and in some cases, it may help relieve the distress and emotional numbness caused by trauma memories. Several kinds of antidepressant drugs have contributed to patient improvement in most (but not all) clinical trials, and some other classes of drugs have shown promise.

At this time, no particular drug has emerged as a definitive treatment for PTSD. However, medication is clearly useful for symptom relief, which makes it possible for survivors to participate in psychotherapy.

Eye Movement Desensitization and Reprocessing **(EMDR)** is a relatively new treatment for traumatic memories that involves elements of exposure therapy and cognitive-behavioural therapy combined with techniques (eye movements, hand taps, sounds) that create an alternation of attention back and forth across the person's midline. While the theory and research are still evolving for this form of treatment, there is some evidence that the therapeutic element unique to EMDR, attentional alternation, may facilitate the accessing and processing of traumatic material.

Group treatment is often an ideal therapeutic setting because trauma survivors are able to share traumatic material within the safety, cohesion, and empathy provided by other survivors. As group members achieve greater understanding and resolution of their trauma, they often feel more confident and able to trust. As they discuss and share how they cope with trauma-related shame, guilt, rage, fear, doubt, and self-condemnation,

they prepare themselves to focus on the present rather than the past. Telling one's story (the "trauma narrative") and directly facing the grief, anxiety, and guilt related to trauma enables many survivors to cope with their symptoms, memories, and other aspects of their lives.

Brief psychodynamic psychotherapy focuses on the emotional conflicts caused by the traumatic event, particularly as they relate to early life experiences. Through the retelling of the traumatic event to a calm, empathic, compassionate, and non-judgemental therapist, the survivor achieves a greater sense of self-esteem, develops effective ways of thinking and coping, and learns to deal more successfully with intense emotions. The therapist helps the survivor identify current life situations that set off traumatic memories and worsen PTSD symptoms.

Psychiatric Disorders That Commonly Co-occur With PTSD

Psychiatric disorders that commonly co-occur with PTSD include depression, alcohol/substance abuse, panic disorder, and other anxiety disorders. Although crises that threaten the safety of the survivor or others must be addressed first, the best treatment results are achieved when both PTSD and the other disorder(s) are treated together rather than one after the other. This is especially true for PTSD and alcohol/substance abuse.

Complex PTSD

Complex PTSD (sometimes called "Disorder of Extreme Stress") is found among individuals who have been exposed to prolonged traumatic circumstances, especially during childhood, such as childhood sexual abuse. Developmental research is revealing that many brain and hormonal changes may occur as a result of early, prolonged trauma, and these changes contribute to difficulties with memory, learning, and regulating impulses and emotions. Combined with a disruptive, abusive home environment that does not foster healthy interaction, these brain and hormonal changes may contribute to severe behavioural difficulties (such as impulsivity, aggression, sexual acting out, eating disorders, alcohol/drug abuse, and self-destructive actions), emotional regulation difficulties (such as intense rage, depression, or panic), and mental difficulties (such as extremely scattered thoughts, dissociation, and amnesia). As adults, these individuals often are diagnosed with depressive disorders, personality disorders, or dissociative disorders. Treatment often takes much longer than with regular PTSD, may progress at a much slower rate, and requires a sensitive and structured treatment program delivered by a trauma specialist.

SO WHAT ARE COUNSELLING SKILLS?

Counselling skills are the skills many of us use in our daily lives. They are the same as the counsellor will use as part of their job. But obviously the role of the counsellor is a bit more complicated than that, but counselling skills are very important to assisting them in that role.

Activity: Make a list of skills you consider are counselling skills. Consider the skills you use when communicating with others.

You've probably come up with a list similar to this:

Counselling Skills
Listening
Giving the speaker your full attention
Clarifying statements that are ambiguous or general
Creating a relationship with a person, so that they feel accepted, that is a warm relationship, creating a "rapport.
Problem solving
Planning actions to be taken and how to go about them
Summarising important themes and trying to get the person to see things from another point of view

Putting statements into your own words so the person you are speaking to knows that you have really understood what they are trying to say

Communication skills enhance almost every caring role. Counselling skills focus on helping people to express their feelings, as well as having an ethical basis to emphasise counselling values. Counselling skills are used to support the client's healing or decision making process, without the counsellor imposing his/her personal opinion on the client.

