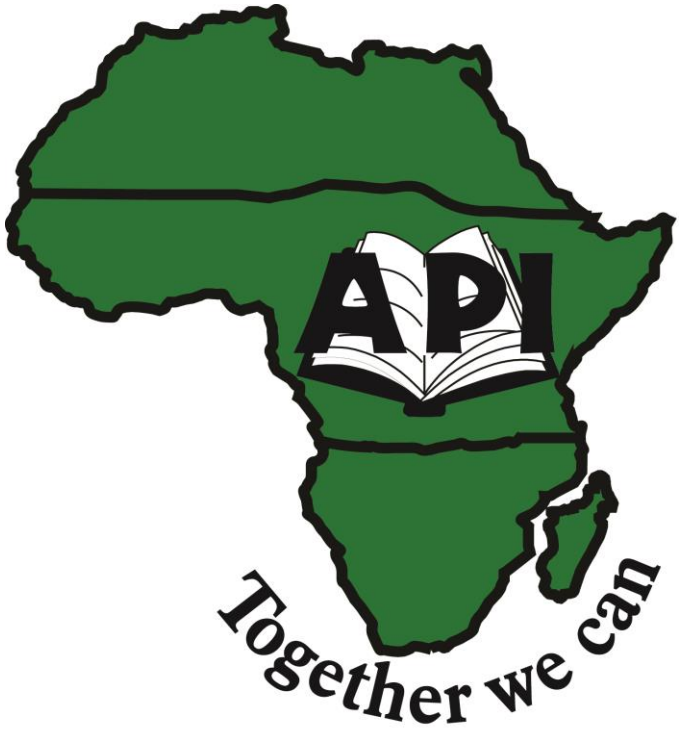
AFRICA POPULATION INSTITUTE (API)



GUIDANCE AND COUNSELLING (G&C) HANDBOOK

Website: www.africapopulation.net
Email: info@africapopulation.net

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Forward:

API is a registered organization with 4 years' experience of supporting voluntary organizations, agencies and individuals in developing quality systems. A major part of our work is providing external evaluations and trainings to organizations or specific projects and also building capacities of the members to have relevant skills applicable to their working environment.

How we work:

We aim to understand the precise needs of your organization and to offer you good value, an integrated service, and work which is based on clear principles. Our style is inclusive, participatory and flexible.

We aim to help you:

- Develop your skills, reflect and gain focus
- Make your organization more confident, effective and efficient, and able to demonstrate this to others
- Help you plan more effectively and strategically for the future
- Demonstrate the benefits (or outcomes) for your service users.

Our approach

- Starts by listening carefully to what you need and tailoring our services accordingly
- Includes clear and practical advice, plans and reports
- Is based on extensive knowledge and experience of the voluntary sector
- Is supportive and friendly.

Courses offered in our training workshops that are client tailored

Monitoring and Evaluation Training
Project Planning and Management
Public Health and HIV/AIDS management
Guidance and Counseling Techniques
Family Planning and RH issues
Research Methods and Data management
Specialized Statistical Packages for data analysis (SPSS, STATA, EVIEWs, ATLAS TI, SUDAN, EPINFO and Epi Data etc)
Training of Trainers Course
Management and Leadership Skills Development
Procurement and Contract Management
Peace and conflict Management/Resolution
Disaster Preparedness and Management Course
Communication Skills and Technique
Heath Care Administration (HCAD)
Interdisciplinary Environmental Health Studies (ENVHs)
Substance Abuse and Addictions Management (SAAM)
Advocacy and Lobbying Techniques
Strategic Planning and Management
Business Sales and Marketing Strategies
Health Marketing and Health Promotion
Logistics, Transport and Supply Chain Management

Module 1: Introduction to Guidance-And-Counseling

Guidance and counseling, concept that institutions, especially schools, should promote the efficient and happy lives of individuals by helping them adjust to social realities. The disruption of community and family life by industrial civilization convinced many that guidance experts should be trained to handle problems of individual adjustment. Though the need for attention to the whole individual had been recognized by educators since the time of Socrates, it was only during the 20th cent. that researchers actually began to study and accumulate information about guidance.

Early guidance programs dealt with the immediate problem of vocational placement. The complexities of the industrial economy and the unrealistic ambitions of many young people made it essential that machinery for bringing together jobs and workers be set up; vocational guidance became that machinery. At the same time, counseling organizations were established to help people understand their potentialities and liabilities and make intelligent personal and vocational decisions. The first vocational counseling service was the Boston Vocational Bureau, established (1908) by Frank Parsons, a pioneer in the field of guidance. His model was soon copied by many schools, municipalities, states, and private organizations.

With the development of aptitude and interest tests, such as the Stanford-Binet Intelligence Test and the Strong Vocational Interest Blank, commercial organizations were formed to analyze people's abilities and furnish career advice. Schools organized testing and placement services, many of them in cooperation with federal and state agencies. Under the provisions of the National Defense Education Act (1958), the federal government provided assistance for guidance and counseling programs in the public secondary schools and established a testing procedure to identify students with outstanding abilities. The U.S. Dept. of Labor has been an active force in establishing standards and methods of vocational guidance, helping states to form their own vocational guidance and counseling services. The personnel departments of many large corporations have also instituted systems of guidance to promote better utilization of their employees.

Modern high school guidance programs also include academic counseling for those students planning to attend college. In recent years, school guidance counselors have also been recognized as the primary source for psychological counseling for high school students; this sometimes includes counseling in such areas as drug abuse and teenage pregnancy and referrals to other professionals (e.g., psychologists, social workers, and learning-disability specialists). Virtually all teachers colleges offer major courses in guidance, and graduate schools of education grant advanced degrees in the field.

The role of a Guidance Counselor

The primary role of the high school guidance counselor is to be a student’s advocate, providing each student with the opportunity to acquire the academic, civic, and social skills essential to graduating from high school and becoming productive citizens who respect themselves and others.

In addition to working with students, counselors are a part of the educational team including parents, teachers, administrators, and specialists. This team works in a partnership assisting students in meeting Dover-Sherborn’s graduation requirements and in planning post-secondary options. Each student is assigned to a guidance counselor who will follow the student through his or her high school years, allowing an opportunity for the counselor and student to develop a working relationship. In addition to the guidance counselors, the region employs an adjustment counselor to provide additional support and advocacy to students who may benefit from more specialized services. Students may seek a counselor’s assistance with any or all types of questions and concerns. Academics, work habits and study skills, post-secondary planning, and personal concerns are all common issues of high school students.

