Identification of Common Mental Disorders and Counseling Skills

A Trainer's Manual for Community Based Organizations

Department of Health and Family Welfare, Government of Gujarat, India

2004

This manual is the outcome of the training programs carried out under the project titled **"Capacity Development for Community Based Mental Health Interventions in Gujarat"**, commissioned by the Government of Gujarat, implemented by Ahmedabad Management Association in July 2003. The information given in the manual does not necessarily reflect the views of the Government of Gujarat.

Government of Gujarat does not guarantee the accuracy of the information included in this manual.

The production of this manual was supported by the Royal Netherlands Embassy, Development Cooperation Division, New Delhi.

Identification of Common Mental Disorders and Counseling Skills: A Trainer's Manual (2004)

First Published 2004

Cover and lay

Printed by Sh

Published by ernment of Gujarat, Gandhinagar

Foreword

It gives me great pleasure to write a foreword for this manual. During my clinical experience of more than 40 years, to my mind, the most important lacunae in mental health delivery services in our country, has been the absence or inadequacy of counseling services. With the advent of great advances in Biological Psychiatry, it is possible to affect improvement in most of the psychiatric disorders to a significant level. However, I have always felt that this can never replace counseling to deal with psychosocial factors that not only contribute to mental disorders but are also important in relapse of disorders. Further, in the field of Preventive Psychiatry, counseling has more important a role to play. It is, therefore, evident that we need a network of counselor services to provide effective mental health services.

In India there is a shortage of mental health professionals and it may not be possible to meet the ideal requirement of patient-doctor ratio in the years to come. It, therefore, becomes necessary to train lay counselors working with NGOs and medical doctors to provide primary care. At the same time it is necessary that training should be standardized so that the basic minimum standard of care can be maintained. This manual has been prepared keeping these training needs in mind.

The manual covers both theoretical and practical aspects of mental health interventions, such as identification of common mental disorders, interview and counseling skills, techniques of counseling, counseling process and ethics of counseling. The appendices will be of great practical use for identification of signs and symptoms of CMD.

It is therefore highly commendable that Dr. Snigdha Nautiyal and Ms. Shveta Kumaria have prepared this manual. I have no hesitation in recommending this manual as an important guideline for training counselors. I also wish to congratulate the authors for doing such an excellent job.

Dr. Anil. V. Shah
Consulting Psychiatrist
Former Head of the Department of Psychiatry
B. J. Medical College and Civil Hospital
Ahmedabad

Preface

The Government of Gujarat has a vision: to provide complete health for the people of Gujarat. But this cannot be achieved unless the issue of mental health is also addressed. Keeping the paucity of resources and the social dimension of this issue in mind, the Mental Health Mission Report 2003 recommended the development of cost-effective community based mental health interventions.

The Government of Gujarat, therefore, commissioned the project, **"Capacity Development for Community Based Mental Health Interventions in Gujarat".** The project was implemented by Ahmedabad Management Association, Ahmedabad. The nodal agency for this project was Indian Institute of Management, Ahmedabad, and it was supported by the Royal Netherlands Embassy, Development Cooperation Division, New Delhi.

This manual is the culmination of the capacity building training programs in mental health conducted for various community based organizations in Gujarat during the period of 2003-2004.

This is a trainer's manual and should be used ***only by mental health professionals or by those with at least a bachelor's degree in Psychology or by those who have undergone training in capacity building for mental health interventions.*** The manual can be used as a reference for developing training modules in mental health.

This manual has two sections – Identification of Common Mental Disorders and Counseling Skills. Section I gives an introduction to the area of mental health, outlines the interview skills required to conduct an identification interview and describes the various Common Mental Disorders. While reading Chapter 2 (Interview Skills), it would be advisable to refer to Appendix A, a pro forma for history taking. Chapter 3 gives brief descriptions of the Common Mental Disorders and is supported by Appendix B, which features the detailed criteria for identifying a disorder. It is best that they are used together.

Section II is dedicated to counseling skills, which includes information on the qualities and skills of a counselor, the counselor-client relationship, the various techniques of counseling, the counseling process and the ethics of counseling.

This manual comes with an audio-visual aid, which can be used as an adjunct to the text during training sessions. The video has been developed in Gujarati. The English script has been provided

in Microsoft Word Document in the CD. It has five sections, four role-plays and one puppet show. The first two sections are devoted to the identification of Common Mental Disorders with the help of role-plays and support Section I of the text. The third and fourth sections are role-plays on counseling skills and relate to Section II of the text. The fifth section is a puppet show, which can be used as part of an Awareness Program on Mental Health conducted either at the organizational or community level.

Both the text and the audio-visual aid can be used either in parts or as a whole for developing a training program, depending on the modules covered. This manual is by no means the last word in mental health interventions. It is meant to be used only for basic training in mental health.

Acknowledgements

This manual is the result of the training workshops held during the project period, feedback received from participants of workshops and assessment of NGOs needs for inputs in mental health. The aim of this manual is to provide a framework of structure and content to trainers who wish to do capacity building or strengthening in mental health. In the process of giving the manual a final shape we have received inputs and cooperation from many individuals and organizations. Throughout this challenging and gratifying process their faith and unstinting support made this manual a reality. We would like to take this opportunity to thank them.

We express our gratitude to the Department of Health and Family Welfare, Government of Gujarat, for commissioning the project in 2003. In particular we thank the Honorable Minister of Health and Family Welfare, Mr. I. K. Jadeja, Mr. R. L. Meena, Principal Secretary, Department of Health, Dr. Amarjeet Singh, Commissioner of Health, Medical Services and Medical Education, and Dr. Manorama ben Shah, Additional Director, Medical Services, Department of Health and Family Welfare, Government of Gujarat. We would also like to thank former health secretary, Mr. S. K. Nanda and former Commissioner of Health, Mr. V. A. Sathe, for their support and encouragement. We extend our heartfelt gratitude and thanks to Dr. Ravi. H. Bakre, Program Officer, Mental Health Program, Medical Services and Medical Education, Government of Gujarat. Dr. Bakre provided us with technical support throughout the manual development and review phase and was generous and unconditional with all information.

We would like to thank the Royal Netherlands Embassy, Development Cooperation Division, New Delhi, for supporting this endeavor. In particular we would like to thank Mr. Jaap Jaan Speelman and Mr. Rushi Bakshi, Senior Program Officer for their support and encouragement.

We thank Dr. Anil. V. Shah, practicing psychiatrist, Ahmedabad, for kindly agreeing to write the foreword for this manual.

We would like to express our thanks to Indian Institute of Management, Ahmedabad, the nodal agency for the project. Our deep gratitude and sincere thanks to Professor Ramesh Bhat, Professor Sunil Maheshwari, IIM, Ahmedabad, whose support, advise and guidance at every stage helped us overcoming the obstacles in the path. We would also like to thank Prof. Dileep Mavalankar from IIM, Ahmedabad.

We extend our sincere thanks to Dr. Kiran Rao, Additional Professor, Department of Clinical Psychology, NIMHANS, Bangalore, for guiding us through every step of this manual. Her unstinting critical review and evaluation, technical support and guidance helped us fine-tune the manual to its final stage.

This manual went through an exhaustive review process and we would like to thank our reviewers for taking out valuable time to give us their vital feedback. In particular we thank Dr. G.K. Vankar, Professor and Head, Dr. Minakshi Parikh, Associate Professor, Mr. B.K. Sinha, Associate Professor (Clinical Psychologist), Department of Psychiatry, B.J. Medical College and Civil Hospital, Ahmedabad, Dr. Rithambhara Mehta, Associate Professor and Head of the Department of Psychiatry, Surat Medical College, Surat, Dr. Bharat Panchal, Professor and Head of the Department of Psychiatry, Sir Takhtasinghji Hospital, Bhavnagar, Dr. Mukesh. J. Samani, Professor and Head of the Department of Psychiatry, Pandit Din Dayal Upadhayay General Hospital, Rajkot, and Dr. Jitendra. N. Nanawala, Surat.

Our deep appreciation and thanks to all NGOs who participated in the training workshops from the five regions of Ahmedabad, Vadodara, North Gujarat, South Gujarat and Kutch. The incomparable experience that we had with them in the training programs has enriched our knowledge in many ways to make this manual practical and useful. In particular, we would like to thank Ahmedabad Women's Action Group (AWAG), Ahmedabad, Sarjan (ASAG), Ahmedabad, Saath Suicide Prevention Center, Ahmedabad, Saath Charitable Trust, Ahmedabad, Mahila Patchwork Cooperative Society, Ahmedabad, Samarthan Trust, Ahmedabad, and SWATI, Dhrangadhra, for giving their consent to do the role-plays for the audio-visual part of the manual. We also owe a special thanks to Mr. Harinesh Pandya and Mr. Imitaz from Janpath, Ahmedabad who helped us to network with NGO's from South and Kutch regions of Gujarat.

We would like to thank Ahmedabad Management Association for their invaluable service in the flawless implementation of this project and manual. Many thanks to Mr. K. K. Nair, Executive Director, AMA, Ahmedabad and his staff for maintaining an efficient system which ensured that the manual faced no glitches in running smoothly and reaching its final destination.

We would like to thank Ms. Swati Merh for translating the English version to Gujarati. Our grateful thanks to Ms. Subashree Krishnaswamy for the excellent editorial work she has done for this manual. We owe many thanks to Mr. Nagji Prajapati and Mr. Anil Gajjar for designing the cover page and illustrations in the manual. Our appreciation and thanks to Ms. Juhi Dua, who directed the audio-visual part of the manual and Mr. Vipul Patel and his team who shot the video.

We would like to thank Ms. Sejal Prajapati, Research Associate for the project for efficiency, commitment and hardwork.

Lastly, we would like to thank Shree Ambica Traders for printing this manual.

Dr. Snigdha Nautiyal
Project Coordinator

Ms. Shveta Kumaria
Technical Associate

List of Contents

Section I

Chapter 1 – Introduction 3

Chapter 2 – Interview Skills 13

Chapter 3 – Identification of Common Mental Disorders 23

Section II

Chapter 4 – Overview of Counseling 41

Chapter 5 – Techniques of Counseling 51

Chapter 6 – Counseling Process 77

Chapter 7 – Ethics in Counseling 85

Appendix A

Appendix B

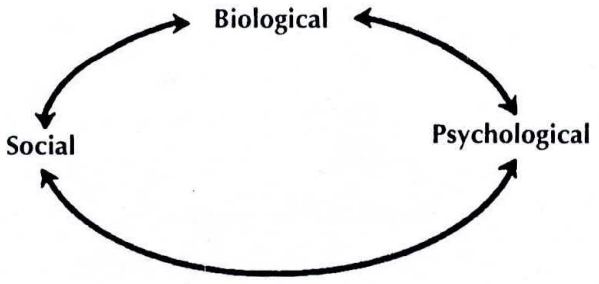
CHAPTER 1

Introduction

The emotional and psychological well-being of a person is called *Mental Health*. It is the balance between the mind, body and the social environment. These three parts are a whole, interacting and influencing each other. Ill health or distress in one sphere may also reflect in the other spheres.

Mental health is defined as the successful performance of mental functions, in terms of a stable mood and behavior that results in productive activities, fulfilling relationships and the ability to adapt, change and effectively cope with adversity (Sadock & Sadock, 2003).

The area of mental health is best understood in terms of a ***bio-psycho-social model***. This model adopts an integrated approach to understanding human behavior. The biological system refers to the anatomical, structural and cellular substrates of an individual's physiology. The psychological system refers to the motivation and the personality make-up of an individual. The social system includes the familial, environmental and cultural factors in which the individual lives. These three systems interact to influence an individual's behavior.



Life Cycle Theory

The life cycle theory helps us to understand human behavior and the stages through which all individuals pass – from birth to death. This theory states that development occurs in successive, clearly defined stages and in a particular order in every person's life. Each stage in life is characterized by events or crises (difficulties, problems or conflicts) that must be resolved satisfactorily if development is to proceed smoothly. If resolutions to these problems are not achieved within the given life stage, all the subsequent stages may reflect difficulties in the form of physical, cognitive, social or emotional mal-adjustments.

At every stage of the life cycle individuals are expected to play different roles. As children they are expected to study and do well in school. Passing exams successfully to go to higher classes is one of the difficulties that every child faces. Failure or not doing well in an exam leads to frustration, humiliation and a sense of defeat in the child, which may cause emotional problems. As children grow older, new demands are placed on them. They are expected to become economically independent, marry, have children and take on more responsibilities. Each stage, therefore, comes with different sets of demands and successful resolution of difficulties at every stage is important for the growth of an individual into a mature adult. If individuals are not biologically, psychologically and socially ready to take on the expectations and demands of that stage, then they may face crises or conflicts. This in turn may cause mental tension and stress. For example, an 18 years old girl is biologically ready for marriage, and socially it may be the accepted norm. However, if the girl does not feel ready psychologically to marry and take on the role, she will face a crisis in her life. She may find it difficult to adjust to a married life and cope with the role demands placed on her.

The life cycle theory helps us understand the development of individuals in society, the role expectations that are placed on them, the way they learn to adapt and cope with different kinds of crises in their lives, and, finally the social context in which they grow. It helps us to understand the development of an individual's behavior in terms of biological maturity, psychological capacity, adaptive behavior, role demands, social behavior and interpersonal relationships. In that sense it takes a bio-psycho-social perspective. In addition to going through the successive stages of life, it takes into consideration the fact that each individual has to be prepared to take on the role demands of that stage. All these components are necessary in order to understand both the concept of mental health and the kinds of mental disorders people are likely to develop in their lifetime.

What is Mental Disorder?

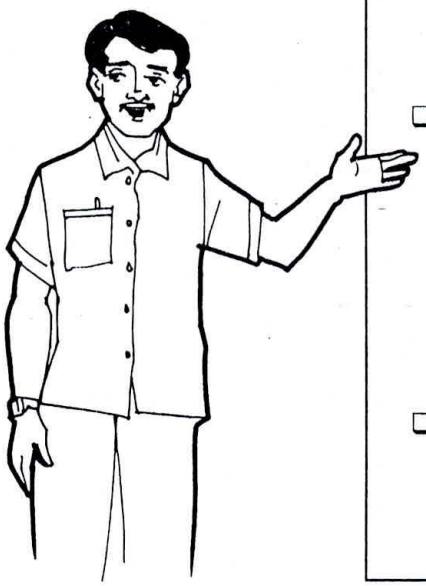
People sometimes show changes in the usual way of thinking, the way they express their emotions and the way they perceive the world and the people around. This results in poor judgment and socially inappropriate behavior – the person is then said to be mentally ill. Sometimes stressful events or problems may result in a person feeling sad, depressed or anxious. He/she may find it difficult to concentrate on work, enjoy pleasurable activities or feel tired and dull for most part of the day. These changes can cause distress to the individual and to the people around him/her, like family, friends or colleagues. These changes also disturb the day-to-day functioning of the individual.

Let us take a moment here and differentiate ***mental disorder*** from ***psychological distress***. Often we come across individuals who may be experiencing tension and stress due to life problems. Stress and tension can arise from certain issues in the environment of the individual – financial problems, domestic violence, broken marriage, long-term illness, discrimination, poor living conditions, poverty, etc. Problems can also arise because of the way individuals think or perceive the world around them. For example, a person might think, "Whatever I do I will fail", "How can I do this thing when I don't have any education or talent". Such a person is likely to feel sad and not attempt to do that job at all. The problem then is related to the way the person thinks rather than the difficulties found in the environment. Any stress or tension, whether arising from difficulties in the person's social context or environment or the way he/she thinks and perceives the world, causes ***distress*** (stress that makes us unhappy, uncomfortable or sad). This is known as psychological distress and it may arise due to life situations, which cause stress, tension, worry or sadness. But, it does not necessarily mean that the person will develop a mental disorder, which may require medication. The levels of distress may vary with time, the age of the person and the socio cultural factors. Mental disorder, on the other hand, is identified when a certain number of signs and symptoms are present together for a certain period of time (discussed in the next segment).

NGOs are more likely to come across individuals with psychological distress in their fieldwork. If distress in this target group is identified in the early stages itself, it can be easily handled through psychosocial methods of counseling.

Classification of Mental Disorders

Let us begin with defining some of the concepts that will be used frequently in the text.



- ***Symptoms*** are the complaints that a person comes with to the doctor. For example, a person may come to a doctor with a complaint of feeling tired through the day or difficulty in sleeping. Symptoms are complaints reported by the person.
- ***Signs*** are those observations and objective findings that the doctor picks up on examination. For example, if an individual complains of tiredness through the day, the doctor may also note that the person is looking tense, worried and has lost a significant amount of weight. Signs are drawn out through specific questioning.
- A ***mental disorder*** is identified when a certain number of signs and symptoms are present together for a certain period of time.

For the ease of understanding, mental disorders are divided into four categories –Severe Mental Disorders (SMD), Substance Abuse (SA), Childhood Disorders and Common Mental Disorders (CMD). The focus of this manual is largely on CMD. We have tried to give some basic information on SMD, Substance Abuse and Childhood Disorders as well. Our reason for focusing on CMD is that this is the group of disorders commonly found in the community that often go unreported. These disorders are often associated with social and economic stressors. If identified early, they respond well to both medical and psychosocial treatment methods. These are the type of disorders NGOs are likely to find in the community. Therefore, our effort is towards providing information on CMD, so that NGOs can do early identification/psychosocial counseling with clients and refer them to the mental health professionals when needed. The descriptions of CMDs are based on the International Classification of Diseases (ICD-10), published by the WHO and is widely accepted by mental health professionals in India for diagnosis of mental disorders.

A preliminary data on the prevalence of mental disorders in Gujarat is given in the following table.

	Range of Prevalence		High Risk population
	Community	PHC/CHC	
CMD	3.23% – 13.9%	11% – 46.5%	Women, illiterate, low socio-economic(SE) status, disaster affected, violence affected.
Substance Abuse	17.3% – 38.6%	–	Men, older or retired men, unemployed, low SE status, youth labor.
SMD	1.61% – 14.2%	–	Migration, social isolation, illiteracy and low SE status
Overall psychiatric morbidity	4.8% – 26.9%	18.4% – 53.7%	Low SE status

Source: The Mission Report 2003: Priorities for mental health sector development in Gujarat. Department of Health and Family Welfare, Government of Gujarat, India.

The overall psychiatric morbidity (i.e., the number of people suffering from mental disorders) in the community in Gujarat is 10 percent, which means 2.8 million adults at any given time are likely to be suffering from mental disorders.

Severe Mental Disorders

SMDs are less common and these are the ones usually recognized in the community as 'mental illnesses'. They are often associated with neuro-developmental, genetic or neuro-chemical factors in the brain. These disorders are easily identifiable because the signs are very obvious to other people. The changes may occur in the form of withdrawn behavior, reduced activity, talking to oneself, making bizarre gestures, talking and laughing loudly without relevance to the context, being abusive to others, tearing off one's clothes, behaving inappropriately in a social situation, etc. SMD affects role functioning – for example, the individual may stop going to work or attending to household activities and may not attend to personal hygiene. These disorders impose a heavy burden on families who are the primary caregivers. Examples of SMD: Schizophrenia, Bipolar Affective Disorders (BPAD).

Substance Abuse

Substance Abuse refers to the category of disorders where an individual develops dependence on a particular substance like alcohol or drugs (ganja, hashish, cocaine, heroin, etc.). Dependence on a substance is defined in two ways – behavioral and physical.

Behavioral dependence develops when an individual actively seeks ways of finding a substance, whereas physical dependence refers to the physical effects of the use of a substance. These substances affect the mood state (feeling elated, happy, sad, irritable) and behavior of a person. Those with substance abuse have often been found to have other mental disorders like Depression, etc.

Childhood Disorders

Childhood Disorders refers to that category of mental disorders found among children and adolescents. Individuals below the age of 18 years come under this category. Some of the more commonly found disorders among children are Attention Deficit Hyperactivity Disorder, Conduct Disorder, Childhood Depression and Substance Abuse. Sometimes severe mental disorder like Schizophrenia is also seen in children. Counseling children also includes counseling parents or caregivers and sometimes school teachers. Apart from the conventional methods of counseling, play and art therapy have been found to be very effective with children.