A central aim of counselling is that the person will have the inner resources that they need to help them decide what is best for them. The counsellor's role is therefore to help them find the resources they need and start to use them. When a person has explored what they think they can and cannot do, they are more likely to implement any changes and stick to their plan.

Many different jobs include helping people to change and supporting them to put that plan of change into action.

Activity: Make a list of professions where you consider they may use counselling skills to help people change and to implement their plans to change.

You may have come up with:

- Teacher
- Nurse
- Social worker
- Dentist
- Doctor
- Youth worker
- Alcohol and addiction worker
- Dietician
- Manager
- And so on…

Activity: Make a list of the difference between using counselling skills and listening as a friend.

You may have come up with a range of different answers. The main difference is that by using counselling skills, we are using specific techniques to establish a relationship and encourage a person to talk. Also, we should not be giving our opinion or trying to influence the person, we should be encouraging the person to come to their own conclusions. When listening as a friend, we may want to interrupt, to say what we want to say, give our opinion and so on…. Not always the same thing as the person we are listening to wants.

Methods of Learning

With more than 450 psychological and counselling theories on offer today, the main theories that have been tried and tested and have received consistent positive outcomes, are the one's which are being used the most by practitioners. These theories have not only been tested for their reliability but for the validity as well.

An integrated or eclectic approach that is client-centred and client-driven will usually bring the best results. Being able to integrate the most effective communication skills, coupled with the most effective counselling theories takes time, persistence and patience.

The main learning techniques are:

- Experience
- Reading texts
- Practical counselling courses

- Counselling supervision
- Discussions with other counsellors

Counsellors who join professional associations (or other peak bodies) and who undergo ongoing supervision throughout their career will more readily be at the forefront of new techniques and theories, so that they can constantly upgrade and improve their skills. Hence, it is highly recommended that upon completing any course, book or work experience, a trainee counsellor continues to learn and upgrade their skills.

Most trainee counsellors will find a combination of practical consistent experience and ongoing reading to be most beneficial learning tools.

Counsellor training can be seen as being threefold:

> Reading about techniques in order to establish the general framework from which you are going to operate.
>
> Practicing those techniques in a professional setting
>
> Undergoing supervised training sessions to further develop and work on these techniques.

Many of us have 'natural counselling abilities'. We use them when we offer a shoulder to cry on or when we help our neighbour in distress or even just listen to the local shop assistant! Obviously some people are more talented than others in this respect. The goal of counselling training is to build on these natural abilities so that they become effective skills that can guide a person to consider the many possible solutions available to their problem, while validating their emotional perspective about the situation.

In order to be an effective counsellor, a person must learn to be client centred (based on the work of Carl Rogers). Counsellors must have a genuine/authentic and friendly warm manner with all people, regardless of their background, culture, race, etc. Possessing a non-judgemental attitude is essential for creating and building an accepting rapport. Remember too that counsellors do not need to be 'perfect'. In fact hiding behind a mask or pretending that you don't suffer from any of the regular everyday problems many people do, will actually alienate you from your clients. Being able to meet people where they are at and relate to them on their 'level' will help ensure that a warm trusting relationship is developed that will encourage clients to openly share and express their concerns. Finding your own personal style and balance in creating this professional environment comes with experience.

Micro Skills

The techniques available to the counsellor to improve the effectiveness of the counselling process are known as micro skills. Micro skills help the communication between counsellor and client, and enable the counsellor to engage the client into a helpful and meaningful conversation. Micro skills include attentive listening, questioning, reflection, summarising, confrontation and reframing. These skills are usually learnt individually and applied to the counselling process. They become mastered (like second nature) through practice. These skills will be discussed in detail in following lessons. Before we begin to cover these skills, let's take a look at what we might need to help practice them.

Triads

Triads are a valuable method of learning new counselling techniques for students. Within the triad, each person takes on one of the following roles:

- Counsellor
- Client
- Observer

For face-to-face practice, chairs should be arranged so that the counsellor and client face each other and the observer looks on (the importance of this will be addressed further on). For telephone counselling the counsellor and client should face away from one another while the observer looks on. The observer can then relay back information to the other two with regard to their body language, facial expressions, tone of voice and so on.

In counselling training, the students may be expected to meet weekly to practice. Each member of the triad should expect to receive feedback on their skills at each session. Therefore, each student must play each part of counsellor, client and observer each week. Videotaping of practice sessions is useful. The supervisor/trainer will also meet with the triad to observe the students' abilities to demonstrate the skills practiced and give written or verbal feedback.