When seeking a conference with a counselor, students and parents may directly contact their counselor through an email message or make an appointment by speaking with a department secretary. Parents are encouraged to call the guidance office whenever they have questions or concerns about their child’s well-being or welfare. Individual concerns about a specific course or class are best addressed directly with the subject teacher. Communication is particularly important whenever there is an illness, death, separation, divorce, stress, or other family crisis.

Responsibilities of a Guidance Counselor

The guidance department curriculum includes a number of activities and services such as:

- New student registration
- Schedule development
- Course selection and course registration
- Monitoring student academic progress
- Facilitate Instructional Support Team meetings
- Attend parent/teacher conferences
- Participate in IEP and Section 504 meetings
- Consultations with teachers, administrators, parents and students
- Provide mediations for students to help resolve conflicts
- Assist with freshmen year transition
- Development of Four Year Plans
- Curriculum development aligned with National and State Standards
- Individual counseling and small group counseling
- Academic counseling

Module 2: Relationship/Family Counseling

Relationship counseling is the process of counseling the parties of a relationship in an effort to recognize and to better manage or reconcile troublesome differences and repeating patterns of distress. The relationship involved may be between members of a family or a couple (see also family therapy), employees or employers in a workplace, or between a professional and a client.

Couples therapy is a related and different process. It may differ from relationship counseling in duration. Short term counseling may be between 1 to 3 sessions whereas long term couples therapy may be between 12 and 24 sessions. An exception being brief or solution focused couples therapy. In addition, counseling tends to be more 'here and now' and new coping strategies the outcome. Couples therapy is more about seemingly intractable problems with a relationship history, where emotions are the target and the agent of change.

The methods may differ in other ways as well, but the differences may indicate more about the counselor/therapist's way of working than the title given to their process.

History of Relationship Counseling

Relationship counseling as a discrete, professional service is a recent phenomenon. Until the late 20th century, the work of relationship counseling was informally fulfilled by close friends, family members, or local religious leaders. Psychiatrists, psychologists, counselors and social workers have historically dealt primarily with individual psychological problems. In many less technologically advanced cultures around the world today, the institution of family, the village or group elders fulfill the work of relationship counseling. Today marriage mentoring mirrors those cultures.

With increasing modernization or westernization in many parts of the world and the continuous shift towards isolated nuclear families the trend is towards trained relationship counselors; these are often volunteers who wish to help others, and are trained by either the Government or social service institutions to help those who are in need of counseling. Many communities and government departments have their own team of trained voluntary or professional relationship counselors. Similar services are operated by many universities and colleges, often staffed by volunteers from among the student peer group. Some large companies maintain a full-time professional counseling staff to facilitate smoother interactions between corporate employees, to minimize the negative effects that personal difficulties might have on work performance.

Basic Principles of Relationship Counseling

Before the relationships between the individuals can begin to be understood, it is important for all to recognize and acknowledge that everyone involved has a unique personality, perception, set of values and history. Sometimes the individuals in the relationship adhere to different value systems. Institutional and societal variables (like the social, religious, group and other collective factors) which shape a person's nature, and behavior must be recognized. A tenet of relationship counseling is that it is intrinsically beneficial for all the participants to interact with each other and with society at large with the least conflict possible. And where conflict arises as inevitably it does, to manage those conflicts consciously.

Most relationships will get strained at some time, resulting in their not functioning optimally and producing self-reinforcing, maladaptive patterns. These patterns may be called negative interaction cycles. There are many possible reasons for this, including insecure attachment, ego, arrogance, jealousy, anger, greed, poor communication/understanding or problem solving, ill health, third parties and so on.

Changes in situations like financial state, physical health, and the influence of other family members can have a profound influence on the conduct, responses and actions of the individuals in a relationship.

Often it is an interaction between two or more factors, and frequently it is not just one of the people who are involved that exhibit such traits. Relationship influences are reciprocal - it takes each person involved to make and manage problems.

A viable solution to the problem and setting these relationships back on track may be to reorient the individuals' perceptions and emotions - how one looks at or responds to situations and feels about them. Perceptions of and emotional responses to a relationship are contained within an often unexamined mental map of the relationship, also called a love map by John Gottman. These can be explored collaboratively and discussed openly. The core values they comprise can then be understood and respected or changed when no longer appropriate. This implies that each person takes equal responsibility for awareness of the problem as it arises, awareness of their own contribution to the problem and making some fundamental changes in thought and feeling.

The next step is to adopt conscious, structural changes to the inter-personal relationships and evaluate the effectiveness of those changes over time.

Indeed, "typically for those close personal relations there is a certain degree in 'interdependence' - what means that the partners are alternately mutually dependent on each other. As a special aspect of such relations something contradictory is put outside: the need for intimacy and for autonomy."

"The common counterbalancing satisfaction these both needs, intimacy and autonomy, leads to alternately satisfaction in the relationship and stability. But it depends on the specific developing duties of each partner in every life phase and maturity".

Basic Practices of Relationship Counseling

Two methods of couples therapy focus primarily on the process of communicating. The most commonly used method is active listening, used by the late Carl Rogers and Virginia Satir, and recommended by Harville Hendrix in *Getting the Love You Want*. More recently, a method called Cinematic Immersion has been developed by Warren Farrell in *Women Can't Hear What Men Don't Say*. Each helps couples learn a method of communicating designed to create a safe environment for each partner to express and hear feelings.

When the Munich Marital Study discovered active listening to not be used in the long run, Warren Farrell observed that active listening did a better job creating a safe environment for the criticizer to criticize than for the listener to hear the criticism. The listener, often feeling overwhelmed by the criticism, tended to avoid future encounters. He hypothesized that we were biologically programmed to respond defensively to criticism, and therefore the listener needed to be trained in-depth with mental exercises and methods to interpret as love what might otherwise feel abusive. His method is Cinematic Immersion.

After 30 years of research into marriage John Gottman has found that healthy couples almost never listen and echo each other's feelings naturally. Whether miserable or radiantly happy, couples said what they thought about an issue, and "they got angry or sad, but their partner's response was never anything like what we were training people to do in the listener/speaker exercise, not even close. "

Such exchanges occurred in less than 5 percent of marital interactions and they predicted nothing about whether the marriage would do well or badly. What's more, Gottman noted, data from a 1984 Munich study demonstrated that the (reflective listening) exercise itself didn't help couples to improve their marriages. To teach such interactions, whether as a daily tool for couples or as a therapeutic exercise in empathy, was a clinical dead end.