Common Mental disorders

CMDs are typically those disorders, which are commonly found in the community. They do not cause major disruptions in day-to-day functioning. These disorders often go unreported because the signs are not very apparent. Persons suffering from CMD may neglect or ignore the symptoms because the functional level is not disrupted and they are able to carry on daily activities, although, with greater difficulty, effort and less interest. As a result, family members also do not pay attention to these problems. If at all treatment is sought, it is usually for the physical symptoms that cause distress. For example, people may go to a general physician because of complaints of bodily aches and pains, loss of appetite, poor sleep, low energy levels, but not because they feel irritable, tensed, cry often, etc. It is in the course of examination that the physician may recognize that the person shows signs and symptoms of a common mental disorder. Examples of CMD are Depression, Anxiety, Phobia, etc.

A Common Mental Disorder can be present at a clinical or sub-clinical level. ***A disorder is described as being at a clinical level when it fulfills the criteria as per the classificatory system (in our case the ICD-10) of the number of signs and symptoms and the time duration for which they should be present.*** For example, in order to be identified as Depression, at

least 4 symptoms must be present for a period of 2 weeks continuously – only then it can be called Depression. In case of Anxiety Disorder, for example, at least 4 symptoms must be present for a period of 6 months continuously. If the signs and symptoms meet the criteria, it is then called a clinical disorder.

However, sometimes the signs and symptoms of a particular disorder may be present, but may not fulfill the criteria according to the classification of disorders. In which case, the disorder is said to be at a sub-clinical level. For example, a person may be feeling sad and dull, is not able to concentrate on work and is not sleeping very well. These are signs of Depression. However, if these symptoms have been present for less than a period of 2 weeks continuously then the Depression would be at a sub-clinical level. Alternatively, the person may have just 2 symptoms of Depression for a period of 3 months – it will still be called sub-clinical Depression.

A point to remember: in order for a disorder to be identified as clinical it must fulfill the criteria of both *the number of signs and symptoms and time duration*. This distinction between the clinical and the sub-clinical is important because in the community NGOs may often come across individuals who show sub-clinical symptoms of a disorder. Another factor to be kept in mind is that when an individual with a clinical disorder is identified, it is important that she/he must be immediately referred to a mental health professional.

Factors Related to Mental Disorders

There are several factors that contribute to the development of mental illness. For ease of understanding we have divided these into three main areas – biological, familial, and social.

Biological factors – Certain types of changes in the brain can lead to severe types of mental illnesses like Schizophrenia, Mania, etc (described in chapter 3). These changes can arise because of increase or decrease of certain chemical substances in the brain. A family history of mental disorder is also seen as a risk factor for developing mental disorder.

Family and childhood factors – A number of commonly found mental disorders seem to be related to childhood and familial factors. A child's first experience of the world is at home. While growing up children need love, support, guidance, emotional understanding and discipline. A lack or excess of any of these can lead to problems in their healthy development. Such children, when they grow up and are exposed to difficulties in life,

may develop emotional or behavioral problems. Another related factor is the temperament of the child. All children are born with a temperament. Some children are easy going, whereas others are difficult to handle. Some children get along easily with others, whereas others are shy and withdrawn. When temperament and environment interact, they together influence an individual's personality.

A happy and healthy family environment also influences the development of the personality of an individual. Poor communication between parents and children, marital discord among parents, frequent and violent fights, broken families, etc., can cause mental problems in an individual. When resources are limited and have to be shared, there is a lack of understanding and interpersonal relationships get strained. Thus people living in such families find it stressful to interact with others. Poor interpersonal relationships within the family may affect interpersonal functioning in the social world, thereby leading to psychological distress.

Social factors – Every individual is a part of the society he/she lives in. Chronic stressful situations and events, such as financial difficulty, poverty, domestic violence, divorce, problems in the occupational area, sexual difficulties, failures, frustrations, etc., can cause distress in an individual. Discrimination on the basis of caste, religion, community, injustice, exploitation, crimes, violence, etc., can also lead to a high level of psychological distress or a mental disorder. Poor living conditions, a disorganized way of life, inconsistent and confusing value systems add to the stress in an individual's life. If these stressors are severe and/or continue over a period of time then the individual is at a risk of developing a mental disorder.

A point to be noted: mental disorders do not arise out of a single factor. Often a mental disorder or psychological distress is related to a combination of physical, social, cultural and familial factors. These factors interact and influence each other, thereby leading to psychological distress. That is why mental health is best understood in the context of a bio-psycho-social model.

Why should We Pay Attention to the Area of Mental Health?

The Mental Health Mission Report prepared by the Government of Gujarat (2003) states that there are 2.8 million adults with common and severe mental disorders at any point in time in the state of Gujarat. This increases the burden of disease on the health system, society and the family of the ill person. At this point in time, mental health services (public and private) are more focused towards the treatment and care of the severely mentally ill individuals who usually need hospital based care. The need of the hour, however, is to develop a system where treatment and care can focus on common mental disorders as well – Depression, Anxiety, etc. These commonly found disorders do not usually require hospitalization and can be treated with medicines and counseling.

NGOs have played an important role in the health sector. Given the history and strength of NGOs in community-based approaches, their involvement in the mental health sector is crucial and significant. The major strength of NGOs is their ability to develop an effective and sustainable relationship with the community at large. They can thus play an important part in the integration of mental health into their area of service delivery and become a bridge between mental health care personnel and the communities.

However, there is relatively little knowledge and skills available to the personnel working in NGOs. This affects their ability to develop and implement good intervention programs in the area of mental health. Though NGOs are not trained or skilled in the area of mental health, it is by no means a new concept for them. In their existing service delivery, they often come across people in whom they are able to recognize emotional or behavioral problems. Not being able to adequately handle these problems often frustrates them and makes them feel helpless.

Therefore, if people working in NGOs are trained adequately to identify individuals with CMD, they will be able to help people with psychological distress. They can refer people, when needed, to mental health professionals. Community care and early identification of Common Mental Disorders leads to cost-effective methods of treatment in the community and reduces the disability and distress.

At the end of this chapter you should have learnt:

1. The definition of mental health.
2. How mental health is understood in terms of a bio-psycho-social model and the life cycle theory.
3. The classification of mental disorders.
4. The factors related to mental illness.
5. Why mental health is an important area.
6. The role NGOs can play in developing the mental health sector.

CHAPTER 2
Interview Skills

An interview is a conversation with a specific purpose. It involves two people, an *interviewer* (the person who will ask questions to get information) and an *interviewee* (the person who will give information). We will refer to the interviewer as the ***counselor*** and the interviewee as the ***client***. In the kind of interview that you will be conducting as a counselor with clients, your aim is:

1. To help clients explore in detail the distress they are experiencing. Here the counselor tries to obtain information on the signs and symptoms that clients have.
2. To understand the nature of the problem and the circumstances associated with or related to the distress that clients experience – family situation, marital history (if married), chronic stressors, socio-cultural factors, etc.
3. To identify whether the symptoms are at a sub-clinical or a clinical level.
4. If the symptoms are at a clinical level – convince clients to seek help from a mental health professional.
5. If the symptoms are at a sub-clinical level – inform clients how you and your organization can help them with their problems and the distress they are experiencing.
6. To give information, advice, guidance and suggestions – explain the nature of the problem, talk about available methods of treatment. If clients agree to counseling, they have to be given information about counseling: how it will be done, what clients are expected to do during the process of counseling and what benefits (both short-term and long-term) they are likely to get from it.

The interview is an opportunity for the counselor to begin the process of establishing a relationship with the client. Such a relationship is called a ***working relationship***. A good working relationship with the client is essential to build trust. Unless clients trust the counselor, they will not be comfortable with sharing information about themselves. They have to be convinced that the counselor will work in their best interests and keep the information confidential. Therefore use the first interview with clients as an opportunity to establish a good working relationship with them.

The first interview with the client can be divided into three phases. While describing the phases, we will also pay special attention to the skills the counselor needs to conduct an effective and fruitful interview. Although certain skills have been outlined in each phase, please remember that these are skills that are used throughout the interview and are not specific to any one phase. For example, good listening skills, patience and alertness are required throughout the interview. However, special skills such as assuring confidentiality will have to be used by the counselor in the first phase of the interview and, if need be, repeated at the end of the interview.

PHASE – I

This is the introductory phase of the interview. You meet the client and introduce yourself and once both of you are seated comfortably the interview begins. One of the first things that the counselor does in an interview is to establish a ***rapport*** with clients. What exactly is rapport? The counselor makes an attempt to put clients at ease, provides a secure and supportive environment and encourages them to talk about their problems freely. This establishes a working relationship with clients. Establishing rapport is necessary because often when clients come for help, they are anxious or frightened. They don't know how the counselor can help them. They are already distressed by the problem they are having. Therefore time is taken initially to make clients comfortable, so that they can talk without hesitation, fear, shame or guilt. Establishing rapport is a way of gaining the trust of clients. It is on the basis of this that clients decide whether or not to come for counseling.

A good way to establish rapport with clients is to give some information about yourself (the counselor) – your name, where you work, the name of your organization and what it does.

Once you have introduced yourself to clients, ask them to introduce themselves in return. Allow clients to talk for the first 10-15 minutes. Focus on general topics: for example, the background of clients, what they do, where they come from, whether married or not (refer to Appendix A). These neutral questions help clients to feel comfortable. Sometimes, clients are anxious, frightened or fearful. Take time to make them comfortable. Reassure them that it is perfectly all right to feel a bit hesitant since this is a new situation for them. Reassure them about the confidentiality of information and always tell them that they can start talking about their problems only when they feel really comfortable.

Counselor's Skills

- **Greeting** – Greet clients with a warm and friendly smile.
- **Appear confident** – A counselor's sense of self-confidence will reassure clients that they have come to the right place and are in competent hands.
- **Maintain eye-to-eye contact** – Look at clients so that they get the impression that you are interested in what they are saying.
- **Listen attentively** – Listen carefully to what clients are saying and avoid interrupting when they are talking. Pick up cues from their talk and decide on the questions you should ask in the subsequent phase of the interview.
- **Be alert and observant** – Notice whether clients feel comfortable or not, whether they appear anxious, distressed, upset or tense, whether they are interested in talking to you or not. Information given by clients verbally is important, but equally important is the non-verbal language. How clients sit, the tone of voice, whether they maintain eye-to-eye contact with you, whether what they are saying agrees with their emotional expression, etc., are all important.
- **Ask both open-ended and close-ended questions** – Closed-ended questions can be asked to find out the background information of clients ("How old are you?", "Are you married?", 'What do you do?" etc.). Open-ended questions are asked to encourage clients to talk about the problems they are facing – "Can you tell a little about the kind of problems you are facing?", "What brings you here"? "Tell me, what can I do for you?" etc.
- **Be patient** – Sometimes clients may hesitate to give information, because they are embarrassed or ashamed. Sometimes they may get angry with the counselor if they don't get what they expected out of the interview. At such times, it becomes important for the counselor to be patient and explain clearly the interview situation to clients.
- **Assure confidentiality** – Confidentiality means that the counselor will not reveal any of the information given by clients to anyone, without the consent of the clients. At this phase assure clients that all their disclosures will be kept strictly confidential.

PHASE – II

This is the main phase of the interview. This phase onwards, the focus of the interview is on elicitation of the signs and symptoms and getting information about the nature of the distress. Given below is a format that helps in drawing out systematically the problems and situations in a step-by-step manner. Please refer to Appendix A.

1. **Chief complaints** – These are the problems that clients speak about spontaneously. When you ask open-ended questions like "Tell me what brings you here?", "Can you describe what problems you are having?", "What can I do for you?", clients will start talking about the problems they are having. Note them down carefully. The answers of clients will give you the direction for further questioning and clarification.
2. **Duration** – How long have the signs/symptoms been going on, in terms of days, months, weeks or years? Sometimes clients are not able to give exact details of the number of years or months. A good policy is to ask when it all first started or when they first noticed a change.
3. **Onset and course** – How did the symptoms start? Did they start slowly and become worse with time or did it all start suddenly? Have the symptoms worsened over time, or have they remained the same as in the beginning?
4. **Precipitating factors** – Was there a stressful event (financial loss, death, natural disaster, divorce, fight, physical illness, etc.) that might have upset the clients before these symptoms started? It is important to ascertain whether the symptoms are related to a specific event or general circumstances in life.
5. **History of the present illness** – What are the signs and symptoms that clients have? What is the nature and description of the symptoms? How can they be described? The counselor should question all the relevant signs and symptoms (refer to Appendix B) of the disorder that they have. Counselors usually get an idea of the disorder in the initial questioning. However, it is important to rule out general signs and symptoms of other disorders as well. For example, in the course of interview, the counselor may come to know that the client is suffering from Depression. But in order to establish without doubt that it is Depression alone, the counselor should ask questions about Anxiety, Phobia, etc. (described in Chapter 3). Sometimes clients may show signs and symptoms of two disorders. Alternatively, it may be possible that clients have signs and symptoms of one disorder and some sub-clinical features of another disorder. For example, the client may be suffering from Anxiety, but may also have Panic Attacks,

or a client may be having Depression but may show some features of Anxiety as well. Therefore it becomes important to check all the signs and symptoms.

6. **Biological, social and occupational functioning** – Explore the sleep patterns, appetite and the physical condition of the client. If clients are female, take the menstrual history – when did the menses start, how long is the cycle, what sort of difficulties do they have during the cycle, the flow. Find out whether clients meet people, enjoy social activities, look forward to them or not to ascertain social functioning. Finally, find out if clients have been able to do their routine work (in a job if employed or housework). If yes, then how well, and if not, then what are the difficulties they face? Has there been a drop in the level of functioning? Has anyone complained about their work?
7. **Family functioning** – Use the genogram (see Appendix A) to get the family structure details (how many people live in the family, who all, how many children, whether there has been a divorce, remarriage or death in the family, physical or mental illness in other family members etc). Additionally, explore the relationships among the family members – the roles and responsibilities of each individual, marital discord if any in the family, communication patterns among the family members.

Counselor's Skills

In addition to the skills mentioned for Phase I, these skills are very important for the second phase of the interview.

- **Be focused and purposeful** – The counselor should encourage clients to explain the details of the problems they are having. If clients start talking about other issues, gently guide them back to the topic in discussion. 'Purposeful' means that the aim of the interview – to understand the nature of the problem and identify the mental disorder – should be fulfilled. At the end of the interview, the counselor should have enough information to decide whether signs and symptoms of the client are at a sub-clinical or clinical level.
- **Be flexible** – When you interview clients, it may be the first time that they are getting an opportunity to speak about what they actually feel. Therefore, even though clients may go off the main discussion, if the information is relevant or related to the problem they are having, allow clients to speak at length.
- **Be explorative** – The counselor should explore all aspects of the signs/symptoms, the nature of the problem and the cause of the problem. Exploration means that the counselor should try to understand the how, when, what and where of the problem.

- **Open-and close-ended questions** – Ask both types of questions. When you wish to find out whether a symptom is present or not, ask close-ended questions and when you want to understand the problem in more detail, ask open-ended questions.
- **Be supportive** – Support is provided by giving clients reassurance and acceptance. The counselor should ensure a safe and secure environment for the client while trying to understand the problem.
- **Be persistent** – Only with persistence can you gain information about the problem the client is having. Sometimes, clients may give vague information, or only half the information. At other times, they may refuse to believe that anything can be done to improve their situation and refuse help flatly. It becomes important to be persistent in your efforts with clients. It may take more than one session or meeting to convince clients that they need help. Efforts should not be given up just because clients do not understand that they require help during the first couple of sessions.
- **Non-judgmental attitude** – The counselor must maintain a non-judgmental attitude, whether it is regarding the nature of the problems, behavior, patterns of thinking or feelings of the clients. This means that you do not make a judgment on "right" or "wrong", "correct" or "incorrect". Being non-judgmental means that the counselor accepts clients for what they are, is able to look at the problem and related factors objectively, and does not try to blame clients or anyone involved in the problem situation. Showing acceptance is a way of gaining the trust of clients. Being non-judgmental is especially important when clients talk about behaviors or situations that may be different from the views held by the counselor.
- **Always clarify** – Whenever clients give information that is not clearly understood, always clarify. Repeat the information and ask clients whether it is correct or not. Clarification is also necessary when the counselor gives information to clients. Always ask clients to either repeat the information or ask: "Have you understood"? "Is there anything that you would like me to repeat"?
- **Use facilitating comments** – While clients talk about problems the counselor should always make facilitating comments – "go on", "yes, I understand", "hmmm" etc., which are some of the commonly used expressions. Facilitation can also be done using non-verbal gestures such as nodding the head, leaning forward towards the client, maintaining eye-to-eye contact, etc.
- **Summarize** – At the end of the interview always take some time to summarize the information that clients have given. Summarization has two goals – one, as an

interviewer, you are able to clarify any of the points that you might not have understood properly, and, two, it reassures clients that the interviewer has been listening carefully to whatever they have been saying in the session. This also builds trust in clients. They feel that the counselor is concerned about them and would like to help them in the best manner possible.

PHASE – III

The third and final phase of the interview is called the ***termination*** of the interview. The counselor slowly brings the interview to an end. This phase usually starts with the counselor summarizing all the information that clients have given. If there are any clarifications to be made, they are done right away. The counselor uses this phase to achieve the following:

- **Education/Guidance/Advice/Suggestion** – Clients are given tentative information on the nature of the problem and the importance of treatment. They are told about the various methods of treatment, where they are available, how they can be accessed.
- **Referral** – If clients require a referral to the psychiatrist, then suggestions are made and the reasons for doing so are also explained. Information related to treatments is given to clients.
- **Counseling** – Besides the consultation with the psychiatrist, the counselor should also give information on what the counselor can do for clients (for example, counseling). If the counselor feels that the client needs counseling, then the counseling process is explained.
- **Reassurance and supportive stance** – At the end of the session, once again reassure clients that the counselor (you) is available to discuss any further questions or doubts that they might have. If clients get upset, start crying, or become angry in the course of the interview, take time to calm them down before he/she leaves. Clients should usually walk out of an interview feeling somewhat relieved, reassured and hopeful that their problems may have a solution and that the future does not appear hopeless and negative.

If clients have agreed to come back for further sessions, fix a time and date for the next session. Also give information to clients on how they can contact the counseling center or organization whenever the counselor is not available, This gives clients a sense of continuity and a reassuring feeling that even though they may not be ready to come back for further sessions, the possibility of doing so at any time in the future is always open for them.

- ❑ Greeting
- ❑ Appear confident
- ❑ Maintain eye-to-eye contact
- ❑ Listen attentively
- ❑ Be alert and observant
- ❑ Ask both open-ended and close-ended questions
- ❑ Be patient
- ❑ Assure confidentiality

- ❑ Be focused and purposeful
- ❑ Be flexible
- ❑ Be explorative
- ❑ Be supportive
- ❑ Be persistent
- ❑ Non-judgmental attitude
- ❑ Always clarify
- ❑ Use facilitating comments
- ❑ Summarize

Please Remember!

Here are some important points to keep in mind while doing an interview session:

- ❑ Clients usually talk about their problems without too much difficulty. As long as they are talking spontaneously, do not interrupt, and encourage them to give details. Some clients, however, may be too upset to talk about their problems or may have been forced to go to the counselor by other family members. They may resent the interview situation as well as the counselor. Some clients may feel helpless or ashamed by the fact that they have to seek help from an outsider for their personal problems. A few others may hesitate to talk about their problems because they are not sure about the counselor and may either remain silent or answer with a short "yes" or "no". In such cases it becomes important for the counselor to reassure clients and encourage them to talk. If clients remain silent for a while, do not force them to talk. Once they become comfortable with the interview situation and the counselor, they will be able to talk spontaneously.
- ❑ Always remain alert to feelings of clients. Sometimes when they are talking, the counselor tends to pay more attention to the content of the talk rather than to the feeling component. Information given by clients verbally is important, but equally important is the non-verbal language. How clients sit, the tone of voice, whether they maintain eye-to-eye contact, whether there is agreement between what they say and what you can see on their face, etc., are all important. Sometimes clients may say, "I am feeling well", but may look tearful and not look at the counselor at all. The counselor then

should be able to judge the situation that despite what the clients say, they are not feeling well at all. The counselor should then explore further.