When the student takes on the role of the client, the triad experience is more meaningful if the student is able to role play a realistic situation. The situation can be taken from people you know, your own past situations which you have resolved, or situations you make up. The more real the role plays, the easier it is for the counsellor in the triad to use appropriate counselling skills.

Problems with Triads

It is important not to use triads as a way to get counselling for your own problems. Therefore, it is important for students to only reveal information about themselves that they are willing for others to know about them. In other words, it is important to have clear limits on what you are willing to discuss in the triad. Whilst there is a need to set limits on the personal information revealed, but students should be willing to honestly evaluate their counselling skills development. A student's openness and flexibility to consider their strengths and weaknesses is important. It is also important for the student to seek out feedback as to their performance.

Trainee counsellors or triad participants may be reluctant to reveal problems due to:

Lack of trust in others

A belief that they will be rejected as counsellors

A belief that they will become distressed

A belief that they will not receive adequate support from the trainee counsellor

It is possible to role-play imagined problems or other people's problem's, however it may be difficult to simulate problems and solutions to problems that you yourself are not experiencing. In such instances role-play may be a challenge and issues that are real life ones should be used instead.

Case Study

Alan is a member of a counselling triad playing the counsellor. Richard plays the role of client, Jeremy the role of observer. Richard pretends to have a history of depression. He is finding it hard to cope with his life as a full time worker, father and have a social life. Alan believes that this is truly how Richard feels and pushes for more and more information, using personal information he has of Richard's life to delve further. Richard, who is playing a role, starts to feel that this is intrusive and becomes reluctant to answer. Jeremy tries to encourage Alan to use this as a role playing exercise. Alan becomes more belligerent and argumentative with Richard, before finally storming out of the session. Consider the difficulties with this for Alan.

Past and current life experiences can affect a person's ability or inability to demonstrate helping skills within a class situation. Some helpers will try to take over more responsibility for the client's problems. If this was the case, a tutor or supervisor would have to intervene to discuss this with the student. There is also the issue that students must follow the correct ethical standards, such as those of the Australian Psychological Society, British Psychological Society and so on.

Theory into Practice

When applying micro skills it is important to use one at a time, and to build upon each one when you feel a certain level of mastery has been attained of the current skill being learnt. Even learning just one or two micro skills can produce an effective counselling session.

The observer should literally observe without making any judgements or interpretations (they can write details down so that it can more easily be revisited after). The information gathered can include everything from tone of voice to movement of the hands. The observations are fed back to the counsellor and client at the end of the triad session for evaluation. Comments need not be evaluative, merely observational facts without any personal interpretation.

Modelling

This is a valuable tool for observing the necessary skills required of a counsellor and may take different forms:

- Video
- Demonstration
- Observation of counsellors in real-life situations
- Role play

Note that throughout a counsellor's training they will be exposed to influences from other counsellors, supervisors and lecturers. Each counsellor needs to adapt their own unique qualities to the counselling setting, to develop their own genuine style.

Modelling can be highly useful however it can also have its pitfalls if the trainee counsellor is unaware they are having poor practice exemplified to them.

While some people may pick up on this instinctively, others may find it difficult to observe and therefore may make the same mistakes in their own practice.

Counselling individuals is a highly responsible position. A counsellor can, if not fully prepared and respectful of the process with a client, can cause more harm than good.

Be Prepared

Counsellors must begin each session by obtaining a clear and full background understanding of the client's situation. Completing a comprehensive yet concise history on the client will help collect the vital information required to proceed in the best possible way.

Example

Sarah was a new trainee counsellor who had learnt the skills necessary to conduct a professional counselling session. Within the first few months of practicing Sarah had a client who the intake officer at her place of work experience had told her was depressed. With only this brief information, Sarah proceeded to counsel the client believing that the client may respond to Rational Emotive Behaviour Therapy (REBT). What Sarah did not know was that the client had been diagnosed with bi-polar disorder and had taken herself off medication, and not advised Sarah. Because Sarah never asked, she had no idea of this vital background! Counselling sessions became more 'stuck' and Sarah eventually felt she was a failure when the client's symptoms gradually worsened.

The new counsellor should also be aware that there are vast differences between individual counsellor's average success rates, their case outcomes, and indeed that these differences can be attributable to the individual counsellor. Sometimes, a personality clash can obstruct the very best counselling technique and skills, and prevent effective counselling from taking place. If this occurs, the counsellor must always remember that it is never a sign of weakness or failure to refer a client on to another professional. In fact, to recognise this process and to act constructively to produce a better outcome for the client is a sign of a true professional.