By contrast emotionally focused therapy for couples (EFT-C) is based on attachment theory and uses emotion as the target and agent of change. Emotions bring the past alive in rigid interaction patterns, which create and reflect absorbing emotional states. As one of its founders Sue Johnson says,

Forget about learning how to argue better, analyzing your early childhood, making grand romantic gestures, or experimenting with new sexual positions. Instead, recognize and admit that you are emotionally attached to and dependent on your partner in much the same way that a child is on a parent for nurturing, soothing, and protection.

Relationship counselor or couple's therapist

The duty and function of a relationship counselor or couple's therapist is to listen, respect, understand and facilitate better functioning between those involved.

The basic principles for a counselor include:

- Provide a confidential dialogue, which normalizes feelings
- To enable each person to be heard and to hear themselves
- Provide a mirror with expertise to reflect the relationship's difficulties and the potential and direction for change
- Empower the relationship to take control of its own destiny and make vital decisions
- Deliver relevant and appropriate information

As well as the above, the basic principles for a couples therapist also include:

- To identify the repetitive, negative interaction cycle as a pattern.
- To understand the source of reactive emotions that drive the pattern.
- To expand and re-organize key emotional responses in the relationship.
- To facilitate a shift in partners' interaction to new patterns of interaction.
- To create new and positively bonding emotional events in the relationship
- To foster a secure attachment between partners.

Common core principles of relationship counseling and couple's therapy are:

- Respect
- Empathy
- Tact
- Consent
- Confidentiality
- Accountability
- Expertise
- Evidence based
- Certification, ongoing training and supervision

In both the practitioner evaluates the story as it is narrated, and facilitates development of realistic, practical solutions; individually at first only if this is beneficial to both, is consensual and is unlikely to cause harm, and then jointly to encourage the participants to give their best efforts at reorienting their relationship with each other.

Novel Practices of Relationship Counseling

A novel development in the field of *couples therapy* has involved the introduction of insights gained from affective neuroscience and psychopharmacology into clinical practice. There has been interest in use of the so-called *love hormone* – oxytocin – during therapy sessions, although this is still largely experimental and somewhat controversial.

Popularized Methodologies of Relationship Counseling

Although results are almost certainly significantly better when professional guidance is utilized (see especially family therapy), numerous attempts at making the methodologies available generally via self help books and other media are available.

Some resources include:

- Gottman's what makes marriage work
- The Five Love Languages - what spouses respond to.
- Please Understand Me - determining personal psychological makeup.
- Hold me Tight - 'Love demands the reassurance of touch. Most fights are really protests over emotional disconnection. Underneath the distress, partners are desperate to know: Are you there for me? '
- Getting the Love You want - the Imago dialogue is a process which makes it easier to understand our partner, without feeling threatened or under attack ourselves. And for them to understand us in the same way

Module 3: Relationship Education

Relationship education presents and promotes the principles and practices of premarital education, relationship resources, relationship restoration, relationship maintenance, and research-based marriage preparation.

The formal organization of relationship education in the USA began in the late-1970s by a diverse group of professionals concerned that the results of conventional methods and means of marriage therapy resulted in no appreciable reduction in the elevated rate of divorce and out-of-wedlock births.

The motivation for relationship education was found in numerous studied observations of the elevated rates of marital and family breakdown, school drop-outs, incarceration, drug addiction, unemployment, suicide, homicide, domestic abuse and other negative social factors when either or both divorce or out-of-wedlock pregnancy were noted. In all of the negative categories noted above, statistical over-representation of adults whose childhood did not involve both of their parents was present.

One of the first comprehensive relationship education classes, PAIRS (Practical Application of Intimate Relationship Skills developed by Marriage and Family Therapist Lori Heyman Gordon) began as a semester-long course for graduate students in the counseling program at American University in Washington, D.C. in 1977. Like several other relationship education programs initiated in the same period, including Stanley and Markman's PREP program and Bernard Guerney's Relationship Enhancement courses, PAIRS today offers a range of classes nationwide for singles and couples in all stages of relationship. More information on PAIRS along with a directory of trained professionals and calendar of upcoming classes is available online.

In 2006, the U.S. Department of Health and Human Services began funding significant multi-year demonstration projects through the Administration for Children and Families to expand the availability of marriage education

classes in more than 100 communities nationwide. This project, known as the "Healthy Marriage Initiative," is designed to improve the well-being of children by providing tools and education to strengthen marriages and families. More information is available online.

Initial planning for the field of relationship education involved the participation of psychologists, counselors, social workers, marriage and family therapists, psychiatrists, clergy from various faith traditions, policy makers, academicians in the fields of social science, attorneys, judges, and lay persons. The goal was to seek the broadest possible dispersal of research and marriage education skills courses which could improve interpersonal relationship functioning, especially with married and pre-marital couples.

The relationship and marriage education movement came together under the umbrella of "The Coalition for Marriage, Family, and Couples Education," founded and directed by Diane Sollee, a former director of the American Association of Marriage and Family Therapy (AAMFT). Their first national conference, "Smart Marriages" was held in 1997, near their office in Washington, D.C. The annual Smart Marriages conferences are attended by as many as 2,500 persons from all fifty states and dozens of countries. Participants find that instruction in relationship skills, combined with information about the benefits of marriage and guidelines about what to expect in marriage, will not only increase the marriage rate and reduce the divorce rate but will provide for other social benefits, as well. The programs and methods to teach relationship skills are varied and are often modified specifically to various individual and cultural milieu. The majority of clinical practitioners who participate in the Coalition find within it a positive means to directly and quickly effect positive change for individuals and couples in circumstances where the DSM-IV may not be an appropriate tool. Their internet site provides information on community and national programs along with useful information on the field of marriage education.

Basic Principles and Practices of Relationship Education

- All men and all women can learn improved means and methods of relating to each other;
- All men and all women can learn to manage inevitable differences much better and can accept and plan for the numerous incompatibilities which are inevitable in all relationships;
- There is likely to be far more satisfaction from learning to play complementary roles well than from perpetually nursing the desire for that ideal and perfectly compatible individual;
- Humorous responses (to be used gently and often) and the ability to develop and select light-hearted interpretations of life’s inevitable awkwardness are of great value in aborting downward emotional spirals (interpretations where blaming the other person can cause great harm);
- Great couples and failed (failing) couples have disagreements in identical areas but creating the proper environment to honor the right to differences without perpetually allowing them to rise to the level of conflict is the key behavioral difference, and this can be learned;
- More communication or communication, alone, is never the exclusive answer to a problem situation, but respectful exchange of ideas while noting the preferences of the other thus showing concern and respect for them (including the validation of their importance) is valuable and essential. Building a connection is the goal—not a word count increase;
- To personalize (blame the other) in your difficulties is almost always the wrong thing to do as very few "man mistakes" or "woman mistakes" are exclusive to your personal circumstances (dramatically high percentages of other couples have had your same, exact battles and the ones who accepted this fact graciously and worked to resolve them amicably remain together, in love);
- There is great value in accepting the influence of the other graciously--and in offering one's own influence gracefully and gently;
- Keep the ratio of positive over negative comments overwhelming, in the nature of at least 10:1, while remembering that any negative response or outburst is likely to be remembered far longer;
- In tense moments, "soft starts" to any potentially conflicted conversational exchange is mandatory;
- Always seek healing tones and methods and never give resentment a foothold (allow for human foibles and errors when observing the “mistakes” of others and remember that you are daily and perpetually seeking to build a loving and caring home life);