- It is essential to remain optimistic about the solutions to the problem of the clients. If clients sense at the time of the interview that the counselor feels that the problem is too difficult or cannot be handled, then they will also become pessimistic about the outcome and are unlikely to come back for counseling. But if it is important to be optimistic, it is equally important to be realistic. Clients should not be given any false hopes. The situation and what can be done should be realistically explained to clients.
- Involve the family members in the interview session whenever possible, but always take the consent of the client. Information from the family members is important: it gives the counselor an idea of how the family members understand the problem of the client and to what extent they are willing to help or be involved.
- Avoid fidgeting or playing with the stationery while conducting interviews. If the counselor keeps looking here and there, or plays with items on the desk, clients often gets the impression that the counselor is not interested in listening to their problems.
- If clients start crying during a session, do not rush to console them, or try to stop them. Allow them to have a good cry and then say some reassuring words.
- If clients become disruptive (turn abusive, start shouting at the counselor, pick up objects to hit, start tearing at their hair or their clothes, etc.) during the course of the interview, stop the interview. Tell them to go out of the room or you step out of the room. Before leaving or asking clients to leave, tell them specifically that unless they calm down and are willing to discuss their distress or their difficult situation, the interview will not be held. Also tell them that they can come back to the room or can ask you to come back to the room (if the counselor has stepped out) once they have calmed down. Give clients adequate time to calm down. It may sometimes take 10-15 minutes. If despite the time given, clients continue to be disruptive, terminate the interview and fix a time for another session.
- Do not feel pressured to give an answer to every question that clients ask. Sometimes, the counselor may not have the information or may not know the answer. At other times, clients may pressure the counselor to take up the responsibility of making all the decisions, or may insist that the counselor give them assurances, which are unrealistic. The counselor should be firm but gentle and refuse to give in to such demands. Please remember the counselor is a skilled individual, not a person with magical powers.

- The counselor must keep the socio-cultural background of the client in mind while framing the questions. Language should be kept simple and attempt should be made to speak to clients in their language. Questions should be framed in such a manner that clients are not embarrassed or insulted by them.
- Lastly, if the counselor wishes to document or record information that clients give, always take consent. Record the sessions only if clients agree to it. Notes should be taken down during the interview, but if clients are uncomfortable with the idea of the counselor taking notes, avoid doing so during the session. Write down the notes after the session is over.

At the end of this chapter you should have learnt:

1. The skills the counselor requires to carry out an initial interview.
2. How to conduct the first interview, which is mainly used for identification.
3. How to document information in the three phases of the interview.
4. The essential points to keep in mind while doing an interview.

CHAPTER 3

Identification of Mental Disorders

In this chapter we give information on mental disorders. Basic information is provided on Severe Mental Disorders, but the focus is on Common Mental Disorders. For ease of understanding, we have given brief descriptions of Common Mental Disorders. The criteria have been outlined in Appendix B. Please refer to the Appendix while reading this chapter.

Severe Mental Disorders (SMD):

As discussed in Chapter 1, Severe Mental Disorders (SMDs) are those disorders that are commonly identified and recognized as "mental illnesses". People suffering from these disorders show gross disturbance in thought, behavior, and awareness. The treatment is often done in hospitals and requires medication. Since those who suffer from these disorders face difficulties in carrying out social and occupational functioning, the burden on the caregivers is also high. More so if, the mentally ill person is the breadwinner or the homemaker of the family. In some cases of SMD the treatment may take a very long time and the expenditure incurred also adds to the burden. We list below some of the commonly seen Severe Mental Disorders.

Schizophrenia: This illness usually starts at an early age (15-30 years) and the person loses his/her ability to think, show emotions and process information from the environment correctly. Behavior and talk becomes strange. The person may also hold some unusual, false, firm ideas or beliefs (which are not shared by others), neglects taking food and ignores personal hygiene. Sleep is usually disturbed. He or she is often found walking aimlessly and may at times become violent towards others or harm herself/himself. At times the person may appear dull and withdrawn too (not talking or mixing with others, preferring to be alone). This disorder, unless treated, can carry on for a very long time. Imbalance of certain chemicals (neuro transmitters) in the brain is seen in this disorder and is thought to be cause. Treatment is mainly through medication and the medications commonly given for Schizophrenia are called anti-psychotics (e.g., Chlopromazine, Haloperidol, and Resperidone). Injections like Fluphenazine, Thepenthixol, and Haloperidol are also given.

Electro Convulsive Therapy (ECT) may be prescribed in certain cases. Since this disorder causes a high degree of disability, psychosocial methods of treatment, such as supportive counseling, cognitive behavioral counseling, social skills training and vocational rehabilitation have been found to be very effective, especially in the rehabilitation of these patients.

Bipolar Affective Disorder (BPAD): This disorder is called Bipolar, because it alternates between two extremes of mood states – Mania (excitement) and Depression (sadness). Those affected seem unusually and excessively happy without any reason or for a very small reason. They may talk too much, believe that they are very big and important people, have special powers and special talents. They may become irritable and pick up arguments with other people and at times also become aggressive and violent. They neglect basic needs (like food, hygiene and sleep) and social norms (may take off their clothes, or behave in a sexually inappropriate manner). The cycle of excitement usually lasts for about two weeks and reoccurrence is common. Excessive secretion of certain chemicals in the brain is usually seen in this disorder. A manic episode is sometimes followed by a depressive episode. In this episode symptoms are very much like the ones seen in a Mild/Moderate/Severe Depressive Episode (see Depression under CMD). The medications commonly prescribed for BPAD are anti-psychotics and mood stabilizers (e.g., Lithium, Carbamazapine and Sodium Valproate). The treatment of this illness may be long term.

Acute and Transient Psychotic Disorder: Also known as Brief Psychotic Disorder, this disorder can last from 1 day to 1 month and the symptoms resemble those for Schizophrenia (e.g., abnormalities in behavior, thought and perception). It usually arises as a response to a stressor or a group of stressors. The treatment for this disorder is very much like the one used for Schizophrenia, but the duration is shorter, and long term disability is usually not seen.

Common Mental Disorders (CMD):

These disorders are most commonly found in the community. They often go unreported as the symptoms are difficult to recognize. The level of social and occupational functioning of the client might drop but not significantly, i.e., the person will continue to carry out his/her daily routine but the efficiency will come down. The symptoms are not visible physically, hence the person does not go to a doctor, until such time that the disorder starts affecting the daily functioning routine (e.g., not able to carry on his/her work or

unable to sleep at all or not able to attend office). Some adult CMDs are discussed in the following paragraphs.

Depression: In this disorder the individual suffers from sadness of mood, loss of interest or enjoyment, and drop in energy level leading to feeling tired after doing even little work. Other common symptoms include reduced attention and concentration, ideas of guilt and shame, and thoughts or acts of suicide and harming oneself deliberately. Sleep and appetite are also disturbed. For this illness to be diagnosed as clinically significant the symptoms should be present for at least 2 weeks continuously. Depression can be caused by biological factors and psychosocial stressors (e.g., loss of a family member, failure, divorce, financial losses, etc.). It is found more commonly among women than among men. The recommended treatment for depression is a combination of anti-depressant medicines (e.g., Fluoxetine, Sertaline and Amitryptiline) and cognitive behavioral counseling. An episode of Mild or Moderate Depression may at times remit on its own with counseling. Medication is however necessary in the case of a severe episode. The categories of Depression as per the ICD-10 are described in Appendix B, Tables 1,2 & 3.

Mild Depression: In the case of Mild Depression the symptoms of Depression are the same as those described in the preceding paragraph. Individuals might have difficulty in carrying on with day-to-day functioning but they nevertheless carry on and usually do not cease to function completely (Appendix B, Table 1). A group of physical complaints associated with it at times is given in Appendix B, Table 2.

Moderate Depression: In case of Moderate Depression the symptoms are the same as those described for a Depressive Episode but they are present to a higher degree. The person experiences considerable difficulty in carrying out day-to-day functioning both at work or household (Appendix B, Table 1). Moderate Depression may include a group of physical and bodily symptoms in addition to the symptoms of Depression (Appendix B, Table 2).

Severe Depression: In Severe Depression, the client usually shows distress and at times agitation. Loss of self-esteem and feelings of worthlessness and guilt are prominent. The probability of suicide is also high. The group of physical complaints is almost always present in this disorder. During an episode of Severe Depression a person may not be able to carry on with social/work/domestic activities, except to a very limited extent (Appendix B, Table 1 and 2). Sometimes in an episode of Severe Depression certain psychotic symptoms may also be present (like those seen in Schizophrenia – **delusions,** hallucinations, etc.).

Dysthymia: The word Dysthymia means "ill-humored", implying a person who is irritable, angry and complains all the time. This disorder is characterized by a continuous sadness of mood (or low mood) for a period of at least 2 years. Unlike Mild, Moderate or Severe Episodes of Depression the sadness of mood here is continuous. The individuals might worry and complain of symptoms like lack of sleep and how everything is an effort. They are able to carry on with their day-to-day activities though efficiency drops. The other typical symptoms include feelings of 'not being good enough', shame and guilt, irritability and anger, loss of interest in activities that the person used to enjoy, poor concentration, and sleep disturbance. (Appendix B, Table 3).

Women's Mental Health: Certain types of depressive disorders are found only in women. Women usually experience some physical, emotional and behavioral changes associated with phases of their menstrual cycle. These changes include depression, irritability, and other physical and emotional changes. Since a lot of these changes cause sadness of mood we will discuss these changes under Depression.

Premenstrual Dysphoric Disorder: Premenstrual Dysphoric Disorder refers to the physical and mental symptoms associated with the changing hormone levels that accompany the menstrual cycle. It occurs about one week before the beginning of menses and the following symptoms are commonly seen:

- ❑ depressed mood.
- ❑ feelings of inadequacy ("people are better than me/there is something lacking in me as compared to others").
- ❑ feeling of hopelessness ("nothing good is going to happen to me in the future").
- ❑ worthlessness ("I am no good").
- ❑ anxiety.
- ❑ tension.
- ❑ having difficulty in concentration.
- ❑ mood swings (sometimes happy, sometimes sad on the same day and crying spells).
- ❑ prone to tears very easily.
- ❑ extra sensitivity to angry or rude statements by others (to which they may not have reacted to at all on any other day).
- ❑ anger.
- ❑ irritability.
- ❑ increased personal conflicts (getting into arguments and fights with close people very quickly on any small reason).
- ❑ lack of energy and exhaustion.
- ❑ headache.
- ❑ sleep disturbance.

The physical symptoms include edema (body retains a lot of water and therefore feet or hands swell up), weight gain (due to body retaining water), breast pain, headache, and vague/non-specific body pains. The symptoms start receding at the beginning of the

menses in some cases and definitely finish before the end of menses in other cases. Women who experience Premenstrual Dysphoric Disorder are more likely to suffer from depressive disorders and Postpartum Depression (discussed next).

The treatment for Premenstrual Dysphoric Disorder include well balanced diets, calcium and vitamin B6 supplements, exercise, relaxation techniques, yoga, anti-depressant medication and cognitive behavior counseling to handle the negative thoughts that are predominant during this phase.

Postpartum Depression: About 50% of women report feeling moody, sad and tearful in the period immediately after childbirth / delivery. This phenomenon is called "Postpartum Blues" and usually goes away by itself within a period of 1-12 weeks. About 10% women develop Postpartum Depression. This is characterized by:

- ❑ sadness of mood.
- ❑ excessive anxiety.
- ❑ sleeplessness.
- ❑ occasional thoughts of death or suicide.
- ❑ easy tearfulness.
- ❑ excessive dependency (on people close to them).
- ❑ clinging behavior.
- ❑ feelings of guilt or inadequacy.
- ❑ no interest in child care and in some cases thoughts of harming the baby.

Postpartum Depression is attributed to rapid changes in women's hormonal levels, stress of childbirth and the increased responsibility that motherhood brings. It has been discussed here because it is commonly found after childbirth. If the symptoms of this disorder do not go away in 12 weeks, it is advisable to consult a psychiatrist for medication and counseling. Women who experience Postpartum Depression are at a higher risk for an episode of Depression later in their lives. Postpartum Depression following the next delivery is also likely.

Depression in Menopause: Menopause is a period of time when women stop having their monthly periods and experience symptoms related to a lack of the hormone estrogen. This usually occurs in the late 40s and 50s and is a normal process of aging. Menopause

marks the end of the reproductive age. The lack of hormone produces certain physical and emotional changes.

The physical changes include:

- sleep difficulties.
- urinary problems (burning sensation during passing urine).
- hair thinning or loss.
- weight gain.
- flashes of heat spreading through the body associated with sweating and a sense of unease (hot-flushes).

The emotional problems include:

- irritability.
- mood swings.
- nervousness.
- stress.
- depression.

Women who have had a previous depressive episode are more likely to experience a recurrence during menopause. To reduce the severity of the symptoms certain medicines can be taken to bring back the balance of the hormones. Medication will also help reduce the feeling of sadness. Anti depressants are also prescribed for women who are moderately to severely depressed. Cognitive behavior counseling has been found to be very useful for handling negative thoughts and behaviors that worsen the sadness of mood.

We will now move on to a symptom commonly present in mood disorders.

Suicide: Suicide is not a disorder but a symptom of mood disorders and other mental illnesses. The majority of people who attempt suicide have an associated mental disorder like Depression. Suicide is an attempt by the person to end his/her own life. Psychologically it is seen as a "cry for help" from the person who is feeling unbearably sad, and is stuck in a situation from which she/he sees no escape. It can also be a consequence of stressful life events like unexpected failure, financial loss, chronic poverty, or divorce. It is essential to talk about the factors leading to suicide, since the early signs are often ignored. If they are

recognized in time help can be sought. To clarify suicidal attempts one should assess these factors: were there any previous attempts of suicide? If yes, then how serious was the previous attempt? How determined was the person to end his/her life? How much time and effort had gone into the planning of the suicide? If the individual has made a previous attempt to commit suicide the chances are that the person will make another attempt. Therefore these factors should be carefully assessed and if the risk of suicide is high, steps should be immediately taken to make sure that the person does not make another attempt. Counseling with the family members and the client are helpful in these cases.

Let us turn to a category of disorders related to anxiety and tension.

Anxiety: Anxiety is a non-specific, unpleasant, vague sense of apprehension or nervousness often accompanied by the following physical symptoms:

- ❑ headache.
- ❑ sweating.
- ❑ palpitation (increased heart rate which seems loud).
- ❑ tightness in the chest (as if there is a band around the chest).
- ❑ mild stomach discomfort and restlessness which is seen in an inability to sit or stand still (without fidgeting) for long.
- ❑ muscle tension (stiffness of body).

The other symptoms include:

- ❑ getting tired easily.
- ❑ difficulty in concentrating or mind going blank.
- ❑ irritability.
- ❑ sleep disturbance (insufficient amount of sleep, difficulty in falling asleep, restless unsatisfied sleep).

Anxiety can be distinguished from Fear, which is a response to a real, known, external, definite threat. Anxiety is a response to a threat that is unknown (or unacknowledged), internal and causing some unease in the mind of the person. It is also an alerting signal to warn of impending danger, which may or may not be present. Thus to some extent all of us feel anxious at times but when this anxiety occurs without any reason, is much more

than what is expected as a reaction to a situation and interferes with the day-to-day functioning (social, occupational and domestic) of an individual, it is seen as a mental disorder. Symptoms of Anxiety may at times be mixed with symptoms of Depression and vice versa. In such cases the category of the disorder that has a higher number of symptoms should be accepted. In case symptoms from both categories are equally present, then a diagnosis of Mixed Depression with Anxiety can be given. The treatment for Anxiety Disorder includes anti-anxiety (anxiolytics) medicines, counseling and relaxation exercises.

Generalized Anxiety Disorder (GAD): This disorder is characterized by symptoms of anxiety, which are not specific and not related to any situation, person or circumstance. The person complains of continuous feelings of nervousness, trembling, bodily stiffness, tension, sweating, palpitations and stomach discomfort. These complaints have no specified pattern. This disorder tends to occur more in women. The complaints must be present for at least 6 months before this disorder can be diagnosed. Care should be taken to rule out any physical cause of anxiety like drug withdrawal, side effects of medicines or hyperthyroidism before a diagnosis of GAD is made (Appendix B, Table 4). Relaxation and cognitive behavioral counseling in addition to anti-anxiety medicines have been found to be effective in this disorder.

Panic Disorder: Panic Disorder is characterized by sudden frequent attacks of severe anxiety. These attacks are not related to any particular situation or circumstance, and therefore are unpredictable. In Panic Disorder the person experiences sudden attacks of palpitations, chest pain, choking sensation, dizziness and breathlessness. The person feels that she/he is going to die, is going mad and has no control over himself/herself and the situation. These attacks usually last for a few minutes. The number of times they might occur changes from person to person. A person with panic attacks often fears having the attack. This affects the day-to-day functioning. The person may stop going out of the house or to public places fearing such an attack. The symptoms in a panic attack are very similar to a heart attack and thus very scary for the family and observers. It is advisable to rule

out any medical reason for the symptoms before diagnosing Panic Disorder. The following four points should be kept in mind before making a diagnosis of Panic Disorder:

- ❑ recurrent, unexpected panic attacks.
- ❑ persistent concern about having additional attacks.
- ❑ worry about the implications of the attacks and its consequences.
- ❑ significant change in behavior following the attacks.

Both medication (anti-anxiety) and cognitive behavioral counseling are useful in these disorders (Appendix B, Table 5).

Phobia: In this disorder, the anxiety arises as a response to certain well-defined situations or objects. These situations and objects are themselves not dangerous (e.g., fear of darkness, red objects, black cats, blood, heights, open spaces, etc.). The person tries to avoid these situations or objects as far as possible. If the person faces these situations she/he experiences reactions ranging from uneasiness to terror and fear. Often even thinking about these situations and objects causes similar reactions. Explaining or providing information that other people do not regard these situations as dangerous or threatening does not in any way put the anxiety to rest. People who have this disorder often recognize that this fear is excessive (more than normal or more than what other people experience) and irrational (has no logical or reality basis). Phobic anxiety often coexists with Depression. Phobias except for social phobia are more common in women. Panic attacks can also occur in a phobic situation. Both medication (anti-anxiety) and cognitive behavioral counseling are useful in these disorders (Appendix B, Table 6). The two most common types of phobias seen in the community are Agoraphobia and Social Phobia.

Agoraphobia: In this disorder there is a fear and avoidance of crowds, public places, traveling alone or traveling away from home. Essentially, these are considered as places from which escape to a safe place (usually home) might not be possible. The person fears that she/he will collapse and be left helpless in a crowd. This is one of the most unbearable phobias and some people become totally home bound in order to avoid such a situation. It usually starts in early adulthood (18-24 years) and is more common among women (Appendix B, Table 6). Cognitive behavioral counseling has been found to be useful in the treatment of Agoraphobia.

Social Phobia: This is a disorder characterized by fear and avoidance of social situations. The individual fears that others might pass judgment, comment or look too closely at him/her in small group situations such as eating out, attending marriages and parties, waiting at bus stop, etc. It is a fear of behaving in a way that will be embarrassing or socially inappropriate (like spilling food items, vomiting, appearing ill dressed) in front of others. Such unsuitable behavior,the individual feels, will surely cause others to pass remarks that will be humiliating, shameful and embarrassing. So the individual tries his/her best to avoid such situations. In case that is not possible the person will show symptoms like blushing, trembling, not maintaining eye-to-eye contact, feeling the need to urinate urgently. Other symptoms of Anxiety will also be seen. This disorder is equally common among men and women and usually starts in adolescence (Appendix B, Table 6.1). The treatment of this disorder is done through cognitive behavioral counseling.

Stress related disorders are as follows:

Somatoform Disorders: This disorder is characterized by two years or more continuous complaints of multiple and different types of physical symptoms (pain, weakness, tiredness, vomiting, diarrhea, constipation, inability to carry out normal sexual activity, blindness, deafness, irregular menstrual periods, unusual/excessive vaginal discharge, sleep disturbance, etc.). There is no physical cause for this disorder. The people who suffer from this disorder keep talking, thinking or worrying about the symptoms. They go to several doctors (at least three consultations) including faith healers and multiple investigations are usually done. They refuse to accept that there is no physical explanation for their symptoms in spite of the negative test results and constant reassurances from the doctor. They may take medicines on their own, without the advice of the doctor to get relief from the multiple aches and pains. The symptoms do not allow them to carry out their social or familial responsibilities.