Each counsellor should pay careful attention to the results of their labours, and continuously strive to improve their skills and outcomes.

Each counsellor needs to be aware of:

The complexities of individual counselling processes

The need to monitor client outcomes (short and long term if possible, as this gives useful feedback regarding the strengths and weaknesses of the counsellor)

Being cautious and not to become complacent about their influential role

Maintaining the aspirations to improve their counselling on a continuous basis

Recognising that helping can be detrimental and to know the difference between a manageable client case and one that is way out of their capability.

It is advisable for counsellors to never show shock or alarm at certain factors that clients may disclose. This can have the effect of upsetting the client, or of creating fear for the client that the counsellor cannot cope with the information being shared, breaking the trusting relationship.

Online and Telephone Counselling

Before going further, it is important to clarify the differences in online and telephone counselling. Telephone and online/email counselling are not done face-to-face so will have some similar and some different aspects to face to face counselling.

Telephone and email support may be appropriate for situations when a client wants to:

Discuss ways of solving a problem.

Find the energy to address a problem.

Understand the psychological aspects of a situation better.

Discuss ways to modify the client's behaviour.

Discuss ways to modify the behaviour of others in certain situations.

Generate new ideas or gain fresh perspectives.

Access specialist knowledge and guidance.

Build on progress already made in face to face sessions with a counsellor.

There are some situations that are not suitable for telephone or online counselling where the counsellor may suggest the client seeks an alternative form of assistance.

Activity: Can you think of situations where this might be the case?

The most obvious one is if the client finds telephone or email counselling unhelpful. It may be that they need the face-to-face situation. Other situations where it might not be helpful are if:

It is an emergency

The client is suicidal

There is a risk of violence

The client is homicidal

The client would value a face-to-face assessment of the situation

There is evidence the client may have a mental illness

A response from family or friends may be more effective

There is a clinical indicator that telephone or email support may not be in the client's best interests.

Telephone Counselling

This can be as productive and supportive as face-to-face counselling. The main difference being that body language is not a factor when working on the phone. This should not detract from the process can prove supportive, as distractions are kept to a minimum, which can help increase concentration and focus. Therefore, telephone counselling can work faster than traditional therapeutic encounters. Also, working with a telephone counsellor can enable some clients to express themselves more freely, as they have a sense of anonymity.

There are many different telephone counselling services available. For example, The Samaritans, Child Line and so on. Phone lines may specialise in certain problems, such as bereavement, domestic violence, addictions, mental health problems, rape, and victim support. They offer anonymity and can be a good source for

information about other services that can help the client. Calls may be one-off or regular sessions. Some people find telephone counselling safer than seeing a counsellor face-to-face.

Email or Online Counselling

Email counselling can prove as effective as face-to-face and telephone counselling, but it is again different. It relies on the written word and there is a delay in response times. The counsellor may ask more questions that usual to support their understanding of the client's issues. The client may not wish to answer all these questions, but the process relies on the client giving enough appropriate information to enable productive work to take place. The counsellor will also support the client on issues between sessions by giving them tasks and exercises.

Using email counselling may mean that the client will do a lot of work for themselves, guided and supported by the counsellor.

Case Study - An Example of the Use of Telephone and Online Counselling

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National Centre for Post-Traumatic Stress Disorder, Department of Veterans Affairs
PTSD and Telemental Health - A National Centre for PTSD Fact Sheet (By Leslie Morland, Psy.D., Carolyn Greene, Ph.D., Josef Ruzek, Ph.D., & Linda Godleski, MD)

Many individuals in need of specialized PTSD services live in geographically remote regions, such as on tribal reservations or in rural areas. Because people with PTSD often use self-isolation to reduce stimulation, hyperarousal, and interpersonal conflict, people with PTSD are more likely to settle in remote areas with low population densities. Mental health care in these remote areas is generally only available on a limited basis - especially mental health care for PTSD. Traditionally, the individuals that need treatment do not get the services they need.

Sometimes an individual will travel a great distance to a larger city, or the clinicians based in the larger medical centres will travel a great distance to visit rural communities. As a result, providing PTSD care to these individuals can impose a tremendous financial, travel, or personnel burden. Telemental health technology is increasingly easing these burdens by making PTSD clinical and educational services available in remote areas.