- Remember that experiencing some guilt may be useful in learning and re-directing ourselves, but that shaming another person, that is, finding fault in who they are, their intentions, and their very self, can be very destructive;
- It is essential to recognize difficulty as early as possible--and to tread lightly until the very best moment arrives to address a matter (note that far less than all items need to be addressed--time will allow most potential squabbles to disappear on their own--dying of unimportance in the larger context of the active cultivation of a longer term, enduring love);
- All couples have a significant number of matters of life-long contrast or disagreement. Successful couples "table" the vast majority of these and respect each others differences and creating joy, finding happiness and creating love in areas of greater agreement, cultivating their positive regard and commitment to the relationship.
- Every couple can benefit from the active pursuit of fun and friendship (obviously, this takes special effort while caring for small children or in the presence of people who seem to have grumpy life habits);
- Recreational companionship should be cultivated and recreational compatibility should be pursued;
- Nearly every woman will respond well to the direct promotion of her emotional safety and comfort;
- Nearly every man will respond favorably to positive note or validation of his efforts or contributions;
- It is always valuable to choose warmth over grumpiness in responding to life's annoyances;
- The identification and the elimination of as many bad habits as possible can begin immediately;
- The identification of and the practice and repetition of as many good habits as possible can begin immediately;
- The near universal practice of assigning a mental illness diagnosis to persons experiencing relationship distress is quite likely to be iatrogenic. Boisvert, C., & Faust, D. (2002). Iatrogenic symptoms in psychotherapy: A theoretical exploration of the potential impact of labels, language, and belief systems. American Journal of Psychotherapy, 56, 244-259. ;
- There are many positive and romantic ideas and habits to cultivate--and to not seek them, to not learn them, and to not practice them is to risk missing some of life's greatest pleasures and enjoyments;
- There is great value in scripting, practicing, and faking improved expressions of new knowledge, methods and facts (this is the routine in all new learning—bicycling to bread-making, to being the best spouse that you can be);
- Researching what others want, desire, appreciate and enjoy is essential. Know that what is of high importance to your spouse may be of lesser importance to you. Accommodate these preferences to the highest degree that you can—fully expecting that numerous day-to-day preferences and desires of men and women are likely to be different. Harley, Willard in His Needs, Her Needs;
- Women may be more likely to reveal their annoyances regarding a variety of domestic concerns but they can learn that some of their standards may be well beyond a man's interests and women can learn to negotiate accordingly;
- Men may not be fully sensitive to a woman's domestic standards but they can learn higher levels of respect and participation, thus displaying concern for fairness in the promotion and maintenance of complementary and loving home life;
- Repair mechanisms must be prepared and used regularly, before significant deteriorations can be observed. All repairs involve softened tones and absolutely no harsh words or presentations. If you cannot stage an optimal recovery initially, arrange for a break until you can review essential principles and return to attempt a loving recovery—a repair. Gottman, John in Seven Principles;

Exposing children and youth to these basic principles is compatible with the majority of socialization fundamentals in numerous religions and societies

Module 4: Suicide Intervention

Suicide intervention or **suicide crisis intervention** is direct effort to stop or prevent persons attempting or contemplating suicide from killing themselves. Current medical advice concerning people who are attempting or seriously considering suicide is that they should immediately go or be taken to the nearest emergency room, or emergency services should be called immediately by them or anyone aware of the problem. Modern medicine treats suicide as a mental health issue. According to medical practice, severe suicidal ideation, that is, serious

contemplation or planning of suicide, is a medical emergency and that the condition requires immediate emergency medical treatment.

In the United States, individuals who express the intent to harm themselves are automatically determined to lack the *present mental capacity* to refuse treatment, and can be transported to an emergency department against their will. An emergency physician there will determine whether or not inpatient care at a mental health care facility is warranted. This is sometimes referred to as being "committed." If the doctor determines involuntary commitment is needed, the patient is hospitalized and kept under observation until a court hearing is held to determine the patient's *competence*.

Individuals suffering from depression are considered a high-risk group for suicidal behavior. When depression is a major factor, successful treatment of the depression usually leads to the disappearance of suicidal thoughts. However, medical treatment of depression is not always successful, and lifelong depression can contribute to recurring suicide attempts.

Medical personnel frequently receive special training to look for suicidal signs in patients. Suicide hotlines are widely available for people seeking help. However, the negative and often too clinical reception that many suicidal people receive after relating their feelings to health professionals (e.g. threats of institutionalization, increased dosages of medication, the social stigma) may cause patients to remain more guarded about their mental health history or suicidal urges and ideation.

First Aid for Suicide Ideation

Medical professionals advise that people who have expressed plans to kill themselves be encouraged to seek medical attention immediately. This is especially relevant if the means (weapons, drugs, or other methods) are available, or if the patient has crafted a detailed plan for executing the suicide. Mental health professionals suggest that people who know a person whom they suspect to be suicidal can assist him or her by asking directly if the person has contemplated committing suicide and made specific arrangements, has set a date, etc. Posing such a question *does not* render a previously non-suicidal person suicidal. According to this advice, the person questioning should seek to be understanding and empathetic above all else since a suicidal person will often already feel ashamed or guilty about contemplating suicide so care should be taken not to exacerbate that guilt.

Mental health professionals suggest that an affirmative response to these questions should motivate the immediate seeking of medical attention, either from that person's doctor, or, if unavailable, the emergency room of the nearest hospital.

If the prior interventions fail, mental health professionals suggest involving law enforcement officers. While the police do not always have the authority to stop the suicide attempt itself, in some countries including some jurisdictions in the US, killing oneself is illegal.

In most cases law enforcement does have the authority to have people involuntarily committed to mental health wards. Usually a court order is required, but if an officer feels the person is in immediate danger he/she can order an involuntary commitment without waiting for a court order. Such commitments are for a limited period, such as 72 hours – which is intended to be enough time for a doctor to see the person and make an evaluation. After this initial period, a hearing is held in which a judge can decide to order the person released or can extend the treatment time. Afterwards, the court is kept informed of the person's condition and can release the person when they feel the time is right to do so. Legal punishment for suicide attempts is extremely rare.