This disorder is an indication that the person has some psychological stress, problem or conflict in his/her mind. The inability of the person to express and handle the problem causes stress, which gets converted and expressed through a physical symptom. In a sense Somatoform Disorders can be seen as a "cry for help" and attention from a person who may feel unloved, neglected, unwanted or marginalized. This disorder can be very frustrating for both the doctor and the client and the family. Symptoms for Anxiety and Depression must be checked since they might also be present along with the symptoms of Somatoform Disorders. Counseling through the process of teaching coping skills is seen as an effective way of dealing with stress (Appendix B, Table 7).

Obsessive Compulsive Disorder (OCD): OCD is a disorder characterized by an idea or impulse, which interferes all the time with the person's thinking process or awareness. There is a feeling of anxiety and fear and this leads the person to take some action against the idea or impulse. The person usually recognizes that this idea or impulse is irrational and unwanted (by the person). Obsessions are repeated and continuous thoughts, impulses

or images in the mind. They are interfering, not under the person's control and cause the person a lot of anxiety and distress. These thoughts and worries are not simply about real-life problems. The person tries to ignore them, or suppress them but without much success. The person also recognizes that these thoughts or images are his own and have not been put into his mind by another person.

Compulsions are repeated actions or acts (behaviors) – hand-washing, touching, checking, counting, praying, repeating words or numbers silently, etc. The person feels compelled to do these in response to a repeated thought (obsession). These actions are carried out to reduce or prevent the distress/anxiety the person experiences due to the repeated thoughts. These actions are sometimes done because the person fears that if he/she does not do these acts repeatedly, then something terrible will happen, either to him/her or to the family/loved ones. The anxiety may or may not reduce following the compulsion, but resisting the compulsion creates further anxiety in the client. These obsessions and compulsions are time consuming, cause a high level of distress and interfere with the person's day-to-day functioning (at work, home, social relations, etc). Both medication and cognitive behavioral counseling are effective for OCD, especially when used together (Appendix B, Table 8).

We will now discuss a disorder, which usually occurs after a traumatic event has taken place. The disorder presents itself in the form of physical problems, which arise out of severe psychological distress.

Dissociative Disorders: Dissociative Disorders arise as a consequence of severe, excessive stress. The onset and ending of the disorders is often sudden. This stress can be sudden or a continuous or ongoing one. Dissociative Disorders can produce complete or partial loss of memories of the past, complete or partial loss of awareness of identity and unusual sensations. Lastly it can also produce complete and partial loss of control over those bodily movements, which are usually under a person's control (e.g., walking, turning of head, speech).

Dissociative Disorders are usually associated with traumatic events (e.g., accidents, sudden financial loss, rape, etc.), intolerable and continuing problems, or relationship problems and difficulties. The stress of these events and the situation is seen as unbearable by the person and is "converted" (without the person being aware of it) into a bodily symptom. Another reason for conversion could be that the person does not have effective ways of coping with the severity or suddenness of the problem. The disorder is an outlet to the anxiety and pain and at times also gets the person attention and help, which she/he might otherwise not get.

These disorders stop once the stress goes down but might come back in times of acute stress again. The person suffering from Dissociative Disorder often shows a complete denial of the problem, even though at times the stressor might be obvious to others. Women suffer more from this disorder than men. A reason for this could be attributed to the marginalized status of women in our society. Women do not have the "voice" or means to express their pain and demands. Also there is often no one to listen to their problems. That is why there is a tendency to convert their psychological distress into a more obvious physical symptom. In that sense this disorder is a cry for help. Counseling of a supportive nature, with emphasis on problem solving and assertiveness, is seen as an effective form of intervention with these clients.

A few types of Dissociative Disorders are as follows:

Dissociative Motor Disorder: A diagnosis of Dissociative Motor Disorder should only be made when one has carefully ruled out the presence of any physical reason that may be causing the symptoms. The most common symptom of Dissociative Motor Disorder is a complete or partial loss of ability to move the limbs. Complete or partial paralysis, weakness or lack of coordination of the limbs, which results in clumsiness and problems in walking, may be seen. There might also be severe trembling or shaking of the hands, legs or the whole body. Look closely for stressors in the person's life, especially close to the onset of the illness (Appendix B, Table 9)

Trance and Possession Disorder: In these disorders there is a temporary loss of both the personal identity of the person and an awareness of the surroundings. The person talks and behaves like a different person – like god, goddess, holy person, spirit of dead person, etc. This gives the person a convenient way to express conflicts, demands and problems and also gets him/her attention from others who are concerned.

There may be short episodes of abnormal behavior during which time it might look as if the person has gone mad. She/he might talk nonsense, abuse or assault others, walk naked or half naked, fail to recognize the place, people or time and remain confused. After recovering from the episode the person will claim to have no memory of that specific period. In certain societies they might attribute such behavior to evil spirits, ghosts and witches (Appendix B, Table 9.1).

Dissociative Convulsions: In this disorder the symptoms resemble those for an Epileptic Fit. Jerky movements, tongue biting, falling down, rolling up of the eyeballs, etc., are usually seen. The difference between an Epileptic Fit and Dissociative Convulsions is that the person will not seriously hurt himself/herself in a Dissociative Convulsion. There is no passing of urine or stools while having a dissociative convulsion, and the person does not become unconscious. It usually occurs when there are people or help nearby (Appendix A, Table 9.2).

At the end of this chapter you should have learnt:

1. Some of the Severe Mental Disorders.
2. The different types of Common Mental Disorders
3. To identify the signs and symptoms of CMDs with the help of Appendix B
4. To identify when a disorder is at the clinical or sub-clinical level.

CHAPTER 4

Overview of Counseling

What is Counseling?

Counseling is a process in which one person *(counselor)* helps another person *(client)* to better understand and solve some problems he/she may be facing. *Help* is defined as providing resources and skills that enable people to help themselves. In counseling, conditions are created in such a manner that clients get an opportunity to fulfill their needs for security, love, respect and self-esteem. Clients are encouraged to think and plan rationally, do problem solving, look for alternative solutions and make decisions. The counselor provides the support to clients to handle the pressures arising from their problematic situations.

Counseling is a *change process* (growth and healing). One looks for the strengths within the client. Clients learn new ways of thinking, behaving and feeling (growth). It is also a process where clients who have experienced traumatic or painful events are better able come to terms with them. The counseling process is a *partnership* between the client and the counselor, where the counselor brings his/her skills to help the client in solving the problems, but does not take an authoritarian position (one-up position). Counseling is a relationship in which both partners are equal.

The counselor can learn and benefit as much from the experiences of clients, as can clients from the counselor's skills. In the counseling process, the counselor helps clients to express their feelings in a safe, supportive, collaborative and non-judgmental environment

and to identify and clarify their problems. Clients are also encouraged to talk about how they have dealt with the difficulties on their own and identify coping methods that have been both helpful and not helpful. In the counseling process, the counselor enables clients to learn effective and appropriate coping skills and achieve goals that are important to them.

Aim of Counseling

The aim of counseling is to help individuals *empower* themselves in such a manner that they are able to recognize and strengthen their inner resources as well as adapt and cope with stressful life situations. Counseling is an empowering experience because the counselor helps clients to become self-reliant and find solutions, which they would be most comfortable with. Counseling is time limited to a specific problematic situation or problem. There is no guarantee, however, that clients will never face problems in the future after having gone through counseling once. But, clients can always come back to counseling whenever there is a crisis, stress or problem in the future.

Skills and Qualities of an Effective Counselor

Counseling to a large extent is influenced by who the counselor is and what skills he or she has. For counseling to be beneficial, a counselor must possess the following qualities:

1. **Good listening skills** – An effective counselor is someone who is interested in listening to the concerns of the clients. Listening is different from hearing. A counselor not only listens to what clients are saying but also listens to how they are saying it. Listening is an active attending process with little or no verbalization. Good listening skill is a technique that must be learned. Listening also means being able to tolerate silence. Listening without criticizing, passing judgment, interrupting or getting impatient is an important quality of an effective counselor. A counselor must take the problems of clients seriously and should be willing to openly discuss anything the clients wish to.
2. **Knowledge base and skills** – A counselor must have a knowledge base of the types of emotional and behavioral problems that are likely to occur. A competent counselor should have the necessary skills (practical knowledge) and the ability to help clients with their problems. A counselor should be trained adequately in all aspects of counseling techniques and in the process of counseling. A counselor, therefore, should be trained in understanding various types of emotional and behavioral problems and

the factors that influence mental health. A counselor should be willing to work with clients, but not make decisions for them or tell them what to do. Remember, counselors have ***no magical powers, skills or knowledge*** to solve the problems of the clients. As counselor, you help clients to solve their problems, not solve the problems for them.

3. **Empathy** – This is a very important quality in a counselor. The counselor tries to put himself/herself in the client's place and understand the problem. If the counselor has the capacity to feel yet not get emotionally involved in the experiences of clients, and communicates it sensitively, then clients are more likely to feel relaxed and accepted by the counselor. Being empathic means that the counselor is able to understand what the client is feeling and going through and is able to relate to the client's problems and circumstances. It is important to understand the difference between sympathy and empathy. Sympathy is when a person is able to understand the other person's problems but pities him/her, whereas empathy is when one is able to put oneself in another person's place and understand and relate to the other person's distress and problems.
4. **Unconditional positive regard** – A counselor should be able to accept clients as they are and not show bias, disregard or disrespect because of the problem or the nature of the client. For example, a victim of domestic violence may seek the help of a counselor, but if the counselor believes that she is a weak woman because she is being beaten up by her husband, then the counselor shows disregard and disrespect for her problem.
5. **Objectivity** – A counselor, on the one hand, should be empathic and be able to understand the problems and feelings of clients from their perspective. On the other hand, it is equally important to be objective. Being objective means that the counselor should not get emotionally involved with the problems of clients and should be able to view them as a third party. Objectivity is essential in a counselor, because it helps him/her to be able to help clients explore alternative solutions to their problems. If a counselor loses objectivity and becomes emotionally involved in the problems of clients then he/she starts experiencing the same reactions of the clients and will be unable to show clients a way out of the problem.
6. **Encouragement** – A counselor should always encourage clients by stressing on their strengths and capabilities to boost their self-esteem and prevent demoralization. Often clients come to a counselor because they have lost confidence in their ability to think for themselves, or recognize their strengths. They feel helpless, as if they have no control over what is happening to them or their situation. At such times, a counselor should encourage clients to believe in themselves and make the effort to find solutions to their problems.

7. **Effective communication** – A counselor should be able to ***effectively communicate*** his/her thoughts, feelings and understanding of the problem to the clients. A counselor should use common words from everyday language. Sometimes a counselor might have to point out a maladaptive pattern of behavior, thinking or feeling. Care should be taken to put the message across in such a manner that clients do not feel as if they are being ridiculed, scolded or blamed for the problem.
8. **Trust** – An effective counselor inspires trust and gives confidence to clients to discuss their innermost problems without fear, shame or guilt. Trust and confidence is a function of ***confidentiality*** – a reassurance that the information that clients share with the counselor will be kept in confidence, will not be misused or revealed without their consent. A counselor's ability to communicate honestly and truthfully forms the basis of trust on which the client-counselor relationship rests.
9. **Courage** – Being a counselor demands a special kind of courage – courage to put one's personal needs in the background and let clients become self-reliant and ultimately empowered. A counselor should keep the information confidential and build the confidence of clients. A counselor should have the courage to objectively view the problems of clients without letting it affect himself/herself.
10. **Socio-culturally sensitive solutions** – A counselor's understanding of the problem, advice, suggestions and problem solving should be ***based in reality.*** The counselor should keep the socio-cultural backgrounds of clients in mind while doing counseling. Solutions should be based on the familial and social context of the clients. If a counselor gives solutions, which are not practical, reasonable or applicable, clients will never be able to put them to use in their real-life situations.
11. **Supportive** – A supportive counselor inspires trust in clients. A counselor is supportive if he/she accepts clients, is warm towards them and gives them a secure and supportive environment in counseling. A supportive counselor will gradually make clients believe that she/he is making maximum effort to understand and solve their problems.
12. **Non-judgmental Attitude** – An effective counselor is free from bias and expectations. For instance, bias can be seen in issues of morality – wrong or right judgments. A counselor should not make judgments on the behavior of the clients, whether wrong or right, good or bad. Being non-judgmental also means that the counselor should not force his or her ideas on clients. For example, if the counselor tells the client that she or he is in a bad marriage, then the counselor may implicitly convey to the client not to stay in the marriage or postpone having children. A counselor should not have any

expectations concerning the outcome of the sessions or how clients should respond to what he/she says or does. Often expectations arise when a counselor has been working with a client over a period of time. The counselor may think that he/she has put in a lot of effort, hard work and time and therefore feels that some positive results must be seen. If clients are unable to show positive results, sometimes the counselor may become unhappy or angry with them.

13. **Strength to withstand pressure** – An effective counselor should have the strength to withstand pressure from clients to solve the problems in a quick and painless manner. The counselor should also be able to withstand pressure from within himself/herself to solve the problems for clients and to give answers and solutions. It is often tough to hold oneself back from setting the pace to solve the problem and follow it through. This pressure puts the frustration tolerance (ability to withstand pressure) of the counselor to test, which has to be sufficiently strong, as often clients and their concerned families will really put it to test.
14. **Deal with Failure** – All counselors have to deal with failure at some point. An effective counselor is one who is aware that he/she is not omnipotent, does not have all the answers all the time, and is likely to get stuck now and then in the problem of the clients. When such situations arise, it is best that the counselor talks with his/her peers and discusses the problems in counseling a particular client. At times, despite the counselor's best efforts clients may not improve at all, or may not improve to the expected level. Failure may be seen in the form of clients dropping out – clients may not perceive counseling as an option.
15. **Know your Limitations** – An effective counselor is one who knows his/her limitations and realizes when he/she is getting stuck in the sessions. Sometimes, a counselor may find that she or he is not able to help clients anymore, or feel that clients need to go to an expert for further counseling. In such situations, it is important for the counselor to realize his/her limitations.
16. **Emotionally stable** – An effective counselor should be comfortable with himself/herself and the interpersonal relationships with family, friends and colleagues. He/she should enjoy a wide social support network and seek help whenever necessary. If a counselor has personal difficulties he/she must attend to them before helping clients. Personal difficulties can cause bias or interfere with the counseling process. Effective counselors usually have a variety of interests and hobbies. They find ways of relaxing or relieving their own stress through relaxation methods.

- ❑ Good listening skills
- ❑ Knowledge base and skills
- ❑ Empathy
- ❑ Unconditional positive regard
- ❑ Objectivity
- ❑ Encouragement
- ❑ Effective communication
- ❑ Trust

- ❑ Courage
- ❑ Socio-culturally sensitive solutions
- ❑ Supportive
- ❑ Non-judgmental Attitude
- ❑ Strength to withstand pressure
- ❑ Deal with Failure
- ❑ Know your Limitations
- ❑ Emotionally stable

The Counselor – Client Relationship

The relationship between the counselor and the client is of ***utmost importance*** in the counseling process. A ***strong bond*** between the two determines how successful the counseling process will be and how much change the client will bring to himself/herself. In order to be a good counselor, a person must have certain qualities (described in the previous section), which will help him/her to develop a strong bond with the client.

Each client-counselor relationship is a unique and fresh challenge to the counselor. This relationship is unlike the ones the client has with friends, family members, spouses. The relationship between the counselor and the client is structured and carefully planned. The counselor is both objective and emotionally involved with the client. ***Every counselor should maintain a balance between objectivity and emotional involvement.*** Being objective means that the counselor respects the views of clients, does not force his or her ideas on them, and looks at their problems rationally and analytically.

Emotional involvement indicates that the counselor is warm and caring towards clients, is interested in their problems and gives the clients a feeling of being understood. If the counselor gets too emotionally involved with clients it will be difficult to be objective. Objectivity is necessary to understand the nature of the problems of clients and emotional involvement is necessary to build a safe and secure environment in which clients can express their feelings without hesitation, shame or fear. An effective counselor needs to maintain this balance well.

When clients come for counseling, they will not be able to clearly understand the relationship between the counselor and them. Sometimes this relationship appears to be vague to clients. ***It is the counselor's responsibility to define and structure their roles in the beginning of the counseling process.*** Clients must be given a clear idea of the relationship, the kind of work that will be done by the counselor, and the counseling process. Clients should also be told that the relationship is an equal partnership between the two. In this equal partnership, the ***responsibility of the counseling being a successful process lies with both the client and the counselor.*** This process of defining the relationship in clear terms is called ***structuring.***

Accepting clients as they are is an important aspect of the client-counselor relationship. *Acceptance* is a positive, active attitude. It means, "I accept you, even if I may not necessarily agree personally with what you think or feel". For clients, being accepted means that the counselor understands them, is concerned and cares for them and respects them for what they are. Acceptance by the counselor indicates that clients are worthy, have the right to make their own decisions, have the capacity to choose wisely and are responsible for their own life. Clients should feel that the counselor really cares about what they think, wants to help them and will not judge them. Acceptance does not mean approval. Accepting means, neither approving nor disapproving what clients say or feel. It simply means, that clients as people have the right to feel and think differently from the way the counselor thinks and feels. If clients feel accepted by the counselor, they will become more involved and the counseling process will become more meaningful.

Besides being understanding, accepting, caring and being concerned, the warmth that the counselor shows towards clients is yet another important aspect of this relationship. Being warm to clients means showing consideration. Consideration is shown through a keen interest in the problems and difficulties of clients. Warmth is also expressed through small gestures like smiling at clients when they come into the room, offering a seat, etc.

The counselor must come across to clients as a genuine, honest person with a sincere attitude. Being honest in this relationship means being straightforward. If the counselor tries to put up a "front" or pretends to be interested in clients when not really feeling so, clients will immediately make out that the counselor is not being genuine.

The views of clients regarding their problem are more important than the counselor's opinions. When clients come for counseling, the counselor must help them to set the goal of counseling – what is it that they want to do, what behavior do they want to change, etc. The counselor must communicate to the client "I am here to help you" and not "I will solve your problems for you". The counselor must always remember that solving the problems for clients will harm them more, as it weakens their internal resources in the process and makes them more dependent on the counselor for every answer.

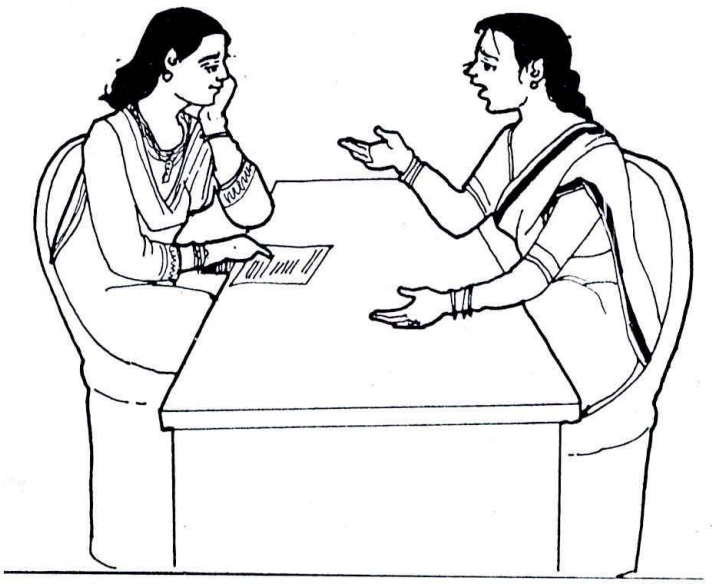
The counseling relationship is an ***equal relationship***. Clients must solve their own problems and becomes ***empowered*** through the process. This process is facilitated by the skills and the personality of the counselor, and the environment of the relationship (safe and confidential client-counselor relationship) provided by the counselor. The counselor often faces pressure from within to solve the problems of the clients, hasten the pace of counseling or even tell clients how to lead their lives. It is important to recognize this pressure as the counselor's need and not the client's expectation. Expression of ideas that would help clients is important to counseling – these ideas must not be forced on or sold to clients.

One of the principle functions of the client-counselor relationship is to provide support for clients, especially in a crisis. Acceptance, warmth, understanding and other such qualities of the counselor help clients to feel secure and supported in the relationship. A supportive relationship has four important values. One, it helps in reducing anxiety that clients feel (because of their problems, or difficulties) and thereby develops a sense of security and comfort in them. Two, it gives assurance to clients that they can be helped, no matter how difficult the problem is. Three, it makes clients realize that they have the freedom and the ability to choose and change their behavior and ways of thinking or feeling. Four, it prevents clients from taking hasty or impulsive decisions that might harm them in the long run. For example, a suicidal person may think that there is no other option for him/her than to commit suicide. A supportive relationship with the counselor will encourage this person to look for alternative solutions to suicide.