What is Telemental Health?

Telemedicine, also known as telehealth, uses electronic communications and information technology to provide and support healthcare when distance separates the participants (Field, 1996). Telemedicine uses various communication methods to connect clinicians and patients - in lieu of them meeting in person. The term *telemental health services* typically refer to behavioural health services that are provided using communication technology. These services include clinical assessment, individual and group psychotherapy, psycho-educational interventions, cognitive testing, and general psychiatry. The term *telemental health* describes the overall situation in which a clinician uses various technologies to deliver mental health care to a patient who is miles away. The major benefit of telemental health is that it eliminates travel that may be disruptive or costly. In addition, telemental health is a useful tool in situations, such as in correctional and forensic settings, where it is difficult to transport the patient to a clinician. Telemental health also allows mental health providers to consult with or provide supervision to one another.

Telemental Health Technology and Services

Although telemental health may utilize a variety of technologies, it is closely associated with video teleconferencing (VTC) technology. In VTC, a patient (or group of patients) in one location and a clinician in a different location each look at a computer monitor or television screen in order to see and hear each other in real time. Although many *psychiatrists* are employing telemental health technology, it is still considered an untapped opportunity for many psychologists, social workers, and counsellors (Maheu, Whitten, & Allen 2001).

In addition to VTC, telemental health also utilizes other technologies. Telemental health can make use of electronic mail (e-mail), electronic administration of psychological tests, online self-help groups, chat rooms, blogs, and websites. Mental health information on websites is available to anyone with internet access (try searching for "National Centre for PTSD"). Some applications of telemental health, such as psychotherapy

through e-mail, have been quite controversial and have not undergone scientific evaluation. In response to such controversies, professional organizations for both psychology and psychiatry have established committees to develop guidelines for behavioural telehealth (i.e., American Psychological Association Ethics Committee in 1997; American Psychiatric Association Ethics Committee, 1997). Plain old telephone service (POTS) is often not included in discussions of telehealth. However, telephones may be very useful; they provide a way for clinicians and patients to conduct simple program evaluations and the necessary aftercare. Most recently, virtual reality has been used to augment treatment for a variety of anxiety disorders and pain-management conditions. Virtual reality is a revolutionary new computer technology that enables clinicians to immerse their patients in a highly interactive, three-dimensional, computer-generated world.

This technology has already demonstrated clinical effectiveness for a variety of psychotherapeutic purposes including the treatment of PTSD (Rothbaum, Hodges, Ready, Graap, & Alarcon, 2001).

Telemental Health Applications for PTSD

While preliminary research has clearly established that a variety of telemental health modalities are feasible, reliable, and satisfactory for general clinical assessments and care (Frueh et al., 2000; Hilty, Marks, Urness, Yellowlees, & Nesbitt, 2004), much less is known about the clinical application and general effectiveness of telemental health modalities employed in the assessment or treatment of PTSD.

For individuals with a history of trauma exposure, the first step in getting the necessary treatment is to have an accurate assessment of psychiatric or psychological symptoms, related problems, and factors influencing functioning. The accuracy of a PTSD diagnosis is important for both treatment implications and benefit claims. Only one study has systematically evaluated a situation where VTC technology was used to conduct comprehensive PTSD assessments with veterans (Miyahira, Morland, Pierce, & Wong).

Only a few randomized clinical trials (RCTs) have been completed that assess the telemental health treatment of PTSD. Although formal outcome data have not been collected at these sites, anecdotal reports suggest strong support among veterans, local providers, and remote clinicians.

Researchers at sites such as the VA Pacific Island Healthcare System and the South Carolina VA Medical Centre are examining the efficacy of VTC group treatment for veterans with PTSD. Findings from pilot data suggest that the veterans, the clinic staff, and the remote clinician all viewed the VTC treatment as helpful. A comparison of the VTC group to an in-person control group revealed no significant difference between the two groups on measures of satisfaction and information retention (Morland, Pierce, & Wong).

In addition, the VA Pacific Island Healthcare System's Traumatic Stress Recovery Program has successfully provided a variety of telemental health PTSD clinical therapy groups to the neighbouring Hawaiian island Community Based Outpatient Clinics (CBOCS). These groups have included a 12-session anger management group (Green & Morland, 2004), a sleep hygiene group, and a PTSD coping-skills group.