Mental Health Treatment

Treatment, often including medication, counseling and psychotherapy, is directed at the underlying causes of suicidal thinking. Clinical depression is the most common treatable cause, with alcohol or drug abuse being the next major categories.

Other psychiatric disorders associated with suicidal thinking include bipolar disorder, schizophrenia, Borderline personality disorder, Gender identity disorder and eating disorders. Suicidal thoughts provoked by crises will generally settle with time and counseling. Severe depression can continue throughout life even with treatment and repetitive suicide attempts or suicidal ideation can be the result.

Methods for disrupting suicidal thinking include having family members or friends tell the person contemplating suicide about who else would be hurt by the loss, citing valuable and productive aspects of the patient's life, and provoking simple curiosity about the victim's own future.

During the acute phase, the safety of the person is one of the prime factors considered by doctors, and this can lead to admission to a psychiatric ward or even involuntary commitment.

Suicide Prevention

Various suicide prevention strategies are suggested by Mental Health professionals:

- Promoting mental resilience through optimism and connectedness.
- Education about suicide, including risk factors, warning signs, and the availability of help.
- Increasing the proficiency of health and welfare services in responding to people in need. This includes better training for health professionals and employing crisis counseling organizations.
- Reducing domestic violence and substance abuse are long-term strategies to reduce many mental health problems.
- Reducing access to convenient means of suicide (e.g., toxic substances, handguns).
- Reducing the quantity of dosages supplied in packages of non-prescription medicines e.g., aspirin.
- Interventions targeted at high-risk groups.

Research on Suicide Prevention

Research into suicide is published across a wide spectrum of journals dedicated to the biological, economic, psychological, medical and social sciences. In addition to those, a few journals are exclusively devoted to the study of suicide (suicidology), most notably, Crisis, Suicide and Life Threateni Stress Management

Historical Foundations of Suicide prevention

Walter Cannon and Hans Selye used animal studies to establish the earliest scientific basis for the study of stress. They measured the physiological responses of animals to external pressures, such as heat and cold, prolonged restraint, and surgical procedures, then extrapolated from these studies to human beings.

Subsequent studies of stress in humans by Richard Rahe and others established the view that stress is caused by distinct, measurable life stressors, and further, that these life stressors can be ranked by the median degree of stress they produce (leading to the Holmes and Rahe Stress Scale). Thus, stress was traditionally conceptualized to be a result of external insults beyond the control of those experiencing the stress. More recently, however, it has been argued that external circumstances do not have any intrinsic capacity to produce stress, but instead their effect is mediated by the individual's perceptions, capacities, and understanding.

Module 5: Stress, Anxiety and Tension Management

All of us experience anxiety, stress or tension at some or other stage in our lives. If we do not cope with it immediately and deliberately it might overwhelm us and immobilise us for the tasks that we have to perform.

It forms the cornerstone of all forms of dis-ease. Therefore it is necessary to know about the effects of anxiety, stress and tension and how we can cope with it. In this case I am talking about stress as dis-ease and not as a disease. It is a symptom of a disease when the thyroid gland is malfunctioning for instance. Then obviously you should get treatment for the thyroid gland that is malfunctioning and that will relieve the stress.

Anxiety, stress and tension are terms that are often used as synonyms. According to the dictionary, anxiety refers to a state of being anxious about eminent danger; being excessively concerned about the future. Anxiety, however, is usually not linked to a specific person, situation or experience which is feared. It is a vague, undefined, tense feeling of dread that one experiences and which is difficult to control.

Stress refers to an effort or demand upon physical or mental energy. Stress produces the same feelings as anxiety but it is usually linked to a specific significant other person, situation or experience that one fears. Examples would include an examination, assignment or a superior person. Tension on the other hand refers to mental strain or excitement; a strained state or relationship. If the symptoms are experienced acutely, it is referred to as a panic attack.

All these definitions have in common the fact that individuals experience excessive uneasiness and that they worry as a result of perceived (excessive or dangerous) demands that are made on them on an interpersonal level. The anxiety, worry or tenseness could result in the impairment of social, occupational, physical and other important areas of functioning. One could also say that individuals experience an excessive sensitivity for other's opinions, attitudes and demands.

Symptoms
Experiencing anxiety, stress or tension can lead to symptoms such as:

(A) Psychosomatic symptoms

- Getting tired very easily
- Muscle tension
- Palpitations - a pounding heart or an accelerated heart rate
- Sweating (cold sweat) or hot flushes
- Shortness of breath, a feeling of being choked or a smothering sensation with pain in the chest
- Nausea or abdominal distress
- Feeling numb or experiencing tingling sensations in certain parts of the body
- Experiencing a dry mouth and the urge to swallow repeatedly
- Diarrhoea
- Impotence or an excessive need for sex
- Asthma
- Feeling dizzy, unsteady, lightheaded or faint

(B) Emotional symptoms

- Feeling depressed and downhearted at times
- Feeling detached from oneself
- Fear of losing control or going crazy
- Fear of dying
- Intense apprehension, fearfulness, or terror, often associated with feelings of impending doom

(C) Intellectual symptoms

- Difficulty concentrating on a specific task or experiencing the mind going blank (clouding of consciousness)
- Forgetfulness, resulting from preoccupation with the problem

(D) Behavioural symptoms

- Restlessness, feeling keyed up or on edge
- Trembling or shaking

- Short tempered
- Withdrawal from interpersonal interaction
- Excessive smoking, sleeping and/or drinking
- Sleep disturbances (finding it difficult to fall asleep or experiencing nightmares, sleeping excessively or restless sleep - waking up tired)
- Not feeling hungry or eating excessively
- Slow psychomotor co-ordination

Very often a person who experiences stress is inclined to shy away from interpersonal contact and is thus inclined to bottle up feelings instead of sharing them with others. This bottling up of feelings and the corresponding tension could lead to psychosomatic symptoms as well as disturbed sleep, sexual and eating patterns. Your need for sex might be diminished or you could experience an excessive need for it to comfort you. You also might not feel hungry.

In an attempt to overcome anxiety or tension you might resort to excessive smoking, sleeping and drinking. When stress is prevalent, depression is underlying or dormant. Once you give up handling and competing with the problems creating the stress, depression sets in. What can we do about it if we experience stress and anxiety or underlying depression?

How to cope with stress
Peter discovered that he was in debt. This realization made it impossible for him to sleep. He became very anxious and depressed and wanted to commit suicide. He complained about it to a good friend. The friend listened patiently as Peter told him of all his problems, but when he replied, he made no mention of the debts. This surprised Peter very much.