How effective counseling will be depends to a large extent on the quality of the relationship between the counselor and the client. Therefore the basic qualities expected of a counselor (described earlier) are very important to this relationship. The attitude of the counselor has a considerable influence on the counseling environment. Giving support in a safe and secure environment creates the right kind of atmosphere for counseling. All this will determine to a large extent whether clients will continue counseling, how useful it will be to them and how successful the outcome of counseling will be.

Counseling Setting

The setting in which the counseling is done is very important. It determines how comfortable clients will be with counseling. It is recommended that counseling to be in a neutral setting, for example, the center of the organization. The room should be well lit and ventilated, with minimum noise level. The setting should provide privacy to clients to talk comfortably. While in session, make sure you are not interrupted by other colleagues working at the center. Make sure no one comes into the room. Avoid having a telephone in the room. The counselor and the client should sit face to face either across the table or on the ground. This facilitates good eye-to-eye contact. The seating should be comfortable for the client (whether on the ground or across the table). If clients are facing a window, draw the curtains so that they are not distracted by what is going on outside. Besides it is best that outside people avoid seeing the clients.



If the counselor goes to the homes of the clients for counseling (which may be the case in NGOs), then he/she has to find a room in the house where the counselor and the client can talk in privacy without interruptions from other family members or outsiders. After such initial sessions at home clients may feel comfortable about coming to the center.

At the end of this chapter you should have learnt:

1. What is counseling?
2. The skills a counselor should learn.
3. The qualities of an effective counselor.
4. The importance of a counselor-client relationship and how it can be established.
5. The nature and type of setting in which counseling can be done.

CHAPTER 5
Techniques of Counseling

There are several types of counseling techniques that are used by counselors. We have chosen those commonly used techniques, which are easy to understand and practice, and are relevant for community-based counseling. The descriptions of the techniques are given for individual sessions; they can, however, be used for group counseling. Although we have described the techniques separately for ease of understanding, in practice, a counselor usually uses a combination of techniques.

I. Supportive Counseling

Supportive counseling draws on the supportive aspects of the counselor-client relationship. It helps clients through a time in their life when they feel stuck, helpless or troubled. The counselor helps and supports clients to cope with their distress. The counselor attempts to handle the distress rather than treat the cause of the problems. The counselor also provides acceptance, security and dependence for the client during a crisis.

In supportive counseling clients are encouraged to talk about their problem situation and the distress associated with it, e.g., guilt, anger, sadness, frustrations, etc. Being supportive towards clients is central in this form of counseling. Support given to clients can be viewed in different ways. A counselor is supportive to clients when he/she:

- ❑ accepts them.
- ❑ is warm.
- ❑ provides a secure and supportive environment
- ❑ is reassuring.
- ❑ encourages clients to explore different feelings.
- ❑ finds alternative ways of solving the problems.
- ❑ respects the thoughts and feelings of clients.

Being supportive towards clients has several benefits. First of all it helps reduce excessive anxiety and makes clients feel secure and comfortable. When clients believe that the

counselor is emotionally supportive of them, they feel worthy, loved and respected. Second, it gives assurance to clients that they can be helped. When clients feel hopeless or helpless about their feelings, the counselor's calm, accepting and reassuring manner is a powerful support, which helps them feel hopeful and confident about the future. It helps clients explore options, look at alternatives realistically and not choose self-defeating options.

Active Listening

The actual approach of supportive counseling is one of active listening and helping clients see alternatives to their situations and problems. Clients are helped to understand the changes that have occurred in their lives (traumatic events, stressful events), accept the situation and move on with their lives. However, before this can be accomplished, clients needs to be given room to express sorrow, anger and hopelessness over the situation, and give vent to feelings that they may not have had the opportunity to express earlier. Clients need reassurance that a supportive counselor can handle their distress and hold out hope for their recovery.

The counselor helps clients understand the difference between recovering and gaining back what was lost. Sometimes clients come with problems that are caused by very real situations. For example, a client may have lost his/her family and home in communal riots. The reassurance that there is no point in crying over what has been lost seems useless and very frustrating to clients. Instead, the counselor should help the client in acknowledging that the loss and pain cannot be forgotten or compensated, and at the

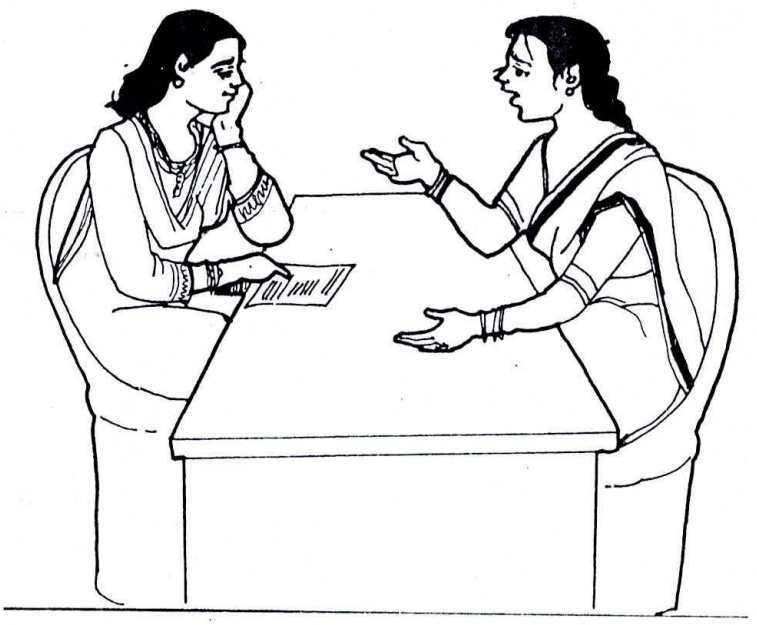
same time, take care to point out ways in which life can become meaningful once again. Often, re-establishing old ways of living may not be possible and the client has to come to terms with the changes that have happened. The supportive counselor introduces these changes in a gentle, but firm manner.

Ventilation

People often try to suppress their emotions. They might want to forget an individual or a situation, which may have caused them stress, distress or anxiety. Or perhaps the environment of the person does not provide an outlet for these issues to be discussed or shared, e.g., talking about child sexual abuse or sexual feelings is not encouraged in our society. These problems and the associated emotions get "bottled up" inside the individual. To explain how it feels people often use terms like 'heavy heart", and "weight on my chest".

When the counselor encourages clients to focus on their "feelings" and talk about their reactions to the problems they are facing, it is called ventilation. An individual who is allowed to talk about these bottled up emotions, situations or people will feel a sense of relief. The suppressed or bottled up feelings are brought out. After a process of ventilation clients feels as if a load has been lifted off their chest.

If the counselor is able to encourage and handle ventilation then clients feel supported and understood. The counselor's non-judgmental and supportive attitude also helps this process. Being empathic, asking open-ended questions and active listening are also important in this process.



CASE EXAMPLE:

Client: I feel that this is the last time that I am going to listen to all these accusations about my character from my mother-in-law.

Counselor: How do you feel when she makes all these accusations? (Open-ended question, facilitating client to talk more)

Client: She just goes on and on. Does not even care if others are listening.

Counselor: What does she say that upsets you so much?

Client: I really think she does... [Starts crying]

The counselor lets her cry for a while, till her weeping comes down and then offers her a glass of water. Allowing clients to cry is also a form of ventilation.

Counselor: you were telling me that your mother-in-law's accusations make you upset. Would you like to tell me more about it?

[Through out the entire session the client talks to the counselor about her problems and the distress she feels and the counselor listens patiently].

Acceptance

Acceptance is a technique of responding with short phrases such as "hmm-hmm", "Yes, go on", which imply that the counselor is listening, attending to what the client is saying and accepting it. It is usually employed in the beginning phase of counseling, when clients narrate the situation or the problem, which is causing them distress. The counselor tries to convey to clients that it is safe to talk about anything, and that they need not be ashamed or scared of expressing how they really feel. There are several ways in which the counselor conveys his/her acceptance of clients. One is to maintain eye-to-eye contact with clients. Another is neutral facial expressions or nodding of the head. The counselor conveys genuine interest through these expressions. Third is the tone of the voice and fourth is the distance and posture the counselor maintains. If the counselor leans forward and sits comfortably close to clients, clients will be assured that the counselor has a friendly attitude. This posture also conveys qualities of openness and sincerity in the counselor. Yawning, crossing and re-crossing of legs, grasping the arms of the chair tightly, shifting constantly are some of the negative cues that can make clients feel uncomfortable in the counselor's presence.

CASE EXAMPLE:

Counselor: *You appear to be worried about something. Is there anything that you would like to talk to me about?*

Client: *sometimes I really wonder if life is worth living.*

Counselor: *Would you like to talk to me about it? Talking and sharing a problem is usually helpful.*

Client: *I don't feel like waking up in the morning. After all there is nothing to look forward to. I just lie in bed most of the time, or say that I am ill. This way I don't have to go out and meet people or work.*

Counselor: *I can understand what you must be feeling and how every little thing must seem like an effort.*

Client: *I feel very bad at times and other may think that I am lying but what else do I do?*

Counselor: *I realize that you must be feeling upset about how others may react to your behavior.*

Reassurance

A key technique of supportive counseling is giving reassurance to clients who are in distress. Reassurance involves focusing on the strengths of clients and helping and reassuring them on the decisions and steps they have taken in dealing with the problems in their life. Showing a realistic goal is a crucial part of this process. This involves encouraging clients to look for alternative ways of solving or handling a problem. Reassurance by the counselor conveys an optimistic and hopeful feeling to clients.

Reassurance encourages clients to explore new ways of behaving, thinking, feeling, and trying out different behaviors. It helps reduce anxiety and insecurity in clients. It has the effect of positively encouraging new patterns of behavior. It provides the hope that change is possible. It shows the concern and supportive stance of the counselor.

CASE EXAMPLE:

A woman comes to the counselor at the domestic violence support center.

Client: *I really don't know if I have done the right thing in leaving home.*
Counselor: *You did what you thought was the best option in the given situation.*
Client: *I feel so scared. What is going to happen now?*
Counselor: *It is all right to feel scared. Leaving home is not at all an easy decision for any one.*
Client: *What will happen now?*
Counselor: *You have been brave to come here for help. Let us see together what are the options available and work out the best plan for you.*

Guidance

In supportive counseling, giving the client guidance and advice is an essential component. By guidance we mean that clients are helped to move in the direction of finding solutions to the problems they face. Guidance involves re-phrasing or re-stating the problem in different words – this reassures clients that in their situation others also may have reacted in the same manner. The counselor attempts to build a link between the difficult situation that clients face and the distress that is being caused by it. This explanation helps clients understand their problems, feelings and reactions and also brings about a sense of relief and hope. Understanding the problem is the first step towards finding a solution to the problem. Explanation helps in giving a direction to clients. When clients are able to understand the nature of the problem and why it is happening, they will be better prepared to look for solutions.

The counselor may at times also give ***advice*** to clients. Advice is usually given in the form of a suggestion, where clients are given alternatives to handle the problem. However, direct advice is avoided, because if, on the one hand, it is important to guide clients in the right direction, on the other, it is equally important to help clients think for themselves. Sometimes clients facing a high level of distress feel they have exhausted all methods to deal with the situation. They may also express helplessness to look or plan for alternatives to deal with the difficult situation. In such cases the counselor might think it necessary to give advice and guidance. This helps support clients and restores their faith in the resolution of the problem.

The counselor, while giving suggestions and advice, should take care not to force a particular decision or strategy on clients. The advantages and disadvantages of each

suggestion should be discussed and clients should be allowed to choose the option they think best. It helps clients gain confidence and a sense of control that they can do something about their problems. The counselor should make sure that the suggestions are practical, realistic and acceptable to clients. Secondly, all suggestions should be made keeping the religious-cultural-social-economic milieu of clients in mind.

CASE EXAMPLE:

A woman talks to the counselor at the health camp that has been organized at her village. The counselor is told that she is a regular patient at all clinics and health camps. Her complaints are of physical aches and pains, which have not shown any response to medicines.

Client: *This pain is making my life very miserable. I am not able to take care of my home and family.*

Counselor: *Have you noticed any worsening in the pain when you are feeling miserable and sad?*

Client: *Yes, the days that the pain is more my mood is also very bad.*

Counselor: *Sometimes our body reacts to how we feel. If we are happy our body feels light and free, if we are tense our body muscles feel stiff and painful, if we are troubled it seems as if there is no energy in the body, there are headaches and sleep is troubled. Do you think this is also true in your case?*

Client: *Could be, why?*

Counselor: *Because if they are related, then improvement in one can lead to improvement in the other.*

Client: *Is that possible?*

Counselor: *It usually is. Shall we look at ways in which we can improve the sad mood and see if your pain also improves? Is that ok with you? Can we try?*

Client: *if you think that will help me then why not.*

Reflection

Reflection of feeling is an attempt by the counselor to re-phrase in fresh words the feelings expressed by clients. The counselor mirrors the feelings of clients for their better understanding. The counselor also tries to convey to clients that he/she is able to understand and share their feelings.

Emotional problems often arise when there is either denial or non-acceptance of certain feelings. It is important to reflect feelings in words different from the ones that clients

have used. All statements made for this purpose are put before the client in the form of a hypothesis or a tentative suggestion. For example, "It seems to me that you are feeling angry because you husband is unable to express his affection for you in the manner that you would like"? Rephrasing validates the experiences of clients and helps them think about aspects that they had not thought about before. It also leads to ventilation or expression of feelings.

Strengthening coping skills

Strengthening coping skills is another technique of supportive counseling. Every individual uses different methods of coping with situations. By coping we mean the ways in which we handle/manage different types of situations and our feelings for those situations. For example, an individual going through a financial loss (a stressful situation) turns to drinking large amounts of alcohol (negative distraction which is a coping method) to deal with the stress. Alternatively, another person with the same situation may do problem solving and seek help and support from family or friends. In counseling an attempt is made to help clients strengthen existing adaptive coping skills and learn alternative coping skills as well. This leads to clients feeling hopeful and reassured.

An attempt is made to first strengthen the existing coping methods of clients. This gives encouragement to clients who feel that they have been doing something, which is effective and has helped them so far. It also gives them hope that since they have been able to handle the problem in some way then in future too they will be able to deal with their

problems. There are several coping strategies that people adopt: Distraction, praying to God, acceptance, denial, support seeking, problem solving, etc. are some of the strategies of coping.

No one coping method is good or bad, ineffective or effective. The method an individual adopts to handle the problem or distress will depend on the situation and the context. Moreover, at any given point in time, people may use more than one method of coping with their distress. For example, if an individual has lost a loved one, in the initial phase there may be denial that the loved one has not actually died. But as time goes by the person begins to accept the loss of the loved one. In the process of grieving over the loss the individual may seek support from family and friends. A point to keep in mind is that a coping method may be useful in a particular situation but not in another. To take the preceding example further, if the individual continues to live in denial over a long period of time, then that method of coping becomes ineffective.

The individual is also encouraged to think and try out new and alternative ways of coping. In this process some risk taking is also encouraged. Every alternative coping method that the client thinks of is evaluated in terms of merits and demerits and the possible difficulties in carrying it out. The counselor then gently and consistently helps the client put into practice these new coping skills.

II. Cognitive Behavioral Counseling

Cognitive behavioral counseling is a time limited structured approach used to treat a variety of common mental disorders – Depression, Anxiety, Phobia, etc. The word cognitive means thoughts or thinking process. The thinking process means how an individual interprets or assesses situations (whether harmful, threatening, painful, happy or positive). The way individuals interpret or assess a situation is based on their past experiences and influences how they think or act subsequently. The word behavior means that which is observable in a person's actions. Thought, feeling and behavior are linked in a circular manner. An individual's thoughts influence the way she/he feels, which in turn influences the way he/she behaves. Therefore, sometimes this becomes a vicious cycle. In cognitive behavioral counseling an attempt is made to break this vicious cycle by changing behavior or thought which results in change of mood or feelings.

Depressed people mostly have negative thoughts about themselves, their world and their future. These thoughts may result in feelings of worthlessness, guilt, incompetence, defeat, loneliness and hopelessness. Clients with Anxiety Disorder often have thoughts about some danger they believe they are likely to fall into. These types of thoughts (or images) are called ***automatic thoughts***. These thoughts come to mind automatically, and most of the time clients do not recognize these thoughts because they are not paying attention to what they are thinking. These automatic thoughts reflect how clients perceived the situation rather than the actual situation. In other words, the actual situations may be quite different from the way clients perceive them.

For ease of understanding we will first describe some of the common behavioral techniques and then the cognitive techniques. However, in counseling, the behavioral and cognitive techniques are used in combination since cognitive behavioral counseling attempts change in thoughts, behavior and feelings.

Relaxation

One of the common techniques used is relaxation. Everybody faces problems or stress during their lifetime (physical, social, financial, etc.). The body responds to stress by getting ready to either fight/face the problem, or escape the situation. In such cases the body is said to be under "stress". Stress to some extent is healthy as it prepares the individual to face the problem. Bodily changes like increase in blood pressure, increased heartbeat, faster breathing and muscles becoming tense are all indicators that the body is under stress. Once the stress passes or is dealt with, the body comes back to a state of relaxation.

When an individual faces problems day after day or if the stressors have been going on for too long (e.g., financial difficulties, bad marriage, disability, illness of family member who needs care giving), the body remains in a state of constant tension/stress. If this stress carries on over a period of time it causes physical problems like blood pressure, heart disease, stroke, migraine, lowered ability to fight diseases and chronic aches and pains. Psychologically, the individual becomes irritable, short-tempered, depressed and anxious. The coping and problem solving abilities of such an individual also become limited and stereotyped (repetitive). Often people do not realize that they are tense till their body breaks down (collapses) under constant stress by developing the previously mentioned physical disorders.

The physiological (bodily) changes that take place during relaxation are the opposite of those that occur when an individual is under stress. A disturbed mind cannot exist in a calm body and neither can the body be stressed when the mind is calm. Based on this principle certain relaxation exercises can be taught and practiced by individuals who show symptoms of stress like irritability, anger, depression and physical symptoms.

The first step in teaching relaxation strategies is to recognize when the body is under stress. Relaxation exercise also has a preventive function. Relaxation exercises are very simple, like taking deep long breaths originating from the stomach (not the chest). Often visualizing alongside that the breath coming from the stomach is useful. Or imagine that the breath is carrying out all the tension through the nose. While breathing deeply one can also repeat a calm word or phrase like 'calm down', 'relax' or a religious word like 'Om'. One such method of relaxation is Guided Imagery.

Guided Imagery

It is a way to achieve relaxation by means of visualizing or creating a relaxed and pleasant experience in the mind. These are the steps to be followed:

1. Make the client lie down or sit in a reclining and comfortable position.
2. The room should be quiet, preferably with dim lights.
3. Make sure that you are not interrupted or disturbed during this period (approximately 20 minutes).
4. Give these instructions: "Close your eyes. Breathe comfortably and normally. Let your body be loose, light and free. Arms should be relaxed lying loosely by your side or on your lap. Fists should not be clenched and palms should be open, facing upwards. Check that your eyes are relaxed. Forehead is relaxed. Lips and tongue are relaxed. Jaws are loose and relaxed. Neck and shoulders are relaxed. Back is relaxed. Stomach and chest are relaxed and breathe normally. Thighs and legs are loose. Feet are comfortable without any tension, loose, and relaxed".
5. Leave the client in this state for a few minutes to allow him/her to relax all parts of the body.
6. Speak to the client again: "Now make a picture in your mind of a place where you would like to go. This picture could be of any place (garden, seaside, hill station, your own bed room, etc.) In the place you have pictured, imagine the colors in that place, the sounds of that place, the smells of that place. Visualize as many details as you

want there. However, keep in mind that you should be alone and not talking with people. Do not crowd this place. Be alone".

7. "Now go into that place ***alone***. You may like to sit or lie down. Do whatever that you enjoy. Stay there for a while. If any thoughts come to your mind, do not force them out. Let them come and go. Gradually as you learn to relax these thoughts will go away". (Let the person be in this state for at least 7-10 minutes).
8. "Now please leave the scene and come back to the room. Remember that this is your place and you can go back to it whenever you want to relax".
9. "Slowly count 1-10 and open your eyes".
10. "Now you may get up".
11. "How do you feel?"