Therapy provided over the Internet has been among the most controversial applications of telemental health services. However, Alfred Lange, et al. (2003), recently published the results of a controlled trial in which they provided psychoeducation, screening, and a protocol-driven treatment via the Internet for people suffering from PTSD and grief. More than 50 percent of the treated participants in this study showed reliable change and clinically significant improvement. The largest changes were seen in measures of depression and avoidance. Although it is too early to recommend web-based delivery of services, it is likely that the Internet will be increasingly used to supplement face-to-face care.

Most would agree that telemental health presents a more convenient and economical way to provide or supplement specialty care services to patients living remotely. However, research is still needed to determine the quality and clinical effectiveness of these services. There is still a great deal we need to know about how, when, and with what patient populations we can effectively apply this new technology. Based on early pilot studies, telemental health appears to be a promising way to offer skills-training and assessment from a distance to individuals with PTSD.

Clinical Considerations

Using telemental health for clinical work requires planning and preparation. It is important to consider logistics, such as preparation of the room and equipment, and to be sure there is technological and clinical backup support. It is also important to consider the patient's convenience and privacy. In the case of VTC services, the quality of the video images can be optimized by providing appropriate lighting and using stationary chairs. One essential key to working with PTSD patients is to establish a sense of safety, comfort, and trust. This can be challenging when the clinician is not physically in the room; however, there are tools and techniques that can be used to achieve these goals.

It is recommended that trauma-focused interventions, such as exposure therapy, *not* be provided using a telemental health technology such as VTC. There is a great possibility that the client will experience intense emotional distress with this type of treatment, and it may be very difficult to manage the discussion and contain the situation when providing remote services.

Since telemental health is offered (in most cases) because there is not adequate or specialized services at the patient's site, it is imprudent to open up an individual's traumatic experiences without having the necessary clinical backup available. However, telemental health can be used to successfully provide clinically significant interventions such as basic PTSD education, symptom management, coping-skills training, and stress management. Trauma-focused telemental-health interventions may be recommended in the future, following closer clinical and empirical evaluation.

Pros and Cons of Telemental Health for Patients with PTSD

Before deciding to provide a clinical intervention utilizing telemental health, it is important to carefully consider the patient's clinical needs and the potential benefits and costs. As with other remote services, it is important to consider what clinical support is available at the patient's site, and what availability there may be for follow-up care. A thorough evaluation of needs at a particular site is the first instance. Using telemental health to provide PTSD treatment can significantly reduce the costs, both in time and money, of having patients or clinicians travel to in-person sessions.

Telemental health allows a small community clinic to offer access to specialized interventions and specialists in PTSD, which the clinic would normally not be able to provide. Home-based telemental health has become a way for housebound patients to get the help that they need.

However, telemental health is not without its drawbacks. The equipment, maintenance, and fees for VTC, for example, can be costly. The quality of the equipment ranges widely, with lower-end equipment being quite unreliable. Clinicians need to be properly trained so that they can maximize the benefits of the technology and minimize technical malfunctions. Some technical malfunctions will inevitably occur, so it is recommended that the clinician have a backup technician available. There are significant clinical challenges when using telemental health for PTSD. Perhaps the biggest clinical challenge is that the clinician is not physically present to address crises such as suicidal thoughts and aggression, which are commonly associated with chronic PTSD. Having a backup clinician on-site with the patient is strongly suggested.

Although quality VTC equipment and connections can render extremely clear images, clinicians may find it somewhat challenging to pick up on nonverbal cues such as psychomotor agitation or poor hygiene. There is also a risk that the patient will not pick up on the clinician's warmth and empathy and will perceive the interaction as impersonal.

Because telemental health is still a relatively new phenomenon, it has not been thoroughly empirically validated. Ethical, clinical, and insurance-reimbursement guidelines are still in development. Clinicians must also be careful to follow interstate licensing rules when applicable.

SET TASK

Activity 1

Spend 30 minutes researching micro skills in counselling on the internet using a search engine. If you do not have access to the internet, spend 30 minutes considering skills that can be used to increase communication and engage the client in a helpful, meaningful conversation. Make notes.

Activity 2

Get two people (e.g. friends, relatives, colleagues) to join you in a mock 'triad' counselling training session. Take on the role of 'observer. Spend approximately 10 minutes on the session getting the 'client' to discuss a real or simulated problem with the 'counsellor'. Make notes and discuss your observations with the others.

Now get the other two to swap roles, and once again make notes.