Instead of discussing the debts, the friend talked about what Peter owned, about his money, and about the friends who were ready to help him. Suddenly the disturbed Peter saw his problems in a new light. He stopped wasting his energy on problems and debts and concentrated on the abilities he actually had. He then discovered that he had enough power and resources to solve his problem.

This story teaches us that a healthy person is not one who is free of problems, but one who deals with them. One day's happiness can make a person forget his/her misfortune, and one day's misfortune can make a person forget his/her past happiness.

- Your subjective perception could be different:
  As I have mentioned, anxiety or stress implies an over-sensitivity to other's opinions, attitudes and demands. It is the meaning that you attach to significant other people's opinions, attitudes and demands that brings about the tension.

  This being the case, then surely communication between the concerned parties should alleviate the matter. It sounds easy enough but we all have reservations about communicating about matters of a personal nature. We always think: 'What will he think of me if I told him this problem that I experience', or ' She would think I am stupid to have such a problem,' or 'Why can't I just cope with problems like anybody else?' or 'I am sure I am the only one with such a problem, nobody will understand me.'

  Most emotional problems are related to the perceptions and expectations we have of significant other people. The questions above confirm this view. One could thus also say that in one's (subjective) definition of the problem lies the solution to it as well.

- Keep fit:
  To be able to perceive and handle problems effectively, one must also be as physically fit as possible. Tiredness can negatively influence the perception of, definition of and possible solution of a problem. The problem may then be perceived as overwhelming and insoluble.

- Your definition of the problem could be different:
  The solution to a problem lies in its meaning, perception and definition. If you define a problem as overwhelming, it will appear insoluble. Furthermore, if you think about a problem on your own, you will only have one point of view.

  In the example earlier, Peter's friend introduced a different perspective and by implication a (different) solution to the problem. When a person is gets ill in the West, they say he must have a rest. He is visited by a few people and visits are socially controlled. In the East, when a person gets ill, his bed is placed in the living room.

  The sick person is the centre of attention and he is visited by many family members and friends. If visitors stayed away, it would be seen as uncivil and as a lack of sympathy. In this way relationships are confirmed. In the West relationships very often become severed when a person becomes ill and the sick person is "forgotten" at his/her office until he/she returns. He/she does not experience being missed by colleagues and friends.

- Begin to communicate about the problem:
  So, if you find it difficult to talk to someone about your problems or negative experiences, find a psychologist or a good friend and start to practise talking to him/her first. Maybe that will give you enough courage to talk to others as well. By sharing a problem and feeling understood, the impact of a problem is alleviated.

  There is a saying: "Nature is explained but people are understood." There is no need for you to ever explain your behaviour if you feel you have done the best you can. We only need to understand each other.

- Take a tranquilliser for stress situations:
  Very often people ask whether or not it may be simpler to take a tranquilliser to alleviate the anxiety or tension. There are times when tranquillisers may come in handy on a short term basis.

  For example when a loved one dies and you find it difficult to cope with the emotional impact of the event or if you are the bridegroom who has to make a speech at your wedding and you suffer from stage fright, tranquillisers could help you cope with a temporary tense situation. (The bridegroom might however pay for it in another way later on that evening - much to his embarrassment! Tranquillisers and sex do not really work together.)

  Feeling tense could be compared to the waves of the sea. You are not equally tense at all times, just as the intensity of the waves differ at different times. The tenseness builds up to a peak and then calms down a bit, similar to high tide when the sea is much more active. The waves come and go.

  The tranquilliser succeeds in cutting out peak emotional experiences so that you do not experience it as so overwhelming. The 'wave' of emotion can thus not develop fully under the influence of a tranquilliser and in this way you are protected for as long as you take the tranquilliser.

- Learn to ride the wave of emotion:
  But can you carry on taking the medication for ever? Would it not be better to learn how to surf, so that you can ride the waves of emotion when they come? For this reason it is important to talk to as many people as possible about your experiences, especially to experts. If you bottle feelings up, you are 'freezing' the emotional wave and the body is kept in a state of readiness, like a horse that is ready to race. The adrenalin is still pumping and the heart rate is still high to keep you in that state of readiness.

  Also many of the corresponding symptoms that were mentioned earlier, still prevail. Obviously the body cannot be kept in a state of readiness indefinitely and something must give in. Usually it is the heart which

works the hardest and is the most vulnerable. So, does it pay to bottle up (and freeze emotions)? Definitely not.

Models of Stress Management

Transactional Model

Richard Lazarus and Susan Folkman suggested in 1984 that stress can be thought of as resulting from an "imbalance between demands and resources" or as occurring when "pressure exceeds one's perceived ability to cope". Stress management was developed and premised on the idea that stress is not a direct response to a stressor but rather one's resources and ability to cope mediate the stress response and are amenable to change, thus allowing stress to be controllable.

In order to develop an effective stress management programme it is first necessary to identify the factors that are central to a person controlling his/her stress, and to identify the intervention methods which effectively target these factors. Lazarus and Folkman's interpretation of stress focuses on the transaction between people and their external environment (known as the Transactional Model). The model conceptualizes stress as a result of how a stressor is appraised and how a person appraises his/her resources to cope with the stressor. The model breaks the stressor-stress link by proposing that if stressors are perceived as positive or challenging rather than a threat, and if the stressed person is confident that he/she possesses adequate rather than deficient coping strategies, stress may not necessarily follow the presence of a potential stressor. The model proposes that stress can be reduced by helping stressed people change their perceptions of stressors, providing them with strategies to help them cope and improving their confidence in their ability to do so.

Health Realization/Innate Health Model

The health realization/innate health model of stress is also founded on the idea that stress does not necessarily follow the presence of a potential stressor. Instead of focusing on the individual's appraisal of so-called stressors in relation to his or her own coping skills (as the transactional model does), the health realization model focuses on the nature of thought, stating that it is ultimately a person's thought processes that determine the response to potentially stressful external circumstances. In this model, stress results from appraising oneself and one's circumstances through a mental filter of insecurity and negativity, whereas a feeling of well-being results from approaching the world with a "quiet mind," "inner wisdom," and "common sense".

This model proposes that helping stressed individuals understand the nature of thought--especially providing them with the ability to recognize when they are in the grip of insecure thinking, disengage from it, and access natural positive feelings--will reduce their stress.