Practice this with clients until they are comfortable doing it on their own.

Modeling and Behavioral Rehearsal

There are certain types of behavioral techniques, which are helpful when the client has to learn a new behavior. For example, the counselor may want to teach a client how to handle an abusive spouse without getting angry or being abusive herself. The counselor will usually take a situation described by the client herself, in which the husband turns aggressive or abusive towards her. The counselor will then rehearse this scene using behavior or statements that the client can use to prevent herself from getting abused or beaten. The whole sequence is rehearsed step by step with the client. The counselor attempts to show how alternative ways of behaving can bring a difference to the situation, e.g., the client preventing the husband from being abusive or aggressive.

In the above example the counselor has used the behavioral techniques of modeling with behavioral rehearsal. "Modeling" means to perform or act and show what exactly has to be learnt by the client. Modeling is used to teach new behavior by breaking it down into smaller parts so that gradually a whole new behavior is learnt. It is an effective way to teach new behavior. In counseling the model can be the counselor. The counselor will model a new behavior and with the help of behavioral rehearsal the client and counselor will enact the new behavior, so that the client is able to learn it in a safe and secure environment. Behavioral rehearsal is a role-play. It helps to strengthen the client's new behavior before the client goes and applies it in a real-life situation. Behavioral rehearsal can be done again and again until the client feels confident of using the behavior in a real-

life situation. After each rehearsal, the counselor gives feedback to the client, modifications are made, and then practiced again.

Reinforcement

With each of these behavioral techniques, reinforcement is given to the client. Reinforcement is a basic principle of learning, a way of encouraging the client to adopt and try new behaviors or ways of thinking. Reinforcement is usually making a positive statement – for example, praising the client or smiling. Therefore, each time clients learn a new behavior or attempt to change their way of thinking, the counselor will encourage or reinforce the behavior by saying, "very good", "yes, I am happy that you made the effort", "that's very nice", etc.

Distraction

Another technique often used in cognitive behavioral counseling is called distraction. It is usually used when clients find it difficult to take their mind off certain problem situations or their distress. For example, when clients are feeling very sad or distressed, they may have negative thoughts about themselves, the future and the world in general. In distraction, the counselor will help clients to divert their mind off the issues that are distressing them. One way of doing this is by identifying a list of things that the clients enjoyed doing. From this list of activities, clients select those that they feel they will be able to do with minimum effort. Examples of such activities are reading, going for a walk, sitting with a neighbor and talking, doing some embroidery work, praying, attending a mandal meeting of an organization or religious gathering, etc.

Distraction can also be done in the thinking process. For example, as soon as clients start feeling anxious, or have negative thoughts, they are asked to think about some pleasant neutral thought or are asked to activate an image of a pleasant past event or natural surrounding. They have to make sure that it is not related to the anxiety provoking situation or the difficult situation. Distraction has been found to be useful with common mental disorders like Depression, Anxiety, and Somatoform Disorders, where clients are so preoccupied with their bodily symptoms that is it often difficult to engage them in counseling which involves talking. Therefore, a good way to start counseling with these clients is to use distraction.

Ignoring

Ignoring is a technique related to distraction. It is a technique based on the learning principle that an individual will gradually stop any behavior that is not paid attention to. The rationale behind it is that people often indulge in disruptive, harmful, dramatic or extreme behaviors as a means of getting attention. When such behavior is ignored, eventually it will be abandoned. This technique has been found to be useful with children, but it has also been used effectively with adults. For example, a client comes to you with complaints that her mother-in-law often makes derogatory comments about her cooking and this distresses her a lot. The client can be taught to ignore the mother-in-law's comments. Initially, when the client uses this method, the mother-in-law's abusive behavior may increase. However, if the client is consistent in ignoring these comments over a period of time, she will notice that it has gradually come down.

Activity Scheduling

In cognitive behavioral counseling, one of the techniques that has been found to be effective and useful is called as Activity Scheduling. This technique involves planning some part of the daily activities of clients (with their cooperation) in such a way, that clients derive pleasure out of them or are able to do routine activities (in case of clients whose functional level has dropped significantly because of the distress). Activity scheduling helps those clients who spend a lot of time brooding over problems and distress. Care is taken to see that the activity schedule has both pleasurable and routine daily activities. This technique is helpful with people who have lost interest in doing things that they enjoy and who find doing basic necessary activities also difficult.

In activity scheduling clients are asked to first write down all those activities they do through the day and the amount of time spent in doing each of those activities. Then they are asked to make a list of things that they do well. Next they are asked to make a list of those activities that would give them pleasure or enjoyment. They can also be asked to write a list of things that they would like to do or those they have stopped doing, either due to lack of time or because they don't feel like doing them anymore on account of the distress they are feeling.

Once these lists are ready then the counselor helps clients in drawing a daily schedule, which attempts to structure their activities. ***The aim is not to fill each hour with some activity.*** The counselor introduces one or two activities that are pleasurable in the schedule given to the clients. Clients are asked to keep a chart of the things that they did each day and rate the activities on a five point scale: how much pleasure it gave them, and how much of a sense of success they had after it (mastery). Attempt is made to achieve a balance between activities that give pleasure and routine activities that have to be done.

The counselor can also introduce a ***Star Chart*** with the activity schedule. This chart is be kept by the counselor and she/he gives a star against each activity that the client has been able to do and derive pleasure from. The star chart acts like a positive reinforcement. It gives clients a sense of achievement and confidence that they will be able to do routine work as well as pleasurable activities that give them enjoyment. Each time clients come back for a session, the counselor also verbally reinforces and encourages them on their success. The counselor should remember that this is a relatively long process and it may take some time. Therefore it is important that the counselor motivates and encourages clients to keep at it, until clients feels that they have achieved mastery over their daily routine.

CASE EXAMPLE:

A 40-year-old man has been feeling sad and dull for most of the days for the last 2 years. He has gradually stopped going to the fields to do farming, feels tired easily and does not derive pleasure from any activity. He has also been found to be sitting alone at home and not talking to the family members. The client has been identified as having Dysthymia and referred to psychiatrist. Apart from the medication given, the counselor is also doing counseling with the client. Speaking about his activities, the counselor finds that he takes care of his basic needs, but after food sits around aimlessly or lies on the bed all day. The family is upset at this behavior and it is causing problems at home.

The counselor asks him to list the things that used to give him pleasure and the routine activities he is supposed to do. In the process of discussion, the client reports that going to the chaupal and meeting people, going to the market, smoking beedis, etc., are some of the activities that he enjoyed. Then he is asked to make a list of things that he did well prior to the distress that he has been feeling for the past two years. The client says farming, milking the cows, going to the market place to sell the agricultural products, etc.

The counselor outlines an activity schedule for the client, which includes one or two pleasurable activities and one or two routine activities. As the client starts doing these activities, gradually more activities are added to the schedule until the client achieves the level of functioning prior to the disorder.

Problem Solving

Problem solving is a vital part of cognitive behavioral counseling. Often frustration arises when people feel stuck in a difficult situation and are so distressed or upset by it that they are not able to find a solution to either reduce the problem or distress.

In problem solving the counselor actively encourages clients to seek alternative ways of solving their problems by:

1. Analyzing the situation that is making clients feel stuck in it.
2. Explaining this process to clients.
3. Encouraging different ways of looking at problem situations.

The counselor acts as a facilitator in problem solving for clients and does not find the solutions for them. The steps involved in problem solving are:

1. The first step in problem solving is asking the client to think specifically about the problem in terms of " How is the situation that I am in a problem for me?" and " How does it affect me"?
2. In the next step, the client is encouraged to think on the lines of: "What is it that I am doing, thinking, feeling because of this problem"? "What is it that I am not doing, not feeling, not thinking, which is contributing to the continuing of the problem situation or distress"? The focus is on the client's actions, behavior or feelings and not on what others are doing to contribute to the problem. The rationale behind this is that, often in counseling, one may not be able to change the situation or the behavior of others because they may not be in the client's control. However, the client's own behavior and feelings are under his/her control.
3. The next step in this process is called ***brainstorming.*** In brainstorming, clients are asked to generate alternative solutions to the problem. They are asked to list down all possible solutions to the problem without evaluating if they are right or wrong. They are encouraged to be creative. All the solutions generated by clients are put into a priority list, in terms of feasibility (which solutions will be more practical and applicable). Clients are encouraged to think of the benefits and drawbacks for each choice that is generated (preferably written down). This process also emphasizes that there are no "perfect" or absolute solutions.
4. Clients are then asked to re-prioritize the alternatives on the basis of the solution they are most comfortable with and are confident of implementing. Clients are asked to adopt the alternative that is highest on the priority list and apply that solution to their real-life situation.

The counselor discusses how clients will implement the solution and the problems they might encounter in adopting it. The counselor also prepares clients for the possibility that the solution might not work. If it doesn't work, clients are asked to review why the solution did not work and also go over the other alternatives that have been generated by them. The alternatives clients have generated can be rehearsed in the counseling session so that clients have the opportunity to practice them in a safe and secure environment before applying them in real life. This also has the advantage of making modifications to alternatives before clients actually apply them.

In the subsequent session, if clients have been successful in implementing an alternative solution to their problem, then the counselor discusses the impact of the solution and how it made clients feel. The positive impact of the solution is used as a means of reassuring and encouraging clients. It also serves to build the confidence of clients in their ability to handle their distress and problems more effectively. On the other hand, if clients have not been successful in implementing the solution or if it has had a further negative effect, then the solution is once again discussed in terms of what could be the possible reasons for it not working. Clients are also encouraged to explore other alternatives from the list prepared earlier.

CASE EXAMPLE:

A woman comes to the counselor saying that she is having a lot of difficulty in handling her 10 year old boy. He is stubborn, gets angry quickly, and does not listen to her. This also causes tension in the house and often the husband gets angry with her for not handling the children well. The counselor uses a problem solving approach with the client. She asks the client to first clearly identify what the problem is in handling her son and the distress she is feeling because of it.

The client is then asked to think about the problem in terms of what it is that she is doing or not doing that is contributing to the problem. The emphasis is on what the client is doing or not doing rather than on what the son does. Following this brainstorming is carried out, where the client is asked to list all the possible solutions to this problem. The client comes up with the following suggestions:

- ❑ *I can shout at and slap my son when he speaks rudely to me.*
- ❑ *I can ignore him when he starts shouting and behaving badly.*
- ❑ *I can lock him up in the bathroom and tell him that I will not let him out until he stops shouting.*
- ❑ *I can hug him tightly and make him sit in my lap until he stops shouting.*
- ❑ *I can try and distract him by giving him something to eat or give a toy to play with.*
- ❑ *I can calmly ask him what it is that is making him angry and try to understand his reasons.*
- ❑ *I can threaten him that I will complain to his father when he comes home and then he will get a beating.*
- ❑ *I can ask my husband to talk to him.*
- ❑ *I can invite an elder from the family and ask him/her to explain to the child.*

The client is then asked to rate the benefits and the drawbacks for each solution that she has generated. After carrying out a similar exercise for all the options the client prioritizes the solutions on the basis of which solution she is most comfortable with and how confident she is of implementing it.

The counselor then helps the client to plan out the first option in the priority list. For example, if the client's first option is to have a talk with her son to find out why he is getting angry, she is asked to practice with the counselor by means of role-play, modeling and actual training in implementing the solution. When she feels confident of these skills she is asked to talk with her son. On the basis of the feedback that the client gets the plan is modified (if needed) with the help of the counselor. If this solution is not working, then the client is encouraged to try out the other alternatives that she has generated in her list.

Assertiveness Training

A part of the problem solving technique is assertiveness, which must be learnt. Assertiveness training is a technique employed when clients are not able to express what they feel in an appropriate manner. They feel that they don't have the words to express, or that what they might say will bring trouble upon them, or that the other person might take it either as a complaint or as being disrespectful, etc. Hence clients are not able to express their feelings and ideas appropriately, and it all remains in their minds causing them sadness, anxiety or anger.

Assertive behavior helps clients say what they are feeling in an honest, open manner without hurting or disregarding the feelings of others. This involves changing the manner (tone, attitude and facial expression) with which a statement is being said, choosing an

appropriate place to express what they feel and being careful about the language employed. Assertiveness training includes teaching clients how to make statements beginning with "I feel/think" rather than "you are". For example, instead of " You are always shouting at me and trying to put me down in front of others" one can say, " I feel very upset when you shout at me in front of others. Can we do something about it"? In such statements clients are taking responsibility for what they are feeling. When clients take responsibility for what they are feeling they will also make the attempt to feel better rather than put that responsibility on others. If the significant other (significant others are those who are important in our lives, e.g., parents, siblings, husband, wife, children, friends) is not able to fulfill that responsibility, then they are likely to get more upset and the blaming will go on. It is a cycle that clients get caught in, where they feel helpless, sad and angry.

Assertiveness training is practiced effectively with clients with the help of modeling and role-play (Behavioral Rehearsal). The counselor explains to clients the difference between assertiveness and aggressiveness. Often when clients are asked to be assertive, they confuse it with being aggressive. In aggression there is an abuse of the rights or feelings of others and the intention is to hurt or negatively affect the other person. In assertiveness the welfare and feelings of the other person are also kept in mind.

CASE EXAMPLE:

A client has communication problems with his wife. Whenever he objects to her spending too much money or the house being untidy, she gets offended and starts shouting at him. He constantly worries that he should not say or do anything to make her angry or upset, because it causes a lot of tension in the house. Yet, at the same time, he feels that he is not able make her understand his point of view. In this case the counselor first discuses with the client the possible statements that he can put across to her in such a manner that she does not get angry. The counselor uses modeling to demonstrate the possible ways in which he can say those statements. The client then practices these statements as part of various role-plays with the counselor in situations where assertiveness is required. The counselor gives the client feedback regarding his attempts. When the client is

comfortable using these statements, the counselor goes on to the next step: to generalize this assertive behavior in situations beyond the house and wife.

The counselor must point out during the feedback session that initially the client might receive negative comments and feedback. Any change in his behavior would also require others to change their behavior, which they might resent. Thus the important thing is to be prepared for such behavior from significant others in the beginning, but to continue with the assertive behavior consistently and firmly.

Some of the cognitive behavioral counseling techniques focus more on the cognitive component. Many people are not aware of the automatic thoughts they think, because they do not pay attention to what they are thinking until they actually start monitoring them and paying attention to them. Clients are encouraged to pay attention to the kind of thoughts that come to their minds and to make links with the situation in which they occur. ***Diary keeping*** is one such method. The diary has to be filled in daily by the clients. It is based on the A-B-C model. A – refers to activating events; B – refers to beliefs or reactions to events; and C – refers to the emotional consequences. The aim of the counseling is to teach clients to modify their beliefs (B) about an event (A) in order to change their emotional reactions (C). Clients are taught to "challenge" their negative thoughts and substitute those with more rational beliefs. The emphasis is also on consistently solving problems and initiating behavioral change.

Diary keeping is a task that requires practice and the counselor has to explain how each step needs to be done. As one carries out such type of monitoring, the counselor and clients gather more information, which helps clients in deciding what their priorities are for changing ways of thinking. The counselor can ask questions like "What sort of situations make you feel more distressed"? "What sort of thoughts, feelings and behavior patterns would you like to change"? This technique can only be used with literate clients. However, the A-B-C model can be used for both literate and illiterate clients to help them understand the circular nature of thoughts, feelings and behavior. In other words, it can be used as an explanatory model by counselors.

CASE EXAMPLE:

Situation	*Emotions*	*Automatic thoughts*	*Rate belief in the thought*
Any event that leads to unpleasant emotion, or any thought or image leading to unpleasant emotion	*Specifically name the emotion - angry, sad, anxious etc.*	*The thought that immediately and involuntarily follows the event*	*On a scale of 1-10, rate how much you believe this thought to be true*
E.g. While boiling milk in the morning, the milk boils over	*Anxious, nervous jumpy*	*I should have been more careful.* *I am always careless.* *I can't do anything well*	 *9* *7*

Once a diary has been kept for a period of time then clients can be helped to challenge their beliefs through the following type of questioning:

1. What is the evidence for and against my belief?
2. What are the alternative explanations for an event or situation?
3. What are the real implications if my belief is correct?
4. Are there any alternative ways of looking at the situation?
5. Where is this way of thinking getting me?
6. What is the effect of thinking this way?
7. Am I jumping to conclusions?
8. Am I taking things personally, which have little or nothing to do with me?

Cognitive Restructuring

Another technique often used in cognitive behavioral counseling is called Cognitive Restructuring. It is based on the principle that if people can consciously change (re-structure) their way of thinking, they can be more productive (behavior) and positive (feeling) about themselves. Cognitive restructuring is a way of giving oneself more control over one's thoughts, feelings and behaviors.

The counselor helps clients in this process by telling them how as humans we are all inclined to errors in thinking and exaggeration of faults. The counselor helps clients substitute these negative thoughts with more rational and positive thoughts. This is a process of re-structuring, where clients discover different patterns of thought, feeling and behavior that they would like to experience more often. It is important to point out to

clients that change is not something that a person does once and then forgets about it. In order to bring about lasting change, it is important to practice this change in their real lives again and again. Therefore, ***practice*** must be emphasized, and for that counselors can give homework to clients. Homework helps clients practice in their real lives what was taught in the session.

Practice in the counseling session is done through Behavioral Rehearsal. One of the ways to ensure that the change process continues is to positively reinforce clients each time they have been able to restructure their way of thinking in the present. The counselor should praise every attempt clients make in their ways of thinking. However, it is equally important to teach clients self-praise. They should be encouraged to praise themselves whenever they have turned an unrealistic thought into a realistic one, or have been able to utilize the technique of questioning irrational thoughts as mentioned earlier, in order to understand and deal with a stressful situation.

The two most powerful keys of constructive change are: ***altering ways of thinking*** – a person's thoughts, beliefs, ideas, attitudes, assumptions, mental imagery, and ***ways of directing attention*** – for the better. This is the *cognitive* aspect of counseling. Helping clients meet the challenges and opportunities in their lives with a clear mind and then taking actions that are likely to have positive results is the behavioral aspect of counseling. Cognitive aspects are used to change ways of thinking and behavioral aspects are used to change the behavior. For example, techniques like diary keeping (cognitive) with problem solving and coping skills (behavioral) are used in combination for this type of counseling.

In brief, these are the following steps of cognitive restructuring:

- Explain the A-B-C model to clients.
- Identify negative automatic thoughts – negative automatic thoughts occur automatically in response to a situation or event.
- Test these negative automatic thoughts by assessing evidence for and against – it is useful to ask clients to monitor their thoughts in relation to certain situations in which they occur (diary keeping).
- Challenge these thoughts.
- Generate more rational and realistic counter thoughts or comments (cognitive restructuring and problem solving).

Thus, cognitive behavioral counseling is a collaborative effort of both the client and the counselor. The emphasis is on an open relationship where the client can ask the counselor all his/her doubts without feeling a sense of shame. Cognitive behavioral counseling is usually done for a shorter period of time. The counselor and the client work towards specific, time-limited, achievable and realistic goals.

Spacing of Sessions

Although counseling is a time-limited activity, the number of sessions for counselors working in a community setting is not specified. The number of sessions will depend on the client's availability of time. The counselor can choose to have one or two sessions, or as many as 10 sessions. The time duration of a single session may vary from 20 minutes to an hour. Avoid having a session longer than an hour. Longer sessions tend to exhaust both the counselor and the client. The optimum period for a regular counseling session is 45 minutes. However, if the counseling has to be done in a single session, the counselor may choose to have a session longer than an hour. Do not start exploring a new problem if you don't have the time for it in the session.

Initially, when counseling starts, the counselor may choose to have frequent sessions (two or three times a week). As counseling progresses, it is preferable to have one session per week. Towards the termination of counseling, the time period between sessions is gradually increased from a week to 15 days, then a month, and finally a follow-up once in three months. The spacing and number of sessions are kept flexible, keeping in mind the target population that the organization is working with. Time may be a constraint for clients, or

they may find it difficult to travel to the organization's center frequently. Therefore these logistics should be worked out initially so that the counselor can plan the counseling sessions.