Techniques of Stress Management

There are several ways of coping with stress. Some techniques of time management may help a person to control stress. In the face of high demands, effective stress management involves learning to set limits and to say "No" to some demands that others make. The following techniques have been recently dubbed "Destressitizers" by The Journal of the Canadian Medical Association. A destressitizer is any process by which an individual can relieve stress. Techniques of stress management will vary according to the theoretical paradigm adhered to, but may include some of the following:

Measuring Stress

Levels of stress can be measured. One way is through the use of the Holmes and Rahe Stress Scale to rate stressful life events. Changes in blood pressure and galvanic skin response can also be measured to test stress levels, and changes in stress levels. A digital thermometer can be used to evaluate changes in skin temperature, which can indicate activation of the fight or flight response drawing blood away from the extremities.

Stress management has physiological and immune benefit effects.

Effectiveness of Stress Management

Positive outcomes are observed using a combination of non-drug interventions:

- treatment of anger or hostility,
- autogenic training
- talking therapy (around relationship or existential issues)
- biofeedback
- cognitive therapy for anxiety or clinical depression

Module 6: Counseling psychology

Counseling psychology is a psychological specialty that encompasses research and applied work in several broad domains: counseling process and outcome; supervision and training; career development and counseling; diversity and multiculturalism; and prevention and health. Some unifying themes among counseling psychologists include a focus on assets and strengths, person-environment interactions, educational and career development, brief interactions, and a focus on intact personalities.

Two differences in particular may distinguish the field of counseling from the field of counseling psychology: first, counseling is almost entirely an applied field: that is, the occupation of counselors is generally counseling and psychotherapy. In contrast, counseling psychology is both a research and applied field; applied work might include teaching, consultation, and clinical work, which in turn could include supervision, assessment, and forensic evaluation, in addition to counseling or psychotherapy. A second distinction is the breadth of topics encompassed by counseling psychology. In addition to studying and teaching *counseling*, counseling psychologists also engage in research in areas such as career development, culture, ethnicity, gender, identity development, personality, sexual orientation, race, and research methodology.

Employment settings

Counseling psychologists are employed in a variety of settings depending on the services they provide and the client populations they serve. Some are employed in colleges and universities as teachers, supervisors, researchers, and service providers. Others are employed in independent practice providing counseling, psychotherapy, assessment, and consultation services to individuals, couples/families, groups, and organizations. Additional settings in which counseling psychologists practice include community mental health centers, Veterans Administration Medical Centers and other facilities, family services, health maintenance organizations, rehabilitation agencies, business and industrial organizations and consulting within firms.

Counseling Process and Outcome

Counseling psychologists are interested in answering a variety of research questions regarding counseling process and outcome. Counseling process might be thought of as how or why does counseling happen and progress. Counseling outcome addresses whether or not counseling is effective, under what conditions is counseling effective, and what outcomes are considered effective- such as symptom reduction, behavior change, or quality of life improvement. Topics commonly explored in the study of counseling process and outcome include therapist variables, client variables, the counseling or therapeutic relationship, cultural variables, process and outcome measurement, mechanisms of change, and process and outcome research methods.

Therapist variables: These include characteristics of a counselor or psychotherapist, as well as therapist technique, behavior, theoretical orientation and training. In terms of therapist behavior, technique and theoretical orientation, research on adherence to therapy models has found that adherence to a particular model of therapy can be helpful, detrimental, or neutral in terms of impact on outcome (Imel & Wampold, 2008). Research on the

impact of training and experience is still somewhat contradictory and even counter-intuitive. For example, a recent study found that age-related training and experience, but not amount or quality of contact with older people, is related to older clients. However, a recent meta-analysis of research on training and experience suggests that experience level is only slightly related to accuracy in clinical judgment Higher therapist experience has been found to be related to less anxiety, but also less focus. This suggests that there is still work to be done in terms of training clinicians and measuring successful training.

Client variables: Client characteristics such as help-seeking attitudes and attachment style have been found to be related to client use of counseling, as well as expectations and outcome. Stigma against mental illness can keep people from acknowledging problems and seeking help. Public stigma has been found to be related to self-stigma, attitudes towards counseling, and willingness to seek help. In terms of attachment style, clients with avoidant styles have been found to perceive greater risks and fewer benefits to counseling, are less likely to seek professional help, compared with securely attached clients. Those with anxious attachment styles perceive greater benefits as well as risks to counseling. Educating clients about expectations of counseling can improve client satisfaction, treatment duration and outcomes, and is an efficient and cost-effective intervention.

Counseling relationship: The relationship between a counselor and client is the feelings and attitudes that a client and therapist have towards one another, and the manner in which those feelings and attitudes are expressed. It may be thought of in three parts: transference counter transference, working alliance, and the real- or personal-relationship. Another theory about the function of the counseling relationship is known as the secure-base hypothesis, which is related to attachment theory. This hypothesis proposes that the counselor acts as a secure-base from which clients can explore and then check in with. Secure attachment to one's counselor and secure attachment in general have been found to be related to client exploration. Insecure attachment styles have been found to be related to less session depth, compared to sessions of securely attached clients

Cultural variables: Counseling psychologists are interested in how culture relates to help-seeking and counseling process and outcome. Helms' racial identity model can be useful for understanding how the relationship and counseling process might be affected by the client's and counselor's racial identity. Recent research suggests that clients who are Black are at risk for experiencing racial micro-aggressions from counselors who are White.

Efficacy for working with clients who are lesbians, gay men, or bisexual might be related to therapist demographics, gender, sexual identity development, sexual orientation, and professional experience. Clients who have multiple oppressed identities might be especially at-risk for experiencing unhelpful situations with counselors, so counselors might need help with gaining expertise for working with clients who are transgender, lesbian, gay, bisexual, or transgender people of color, and other oppressed populations. .

Gender role socialization can also present issues for clients and counselors. Implications for practice include being aware of stereotypes and biases about male and female identity, roles and behavior such as emotional expression.

Outcome measurement: Counseling outcome measures might look at a general overview of symptoms, symptoms of specific disorders, or positive outcomes, such as subjective well-being or quality of life. The Outcome Questionnaire-45 is a 45 item self-report measure of psychological distress. An example of disorder specific measure would be the Beck Depression Inventory. The Quality of Life Inventory is a 17 item self-report life satisfaction measure.

Process and Outcome Research Methods

Counseling process and outcome research employs a variety of research methodologies to answer questions about if, how, and why counseling works. Quantitative methods include randomly controlled clinical trials, correlation studies over the course of counseling, or laboratory studies about specific counseling process and outcome variables. Qualitative research methods can involve conducting, transcribing and coding interviews; transcribing and/or coding therapy sessions; or fine-grain analysis of single counseling sessions or counseling cases.