Sometimes, you may have successfully completed counseling with a client, and after a period of time, the client comes back again with symptoms and a high level of distress. Do not be discouraged. Counseling is not a one-time activity. Having been through counseling once does not necessarily mean that clients will never again have problems or that they will never again need counseling. In fact, if clients come back for counseling at another point in time, it is a good sign. It means that clients recognize that a problem of this nature can be handled through counseling and is actively seeking help.

At the end of this chapter you should have learnt:

1. The different types of techniques of supportive counseling.
2. The different types of techniques of cognitive behavioral counseling.
3. That techniques are usually used in combination.
4. How to space sessions for counseling.

CHAPTER 6
Counseling Process

The counseling process is defined as the steps and changes that take place in counseling. It is a process in which the counselor helps clients either through a difficult period (by being supportive) or a problem solving process involving decisions and actions.

Broadly, the counseling process can be divided into 7 steps.

Step 1: Stating Concerns and Establishing the Need for Counseling

The first step is to do the in-take interview (described in Section I, chapter 2). Here the counselor will take the entire history of the problems of clients and the distress they are facing because of it. Information about the family background and other related factors are also sought. This first step enables clients to state their concerns, problems, distress and reasons for seeking counseling. Often when clients come for counseling they do not recognize the need for help. They may blame others or think that they are victims of fate. They do not have a sense of "ownership" of their problems, nor do they recognize that they may be able to do something to solve the problem or reduce the distress. Therefore, it becomes important to help clients recognize the need for help and "ready" them for doing something actively to change their condition.

It is important for the counselor to realize that clients may initially hesitate to make a commitment to counseling. The process of change is difficult and frightening for clients. Change would mean giving up old habits of behaving, thinking, or confronting painful feelings. The counselor needs to be sensitive to signs of distress or resistance to change that clients may show in the initial process of change.

Step 2: Establishing the Working Relationship

The counselor must establish a working relationship with clients. This is a relationship of trust based on openness and honesty. It is important for the counselor to establish credibility as a trustworthy person. Establishing a working relationship is the responsibility of the

counselor. The success of counseling will largely depend on how effectively the counselor applies his/her skills (described in section II, chapter 1).

Step 3: Determining the Goals of Counseling

Here the counselor discusses with clients what they would like to do in counseling and what their expectations are from counseling. Sometimes clients come for counseling believing that the counselor has extraordinary powers to change their behavior or problem situation. It is important for the counselor to clarify that the counseling process will involve the efforts of both the client and the counselor. The counselor does not have any magical powers to solve the problems of clients. The counselor can help clients to reduce their distress and help them find solutions to their problems. In that sense, the counselor is like a facilitator. Agenda and goal setting should be done with the consent and agreement of the clients.

At times, clients will come with a number of problems, and some of them may not have an immediate or long-term solution. It helps, therefore, if the counselor can make a priority list in discussion with the client and handle first those problems which may have a tentative solution. At other times, the counselor may find that there is no immediate solution to the problem situation. In such a case, counseling should focus on reducing the distress in such a manner that clients are able to deal with the situation more effectively or come to terms with it.

Step 4: Working on Problems and Goals

It is from this step onwards that the change process begins. The process involves:

1. Clarification of the nature of the problem and choosing techniques, which would help clients reduce distress and/or solve the problem (problem solving process).
2. Exploration of feelings.

Once the counselor has an understanding of the problems, it becomes important to determine the sort of techniques that can be used for a particular client. Usually, a combination of supportive and cognitive behavioral techniques is used in counseling. However, in certain cases the counselor may choose to use more of supportive techniques than cognitive behavioral ones. This depends on the kind of problem the client has. For example, if on assessment, it is felt that the client may benefit from modifying his/her

way of thinking, then the counselor may choose to use cognitive behavioral techniques predominantly. If, in another case, it is felt that the client needs support through a difficult phase in his/her life, then the counselor may use supportive techniques predominantly.

The problem solving process has the following steps:

1. Developing a clear statement of the client's problems.
2. Describing the problem solving process.
3. Developing a plan for the counseling process.
4. Trying the plan in a real-life setting.
5. Evaluating the outcome and making modifications in the problem solving plan.

The counselor should try to make sure that clients have an understanding of the process and are also willing to apply the process for change.

Along with problem solving process it is also important to explore the feelings of clients. When clients experience distress because of the problem situation, feelings are explored in detail in order to achieve clarity about the distress as well as help clients take responsibility for them. Observation and alertness are two skills that help the counselor to be aware of the feelings of clients in the counseling sessions. Initially, clients may feel threatened when they come for counseling. They may show resistance to the counselor's explanation of their problems and distress, in accepting responsibility for change and to the actual process of change. Gradually as the working relationship is established and counseling proceeds, clients begin to trust the counselor and feel more comfortable with the counseling situation. They begin to assume greater responsibility for their feelings and have a greater clarity of the problem situation.

Step 5: Facilitating the Change Process

Facilitating the change process involves awareness or understanding of the problem situation and the distress that clients experience. As counseling proceeds clients begin to understand the nature of the problem and the distress they face. Sometimes, during this phase, clients may become uncomfortable with counseling because they come to realize that certain patterns of their own behavior or thinking may be causing or maintaining their distress. Clients often have difficulty in accepting these patterns about themselves. Sometimes clients may feel worse before getting better. It is important that the counselor is alert to these signs and is supportive and reassuring of clients.

Step 6: Planning a Course of Action

Sometimes counseling can result in understanding and comfort. Clients are able to either accept their problem situations (in case a change cannot be brought in to that sphere), or are able deal with it in a more effective manner. A wide range of cognitive behavioral counseling techniques, (described in section II, chapter 2) are used to urge clients from merely being aware of their problems and distress to doing something about them.

In this phase of counseling, clients are encouraged to put into practice some of the techniques that they have learnt (for example, problem solving, cognitive restructuring, relaxation exercises, etc). When clients are able to practice their newly learnt skills in real-life situations, they will be able to judge whether these skills really reduce their distress or solve their problem. Often this is a gradual process. Clients will not see the impact of the change immediately, but it will be evident over a period of time. When clients practice these skills consistently, they will be able to see a change in their way of behaving or thinking. Because this process is often slow, it is also painful and frustrating for clients. They may think of giving up the new way of behaving because it does not seem to give immediate results. At times like this the counselor should encourage and reassure the clients. Each new change (however small) should be positively encouraged. This will motivate clients to continue with the change process.

Step 7: Evaluating Outcome of Counseling and Termination

A key indicator of successful counseling is the degree to which clients have achieved the goals that were set when counseling began. The decision to terminate (complete and stop counseling) is a joint one, taken by the counselor and the client. We list some of the questions that the counselor should ask himself/herself to decide whether counseling has been successful and should be terminated:

1. Did the working relationship between the counselor and client help the client?
2. In what way did it help the client?
3. If it did not help the client, why not?
4. If the goals that the client had set at the beginning of counseling were not entirely achieved, what progress was made?
5. Does the client feel somewhat confident in handling his/her problems?
6. Does the client feel that the distress he/she facing has come down in any way? If yes, then in what way?

7. How has counseling helped the client? Ask the client to enumerate.
8. How does the client feel at the end of counseling?

If the above answers are mostly positive and the client reports a significant decrease in the level of distress, then the counselor can start preparing the client for termination. Termination means ending the counseling contact. As much as it is important to initiate clients into counseling, it is equally important to prepare clients that they do not need regular counseling anymore. An abrupt ending to counseling can lead to clients feeling abandoned and confused, which in turn may lead to feelings of anxiety. They may not feel prepared to face real-life situations without the safety net of counseling. Therefore, the counselor should gradually prepare clients for termination. One of the ways of preparing clients for termination of counseling is to space out the number of sessions. The focus of the session turns towards getting feedback about how clients are using the skills learnt in counseling. The counselor now uses more supportive techniques and clients are encouraged to talk about the positive aspects of the results that the changes have brought about. However, it is equally important to do follow-ups with clients, even after regular sessions of counseling have been stopped. Follow-up is important because it gives clients the assurance of continued contact whenever they feel the need for it. It also gives the counselor an opportunity to see how effectively clients are using the skills learnt in counseling.

Certain conditions should be kept in mind while doing counseling with clients. These are as follows:

1. **The nature and severity of the client's symptoms.** For example, a client coming with severe depression may have difficulty in expressing his/her feelings. In which case, it is important that the client be first referred for treatment to a mental health professional. Only when the depressive symptoms have reduced significantly can counseling be attempted.
2. **The length and persistence of symptoms**. For example, if a client has been drinking for a long period of time and has difficulty in functioning because of that, then it may be difficult to do counseling with such a client. It is best that he/she is referred to a mental health professional first.
3. **What sort of stressful experiences has the client had in the past**? If the client has an ongoing long-term difficulty (for example, economic difficulties) or a series of traumatic events (communal riots, loss of property, loss of job, death of family members in the riots, etc.) then he/she may require more time to come to terms with the distress and

the problems. The counselor needs to be more supportive and patient with the client. Options may be more oriented towards social work. For example, helping him/her find a place to stay (like a shelter), look for income generating avenues, etc.

4. **Coping mechanisms in the past**. This relates to how the client faced the problems in the past, how he/she dealt with it. The client's strengths should be used as a motivating factor to bring about a change.
5. **Readiness for counseling**. How ready is the client for counseling? Does he/she think it is important for him/her? Has he/she been forced into counseling by another person? How does that person think it will benefit the client? These are all important questions. Counseling will not be effective unless the client is ready for it.
6. **Extent of counselor's training**. The counselor's training will to a large extent determine how effectively he/she will be able to handle the problems of the client. The lay counselor will come across certain types of problems, which he/she may not be able to handle. If so, the counselor should recognize his/her limitation and refer the client to a mental health professional.
7. **The amount of time available**. Exploration of feelings and distress should be done depending on the amount of time the client can spare for counseling. If the client does not have time to attend regular counseling sessions, the counselor may decide to use techniques that the client can practice at home.

Essentials of Counseling:

1. Maintain a clear and specific focus in counseling.
2. Through a collaborative effort define goals in counseling. These goals are flexible and can be reviewed and revised as counseling proceeds. Defining goals helps both the counselor and the client maintain a structure and focus in the sessions.
3. Emphasize the "feeling" component in counseling.
4. Recognize and understand the emotional dependency of the client. Encouraging emotional dependency to some extent is necessary to help the client gain trust in the working relationship and counseling. However, excessive emotional dependency will hamper the progress of counseling.
5. Be flexible.
6. Give time to generalize from the counseling session to the real-life of the client. Do not be impatient for a quick change.

7. Clarify when you don't understand something that the client has said and give time for him/her to explain.
8. Help and encourage the client to assume responsibility for success and setback in counseling.
9. Sometimes the client will go back unhappy from the session. Do not feel pressured to make the client "happy" at the end of each session.
10. At times, during counseling the counselor may notice a worsening in the client's level of distress. Do not feel worried and anxious about it. Sometimes, clients will feel worse before they start feeling better. This is because, in the course of counseling, they may have confronted certain patterns of their behavior or thoughts that are painful to accept. Clients need time to come to terms with these painful revelations, and during this period the counselor may see a worsening of distress. However, a supportive and reassuring counselor will eventually be able to help clients get better.

At the end of this chapter you should have learnt:

1. The seven steps of the counseling process.
2. The conditions that should be kept in mind while counseling.
3. The essentials of counseling.

CHAPTER 7
Ethics in Counseling

Ethics in counseling are a set of dos and don'ts that are prescribed for counselors. Ethics also serve as guidelines that assist the counselor to give the best help to clients.

Here are some ethical guidelines that a lay counselor should keep in mind:

1) The counselor should maintain confidentiality of all the information clients have shared. No information should be shared with the families of clients or others without the consent of clients. Even if the problems of clients are discussed as an example in the organization or in training, care should be taken to ensure that no personal names, names of place of residence, village, and town, etc., are used and no identifying information should be shared. It is the counselor's responsibility to see that the information is not misused in any respect.
2) The agenda of the counseling session and the goal of counseling should be set by clients in collaboration with the counselor. The counselor should not try to force on clients what she/he thinks is important for clients or the way they ought to lead their lives. What clients want should be the focus of counseling.
3) The counselor's behavior should be such that clients are able to trust him/her. The Counselor should be open and honest when he/she communicates and should never give false assurances.
4) The counselor should be non-judgmental. This means that the counselor should be free from bias and expectations. He/she should not make judgments like right or wrong, good or bad, etc., on the behavior/thinking/feelings of clients. Being non-judgmental also means that the counselor will not discriminate (in the quality of counseling services offered) on the basis of gender/age/caste/religion/socio-economic status of clients.
5) The counselor should not make assumptions. Making assumptions is a common process that everyone uses to understand another person. Assumptions are often formed automatically without our being very aware of them. In the counseling session,

therefore, it becomes essential that any assumptions that the counselor makes should be clarified first with the clients. These assumptions or preconceived notions can be about factors related to the symptoms, the personality, the thinking process, the behavior, the problem situation, the socio-cultural background of clients

6) The counselor should maintain boundaries in a counseling relationship. This means that the counselor should not reveal any personal information that is more than necessary for establishing a rapport (e.g., marital status, place of residence, personal interests or choices) with clients. Disclosing such information will affect the impartiality of the counseling process.

7) There might be times during counseling when some reaction or behavior of clients might upset the counselor. In such cases it is important that the counselor not show that he/she is angry or upset. The counselor should not shout at clients or belittle (show clients as being unworthy, or look down upon them) them in any situation. There might be times in the counseling session when clients get abusive or take out their anger by throwing things around. The counselor should not threaten clients but should use techniques like limit setting. Limit setting can involve asking clients to go out of the counseling situation and come back when they are feeling calmer. Limit setting can also involve the counselor leaving the counseling situation for a specified period of time or terminating the session for that particular day. It is important that the counselor recognizes that clients are not upset with the counselor per se, but that the emotional outbursts are reactions to the problems that clients are facing.

8) The counselor should always give importance to the problems of clients over any personal interest. The counselor must not gratify his/her own needs in the counseling relationship.

9) The counselor should not carry his/her personal issues and needs to counseling. They can be emotional, sexual or monetary needs.

10) If the counselor has personal issues, he/she should seek counseling for that first before counseling others. Otherwise he/she is likely to be biased or it may interfere with the counseling process.

11) The counselor should not form any personal relationship with clients (e.g., that of a friend) during or after counseling. If clients bring gifts or make attempts to make the counseling relationship personal, the counselor should gently but firmly dissuade them from doing so. Do not accept personal gifts or favors from clients or their families.

12) The counselor must maintain neutrality in the counseling relationship. Neutrality implies impartiality and objectivity, which are very important in any counseling relationship.

13) The lay counselor is only given limited training in the identification of common mental disorders and in counseling skills. He/she must, therefore, acknowledge this limitation and work within the said limits.

14) The lay counselor should take support by discussing with the peer group.

15) The lay counselor must refer clients to mental health professionals when:

    a. A problem is severe or is identified as a disorder at a clinical level.

    b. Despite a series of counseling sessions, clients do not show any improvement and their distress does not seem to have come down.

If the counselor carefully follows these ethical guidelines, he/she will be able to offer the best service to clients.

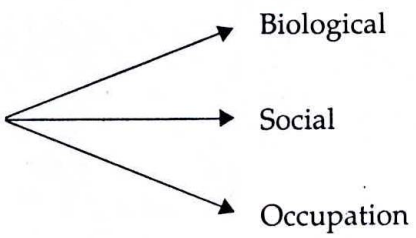
Appendix A

PROFORMA FOR HISTORY TAKING

Name	:	
Age	:	
Sex	:	Male / Male
Address	:	
Region	:	Urban / Semi-Urban / Slum / Rural
Occupation	:	
Marital Status	:	Single / Married / Divorced / Separated / Widowed
Family Structure	:	Joint / Nuclear
Annual Income	:	
Religion	:	Hindu / Muslim / Christian / Others
Family Details	:	
Spouse / Father's Name	:	
No. of Children	:	
No. of Siblings	:	
Illnesses in the family	:	
Physical	:	
Mental	:	

In - Take Interview

1. Chief complaints
2. Duration of the problem
3. Onset
4. Course
5. Precipitating factors
6. History of present illness
7. Level of Functioning



8. Family Functioning (Use genogram)

FAMILY GENOGRAM

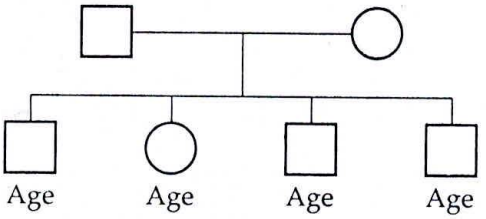
Male

Female

Married

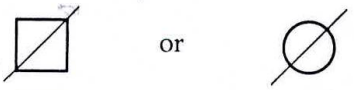
Married within blood relations (Consanginous)

Children



Divorced

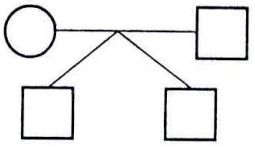
Death



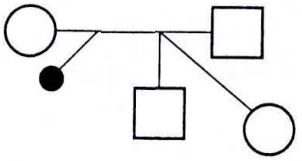
Affected Individual(s)

Index Patient

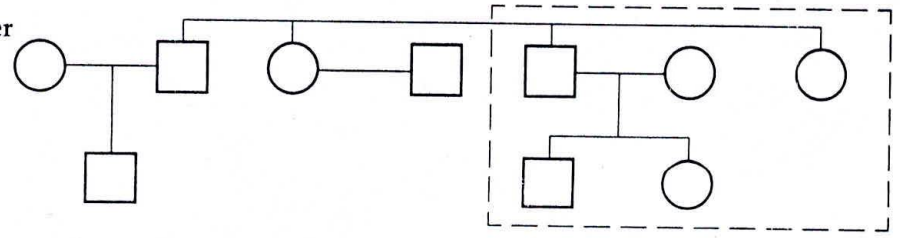
Twins



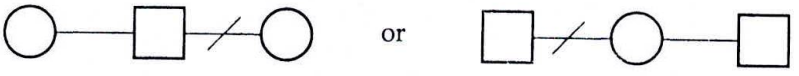
Death in Infancy/Abortion



Individuals that stay together



Remarriage



Please note: Mention age of each individual

Impression

Referral

Plan of Action for the client

Appendix B

Note: For each symptom multiple questions can be asked to find out whether the symptom is present or not.

Table 1: Depression

Mild Depressive Episode: To diagnose this disorder **two** of the first 3 symptoms and at least **2** of the symptoms from number 4 to 11 given in Table 1 must be present for a period of **two weeks continuously** to be diagnosed as Mild Depressive Episode. Therefore the total number of symptoms should be not more than 4.

Moderate Depressive Episode: Two of the first 3 symptoms and at least **3** or more symptoms from number 4 to 11 given in Table 1 must be present for a period of **two weeks continuously** to be diagnosed as Moderate Depressive Episode

Severe Depressive Episode: All three symptoms from 1-3 must be present. Additionally, at least **4** or more symptoms from number 4 to 11 given in Table 1 must be present for a period of **two weeks continuously** to be diagnosed as Severe Depressive Episode.

Note: If these symptoms are not present continuously for a period of two weeks then the disorder is at a sub-clinical level.

Sl. No.	Signs/symptoms	Questions to ask
1.	Sad mood, present every day and for most of the day	1. Do you feel sad or depressed most of the day? 2. Do you feel sad all the time, every day?
2.	Lack of energy and getting tired easily	1. Do you feel that you tire easily? 2. Do you feel that you have no energy to do any of the usual activities that you do through the day? 3. Do you feel that even the smallest tasks make you easily tired?
3.	Not interested or not experiencing pleasure in activities that usually give pleasure	1. Do you find that the activities that gave you pleasure earlier (e.g., meeting people, going out, watching T.V. etc.) now don't interest you at all? 2. Do you find that you have stopped doing all those activities that gave you pleasure earlier? 3. Do you find it difficult to enjoy yourself?
4.	Loss of confidence or self-esteem	1. Do you feel that you are not a good enough person? 2. Do you feel that you lack confidence in yourself in the past few weeks/months? 3. Do you feel worthless? 4. Do you feel you are good for nothing? 5. Do you feel that you cannot do anything well?
5.	Unreasonable and inappropriate guilt or self-blame.	1. Do you feel guilty all the time about things that you might not have done? 2. Do you feel guilty for things that you are not responsible for? 3. Do you blame yourself for things that go wrong in your life/family/house? 4. Do you blame yourself often, even for things that you might not be responsible for? 5. Do you feel guilty thinking that you could have done things better?
6.	Repeated thoughts of death or suicide, or making plans/ attempts to commit suicide	1. Do you get repeated thoughts of killing yourself or ending your life? 2. Do you feel that you don't deserve to live and therefore should end your life? 3. Do you feel that you should end your life because it is not worth living, because there is no hope? 4. Do you feel so helpless that you feel that ending your life may be the best way? 5. Have you ever made plans for taking your life? 6. Have you ever made an attempt to take your life? If yes, in what ways? 7. What plans have you made?
7.	Increased or decreased sleep	1. For how many hours do you normally sleep? 2. Have you been sleeping much more than your normal hours? 3. Do you find that you are sleepy throughout the day and want to go back to sleeping? 4. Have you found it difficult to wake up in the mornings? 5. Have you found it difficult to go to sleep? 6. Have you found that you wake up often in the night and find it difficult to go to sleep? 7. Have you found that you wake up at least 2/3 hours before your normal time to wake up?

Sl. No.	Signs/symptoms	Questions to ask
8.	Increased or decreased appetite	1. Do you feel hungry? 2. Do you feel that you have been eating more than your normal diet? 3. Do you find that you eat all the time? 4. Do you feel that you don't feel hungry at all? 5. Do you feel that you have to force yourself to eat?
9.	Complaints of decreased ability to concentrate or think	1. Do you find it hard to think or concentrate on your work? 2. Do you find your attention getting distracted by things other than your task? 3. Do you find it so difficult to concentrate that you are not able to finish a task? 4. Do you find that you are not able to think or plan anything?
10.	Increased or decreased motor activity	1. Do you feel so restless that you are not able to sit or stand in one place for more than a few minutes at a time? 2. Do you find that you are not able to sit still for more than a few minutes at a time? 3. Do you feel that you have to move about all the time? 4. Do you feel that you aren't able to move from one place to another? 5. Do you find that it takes a lot of effort to move around from one place to another? 6. Do you find that you are sitting in the same spot for more than a couple of hours without moving and do not have the energy to move?
11.	Sad and pessimistic views of the future	1. Do you feel that there is nothing to look forward to in the future? 2. Does the future seem hopeless and depressing? 3. Do you worry that nothing good is going to happen in the future?

Table 2: Somatic Symptoms in Depression

The following are the somatic symptoms often present in Depression. In order to diagnose Depression (Mild, Moderate, or Severe) **with somatic symptoms, 4 of the 8** symptoms must be present for a period of **two weeks** in addition to the criteria for Mild, Moderate and Severe Episode.

Sl. No.	Signs/symptoms	Questions
1.	Significant loss of appetite	1. Do you feel that you don't want to eat food? 2. You don't feel like eating at all. 3. You are not feeling as hungry as you used to? 4. Do you feel hungry at all or do you have to force yourself to eat?
2.	Significant weight loss (5% or more in one month, about 2.5 — 4kgs loss)	1. Have you lost weight in the last one month? 2. If yes, how much? 3. Do you feel that the weight loss is because you are not eating well? 4. Have other people noticed the weight loss?
3.	Lack of sexual desire/ interest in sexual activity	1. Do you feel that you have no interest in sexual acts? 2. Do you feel that you have no sexual desire? 3. You don't feel like having sex with your husband/wife/ partner?
4.	Mood is more sad in the mornings	1. Do you feel that when you wake up in the morning you feel very sad and depressed, and as the day goes by the mood begins to improve? 2. Do you feel that you are sadder in the mornings than in the daytime or the evening?
5.	Consistently waking up 2 hours or more earlier than the usual time	1. How many hours of sleep do you get normally? 2. Have you been sleeping well? 3. Do you wake up at least 2 hours before your normal time of waking?
6.	Not interested in activities that gave pleasure earlier	4. Do you find that the activities that gave you pleasure earlier (e.g., meeting people, going out, watching T.V. etc.) now don't interest you at all? 5. Do you find that you have stopped doing all those activities that gave you pleasure earlier? 6. Do you find it difficult to enjoy yourself?
7.	Significant decrease in response and motor slowness - walking, speech etc.	1. Do you feel that your functioning has slowed down a lot? 2. Do you find yourself taking more time doing activities than you used to earlier? 3. Do you feel you have begun walking, talking and moving slowly? 4. Do all activities take a long time?
8.	Lack of emotional responses to events or activities that normally produce emotional reactions	1. If there is a happy occasion in the family/social circle, do you find it hard to enjoy yourself? 2. If somebody cracks a joke, do you find it humorous and laugh? 3. If somebody is rude to you, or abuses you, or says hurtful things, does it affect you in the same manner as it used to earlier?

Table 3: Dysthymia

At least **3 of the following symptoms** should be present for a period of **2 years** or more.

Sl. No.	Signs/symptoms	Questions to ask
1.	Decreased energy and/or activity	1. Do you get tired quickly? 2. Do you feel that you are not as active as you used to be? 3. Do you feel it takes a lot of energy to do even small things?
2.	Inability to fall asleep	1. Do you find it difficult to fall asleep? 2. Do you toss and turn in your bed for a long time before you fall asleep? 3. Do you find that you lie awake in your bed for 2 – 3 hours before you fall asleep?
3.	Loss of self-confidence or feelings of inadequacy	1. Do you feel that you are not good enough? 2. Do you feel that you lack confidence in yourself? 3. Do you feel that you are worthless?
4.	Problems in concentration	1. Do you find it difficult to concentrate on most of the things? 2. Do you find that you get distracted by small things around you quickly? 3. Do you feel that you are making more mistakes in your work than you used to earlier?
5.	Frequent crying spells	1. Do you feel like crying often? 2. Do you feel like crying about small things? 3. Do you feel like crying for no reason at all?
6.	Loss of interest in pleasurable activities	1. Do you feel that you have lost interest in things that used to give you pleasure earlier? 2. Do you find it difficult to enjoy activities which gave you pleasure earlier (e.g., watching T.V., movie, chatting with family, neighbors, going out)
7.	Feelings of hopelessness and despair	1. Do you feel that there is no hope in the future for you? 2. Do you feel that things cannot change for the better in your life? 3. Do you worry a lot that things will not improve in the future?
8.	Feelings of inability to cope with the routine of daily life	1. Do you find it difficult to take care of your routine daily work? 2. Do you feel that you cannot do your routine daily work as well as you used to? 3. Do you find that it takes a lot of energy in doing routine daily work?
9.	Pessimism about the future or brooding about the past	1. Do you worry about the bad things happening to you or your family in the future? 2. Do you keep on thinking about all the bad things that have happened in the past? 3. Do you worry that nothing good will happen in the future?
10.	Social withdrawal	1. Do you feel like meeting with people? 2. Do you find that you are not able to enjoy meeting people as much as you did earlier? 3. Do you avoid going out or meeting people because you don't enjoy it any more? 4. Do you find that more and more you are spending time away from people in your family, friends or neighbors?

Sl. No.	Signs/symptoms	Questions to ask
11.	Decreased talkativeness	1. Do you feel that you don't like talking as much as you did earlier? 2. Do you or others around you feel that you have become very quiet? 3. Do you find that you are mostly quiet when you are with people? 4. Have others pointed out that you don't speak as much as you used to?

Table 4: Anxiety

Ask these general questions before you go to the criteria for specific disorders.

General Questions:

1. How long have you been feeling worried or anxious?
2. Is this anxiety related to a particular situation or context?
3. Is the anxiety a reaction to some situation, person, event or context?
4. Is this worry, anxiety or apprehension controllable or uncontrollable?
5. What are the situations under which you are able to control the anxiety?
6. How does the anxiety start?
7. Do you feel worried and anxious all the time, even though there is no reason for being so?

Generalized Anxiety Disorder (GAD):

The following criteria must be fulfilled for a period of at least **6 months**. At least **one symptom from 1 - 4 and any other 3 or more symptoms** must be present from **5 - 22** for diagnosing GAD.

Tick against all those symptoms that are present.

Sl. no	Signs/symptoms	Present / absent
1	Palpitations or pounding heart or increased heart rate	
2	Sweating	
3	Trembling or shaking	
4	Dry mouth not due to any medical condition or medication	
5	Difficulty in breathing	
6	Feeling of choking	
7	Chest pain or discomfort	
8	Feeling like vomiting or experiencing churning in the stomach	
9	Feeling dizzy, unsteady, light headed or faint	
10	Feelings that objects are unreal and that they are not really there	
11	Fear of losing control, "going mad", or falling down on fainting	
12	Fear of dying	
13	Hot flushes or cold chills	
14	Numbness or tingling sensations	
15	Muscle tension or aches and pains	
16	Restlessness and inability to relax	
17	Feeling mentally tense	
18	Feeling of difficulty in swallowing, as if there is a lump in the throat	
19	Getting startled easily	
20	Difficulty in concentration	
21	Persistent irritability	
22	Difficulty in falling asleep because of worry	

Table 5: Panic Disorder

For Panic Disorder to be diagnosed the person must have at least **4 attacks in four weeks** to be diagnosed as a moderate panic attack. For severe panic attacks, the person must have **4 attacks per week for over a month.** If the symptoms described in Table 5 are not present for the specified time period, the disorder is at a sub-clinical level.

Remember that the person must develop these attacks suddenly and abruptly and reach a peak within a few minutes. At least **4** of the following symptoms given in Table 5 must be present to diagnose a Panic Disorder, out of which **one** symptom should be present **from 1 – 4.**

The following general questions should be first asked:

1. Have you ever felt intense fear of something going wrong with you?
2. At such times have you felt that you are going crazy or are going to die?
3. Do you have choking sensations at these times?
4. How does it start?
5. Does it start suddenly/abruptly or slowly/gradually?
6. How often does it happen?
7. How long does it last?
8. What do you feel when it happens?

Tick against all those symptoms that are present.

Sl. no	Signs/symptoms	Present / absent
1.	Palpitation, pounding of the heart, increased heart rate	
2.	Sweating	
3.	Trembling or shaking	
4.	Dryness of mouth	
5.	Sensation of shortness of breath	
6.	Feeling of choking	
7.	Chest pain or discomfort	
8.	Nausea or vomiting sensation	
9.	Feeling dizzy, unsteady, faint, lightheaded	
10.	Fear of loosing control or going crazy	
11.	Fear of dying	
12.	Chills or hot flushe	
13.	Numbness or hot flushes	
14.	Feeling that things are not real and 'not really here'	

Table 6: Phobia – Agoraphobia

Marked and consistent **fear** and **avoidance** of **two** of the following, associated with **anxiety symptoms**:

1. Crowds
2. Public places
3. Traveling alone
4. Traveling away from home

General Questions:

1. Do you feel extremely scared or fearful in crowded places, or open public places, or of some specific object, person or animal?
2. Does this happen every time you are in that situation?
3. Do you feel scared or fearful even thinking about these situations?
4. Please describe the way you feel in situations that you fear a lot?
5. Do you feel that this is a normal or excessive reaction?
6. Do you think it is an unreasonable reaction?
7. Do you avoid these situations/persons/objects completely?
8. If you avoid or escape the fearful situation/object/person, does the fear go away completely?
9. Has this affected your social and occupational functioning? If yes, in what way, please describe.

Tick all those symptoms that are present from the onset of the disorder. These symptoms must be present when the person is in the situation or thinking about the situation and not in general. **At least 1 from symptom 1 to 4 should be present**. Altogether there should be **at least 3 - 4 symptoms** present for it to be diagnosed as Agoraphobia; otherwise the disorder is at a sub-clinical level.

Sl. no	Signs/symptoms	Present / absent
1.	Palpitations, pounding heart, or increased heart rate	
2.	Sweating	
3.	Trembling or shaking	
4.	Dryness of mouth	
5	Difficulty in breathing	
6.	Choking sensation	
7.	Chest pain or discomfort	
8.	Nausea or vomiting sensation	
9.	Dizzy feeling, lightheadedness, faint	
10.	Feeling that things are not real and 'not really here'	
11.	Fear of going crazy, fainting, losing control	
12.	Fear of dying	
13.	Hot flushes or cold chills	
14.	Numbness or tingling sensation	

Table 6.1: Social Phobia

1. Marked or excessive fear of being the focus of attention. Fear of behaving in a way that will be embarrassing or humiliating.
2. Active avoidance of being the focus of attention.

Note: In addition to the 2 symptoms mentioned above, **two of the symptoms from 1 to 13, and 2 from number 14 to 16** must be present to be diagnosed as Social Phobia. All together there should be 4 symptoms present. If the symptoms are less than the number mentioned, then the disorder is a sub-clinical level. General questions as given for Agoraphobia can be asked for Social Phobia as well.

Sl. no	Signs/symptoms	Present / absent
1.	Palpitations, pounding heart, or increased heart rate	
2.	Sweating	
3.	Trembling or shaking	
4.	Dryness of mouth	
5	Difficulty in breathing	
6.	Choking sensation	
7.	Chest pain or discomfort	
8.	Nausea or vomiting sensation	
9.	Dizzy feeling, lightheadedness, faint	
10.	Fear of going crazy, fainting, loosing control	
11.	Fear of dying	
12.	Hot flushes or cold chills	
13.	Numbness or tingling sensation	
14.	Blushing or shaking	
15.	Fear of vomiting	
16.	Urgency or fear or urination or defecation (potty)	

Table 7: Somatoform Disorders

General Questions:

1. Do you suffer from multiple aches and pains?
2. Have you been investigated for these aches and pains?
3. How many doctors have you seen for these aches and pains?
4. Have any of the doctors that you have seen been able to explain why these symptoms occur?
5. Do you believe when the doctors tell you that there is nothing wrong with you physically?
6. Do you think that they are right — that there is no physical cause for your aches and pains?
7. How long have you been having these symptoms?
8. Do you find that you are thinking about these physical complaints all the time?
9. Do you think these aches and pains have affected your day-day routine work?
10. Do you feel that you are not able to carry out your daily routine work because these symptoms trouble you a lot?

Note: There should be a history of at least **2 years** of complaints of multiple and different physical symptoms that cannot be explained by any physical disorder. A total of **6 or more** symptoms from at least **two separate groups** (e.g., cardiovascular and gastrointestinal) or any other combination from the list should be present to make the diagnosis. If the symptoms are less in number, then the disorder is at a sub-clinical level.

Category	Signs/Symptoms	Present/Absent
Gastrointestinal	Abdominal pain	
	Nausea	
	Feeling bloated or full of gas	
	Bad taste in the mouth or excessive coating of the tongue	
	Complaints of vomiting	
	Frequent loose motions or fluid discharge from the anus	
Cardiovascular	Breathlessness without exertion	
	Chest pain	
Genitourinary	Frequent urination or difficulty in urination	
	Unpleasant sensation in and around the genital area	
	Excessive vaginal discharge	
Skin & Pain Symptoms	Patchy or discolored skin	
	Pain in the limbs, feet, hands or joints	
	Unpleasant tingling or numbness	

Table 8: Obsessive Compulsive Disorder (OCD)

General Questions:

Note: (i) Either obsessions or compulsions or both should be present on most days for a period of **two weeks**. (ii) Some of these questions require you to note down the answers and others require you to tick against "yes" or "no". (iii) First ask these questions for obsessions (which are repeated thoughts). Then ask the same set of questions for compulsions (which are repeated actions of one kind).

1. Are these thoughts/images/urges coming from within your mind or is someone forcing you to think about them?
2. Can you control them?
3. How do you control them?
4. For how long are you able to control them?
5. What is the content of these thoughts/images/urges?
6. How do you feel when these thoughts come to you?
7. How do you decrease/lessen your distress when these thoughts come to you?
8. Does it work? If yes, for how long does the relief last? Then what do you do?
9. Have you had to make changes in your daily routine because of this problem?
10. When these thoughts/images/urges come to your mind, do you try to resist them?
11. Are these thoughts interfering with your daily routine or any task/work that you are doing?
12. Do they come again and again? Are these thoughts unpleasant?
13. Do these thoughts make you feel distressed?
14. Do you try to stop them?
15. Have you been successful in stopping these thoughts at any time?
16. Are you upset with the nature of the thoughts/images/urges?
17. Even though this thought comes again and again, do you carry out the action repeatedly, is it a pleasurable experience or not?

Table 9: Dissociative Disorder

Remember these two criteria must be present: (i) There is no evidence of a physical disorder to explain the symptoms that a person is showing. (ii) There is a significant relationship between the onset of the symptoms and the time of the stressful event.

Dissociative Motor Disorder:

One of the two criteria given below must be present.

A. Complete or partial (partly or some part of it) loss of ability to perform those movements, which are under voluntary control (talking, moving the limbs, working with the hands, stiffening of the neck, being able to stand without support, rolling of the eye-balls in an upward direction).
B. No coordination in balance or gait while walking, or inability to stand without support.

Note: Questions should be mainly asked to the family members, as they will be able to give more objective information on the symptoms. Before asking the questions, please ascertain what type of motor disorder the person is having. Bear in mind while conducting the interview for diagnosing the disorder that the answers to the questions should be noted in detail. The same is true for all types of Dissociative Disorders mentioned subsequently.

Questions to be to Family:

1. When was the first time you noticed the client behaving in this manner? Was it related to a stressful event? Or did these symptoms come up after a traumatic event?
2. How did the person behave when the attack took place?
3. What did the person do?
4. How long did the episode last?
5. Were you able to talk to this person during the episode?
6. Have you noticed these attacks happening at a particular time or place? Is there a pattern that you have noticed?
7. What difficulties has the client been facing after this problem has begun?
8. What effort does the client make to overcome this problem?

Questions to be asked to the Client?

1. What difficulties do you face after this problem has begun?
2. How do you mange your daily routine after this problem started?
3. What do you think may be the reason/cause of this problem?
4. Do you think these symptoms are under your control?

Table 9.1: Trance And Possession Disorder

In **Trance** there is a temporary alteration of the state of consciousness shown by **two of the three** of the following criteria:

1. Loss of sense of personal identity.
2. Narrowing of awareness of surroundings or selective focusing on one particular environmental stimulus.
3. Restricted or limited movement, posture and speech.

In Possession the individual is convinced that he/she has been taken over by a spirit, power, god, or another person. The individual has no control over his/her behavior. He/she behaves in a way which is characteristic of the entity they believe has taken over him/her. The above-mentioned **first two** criteria must be present. **In addition,** the patient must clearly state that these possessions are unwanted and troublesome.

Questions to be asked to Family:

1. When the person is having this episode, does he/she recognize family members?
2. Does the person recognize the surroundings?
3. Does the person seem as if he/she is aware of what is happening to him/her?
4. Does the person do anything peculiar/new or different actions? For example, muttering, scream loudly, sing, speak in a different voice?
5. Later on, when the person has come back to the normal state, does he/she remember what happened during the episode?
6. Does the person behave in such a manner that it appears to you as if some external person/thing/animal is controlling his/her actions, behavior or speech?
7. Does the person behave as if his/her personality has been taken over by someone or something?
8. Does the person say who that person is?

Questions to be asked to Client:

1. Do you find these episodes troublesome?
2. What according to you is the reason that you are having these episodes?
3. Have there been negative consequences of these episodes (physical — being hurt; social — people being scared of you, not wanting to talk with you, avoiding you; occupational — not being able to perform your job)?
4. Do you remember anything of what happened during the episode?
5. When you come out of the episode, how do you feel?
6. Have there been any events in the recent past, which might have upset or troubled you a lot? If yes, please describe the event and how you felt about it?

Table 9.2: Dissociative Convulsions

Persons suffering from this disorder have sudden and unexpected jerky movements, which **appear like fits but are not fits (epilepsy),** as they are not followed by loss of consciousness. These jerky movements are not accompanied by tongue biting, frothing at the mouth, seriously injuring oneself due to falling or losing control over bladder, as can happen after an epileptic fit.

Questions to be asked to Family :

1. Does the person have sudden jerky movements of the body?
2. Do these jerky movements appear as if the person is having fits?
3. Has the person ever lost consciousness following these jerky movements?
4. Has the person ever got hurt during these fits (e.g., falling down, biting the tongue)?
5. Has there been frothing at the mouth after the fit?
6. During the episode, did the person roll his/her eyes upwards?
7. Has the person ever passed urine in his/her clothes during or after the fit?
8. When the fit is over, does the person have any memory of the episode?