Psychotherapy

Psychotherapy is an intentional interpersonal relationship used by trained psychotherapists to aid a client or patient in problems of living. It aims to increase the individual's well-being. Psychotherapists employ a range of techniques based on experiential relationship building, dialogue, communication and behavior change and that are designed to improve the mental health of a client or patient, or to improve group relationships (such as in a family). Psychotherapy may also be performed by practitioners with a number of different qualifications, including psychologists, marriage and family therapists, occupational therapists, licensed clinical social workers, counselors, psychiatric nurses, psychoanalysts, and psychiatrists.

Etymology

The word psychotherapy comes from the Ancient Greek words *psyche*, meaning breath, spirit, or soul and *therapies* or *therapeuein*, to nurse or cure. Its use was first noted around 1890. It is defined as the relief of distress or disability in a one person by another, using an approach based on a particular theory or paradigm, and that the agent performing the therapy has had some form of training in delivering this. It is these latter two points which distinguish psychotherapy from other forms of counseling or care giving.

Forms

Most forms of psychotherapy use spoken conversation. Some also use various other forms of communication such as the written word, artwork, drama, narrative story or music. Psychotherapy occurs within a structured encounter between a trained therapist and client(s). Purposeful, theoretically based psychotherapy began in the 19th century with psychoanalysis; since then, scores of other approaches have been developed and continue to be created.

Therapy is generally employed in response to a variety of specific or non-specific manifestations of clinically diagnosable and/or existential crises. Treatment of everyday problems is more often referred to as counseling (a distinction originally adopted by Carl Rogers). However, the term counseling is sometimes used interchangeably with "psychotherapy".

Whilst some psychotherapeutic interventions are designed to treat the patient employing the medical model, many psychotherapeutic approaches do not adhere to the symptom-based model of "illness/cure". Some practitioners, such as humanistic therapists, see themselves more in a facilitative/helper role. As sensitive and deeply personal topics are often discussed during psychotherapy, therapists are expected, and usually legally bound, to respect client or patient confidentiality. The critical importance of confidentiality is enshrined in the regulatory psychotherapeutic organizations' codes of ethical practice.

Psychotherapy systems

There are several main broad systems of psychotherapy:

- Psychoanalytic - it was the first practice to be called a psychotherapy. It encourages the verbalization of all the patient's thoughts, including free associations, fantasies, and dreams, from which the analyst formulates the nature of the unconscious conflicts which are causing the patient's symptoms and character problems.
- Cognitive behavioral - generally seeks by different methods to identify and transcend maladaptive cognition, appraisal, beliefs and reactions with the aim of influencing destructive negative emotions and problematic dysfunctional behaviors.
- Psychodynamic - is a form of depth psychology, the primary focus of which is to reveal the unconscious content of a client's psyche in an effort to alleviate psychic tension. Although its roots are in psychoanalysis, psychodynamic therapy tends to be briefer and less intensive than traditional psychoanalysis.
- Existential - is based on the existential belief that human beings are alone in the world. This isolation leads to feelings of meaninglessness, which can be overcome only by creating one's own values and meanings.

- Humanistic - emerged in reaction to both behaviorism and psychoanalysis and is therefore known as the Third Force in the development of psychology. It is explicitly concerned with the human context of the development of the individual with an emphasis on subjective meaning, a rejection of determinism, and a concern for positive growth rather than pathology. It posits an inherent human capacity to maximize potential, 'the self-actualizing tendency'. The task of Humanistic therapy is to create a relational environment where this tendency might flourish.
- Brief - "Brief therapy" is an umbrella term for a variety of approaches to psychotherapy. It differs from other schools of therapy in that it emphasizes (1) a focus on a specific problem and (2) direct intervention. It is solution-based rather than problem-oriented. It is less concerned with how a problem arose than with the current factors sustaining it and preventing change.
- Systemic - seeks to address people not at an individual level, as is often the focus of other forms of therapy, but as people in relationship, dealing with the interactions of groups, their patterns and dynamics (includes family therapy & marriage counseling).
- Transpersonal - Addresses the client in the context of a spiritual understanding of consciousness.

There are hundreds of psychotherapeutic approaches or schools of thought. By 1980 there were more than 250. By 1996 there were more than 450,. The development of new and hybrid approaches continues around the wide variety of theoretical backgrounds. Many practitioners use several approaches in their work and alter their approach based on client need.

General concerns

Psychotherapy can be seen as an interpersonal invitation offered by (often trained and regulated) psychotherapists to aid clients in reaching their full potential or to cope better with problems of life. Psychotherapists usually receive remuneration in some form in return for their time and skills. This is one way in which the relationship can be distinguished from an altruistic offer of assistance.

Psychotherapists and counselors often require to create a therapeutic environment referred to as the frame, which is characterized by a free yet secure climate that enables the client to open up. The degree to which client feels related to the therapist may well depend on the methods and approaches used by the therapist or counselor.

Psychotherapy often includes techniques to increase awareness, for example, or to enable other choices of thought, feeling or action; to increase the sense of well-being and to better manage subjective discomfort or distress. Psychotherapy can be provided on a one-to-one basis or in group therapy. It can occur face to face, over the telephone, or, much less commonly, the Internet. Its time frame may be a matter of weeks or many years. Therapy may address specific forms of diagnosable mental illness, or everyday problems in managing or maintaining person relationships or meeting personal goals. Treatment of everyday problems is more often referred to as **counseling** (a distinction originally adopted by Carl Rogers) but the term is sometimes used interchangeably with "psychotherapy".

Psychotherapists employ a range of techniques to influence or persuade the client to adapt or change in the direction the client has chosen. These can be based on clear thinking about their options; experiential relationship building; dialogue, communication and adoption of behavior change strategies. Each is designed to improve the mental health of a client or patient, or to improve group relationships (as in a family). Most forms of psychotherapy use only spoken conversation, though some also use other forms of communication such as the written word, artwork, drama, narrative story, or therapeutic touch. Psychotherapy occurs within a structured encounter between a trained therapist and client(s). Because sensitive topics are often discussed during psychotherapy, therapists are expected, and usually legally bound, to respect client or patient confidentiality.

Psychotherapists are often trained, certified, and licensed, with a range of different certifications and licensing requirements depending on the jurisdiction. Psychotherapy may be undertaken by psychologists, counseling psychologists, social workers, marriage-family therapists, expressive therapists, trained nurses, psychiatrists, psychoanalysts, mental health counselors, school counselors, or professionals of other mental health disciplines. Psychiatrists have medical qualifications and may also administer prescription medication. The primary training

of a psychiatrist focuses on the biological aspects of mental health conditions, with some training in psychotherapy. Psychologists have more training in psychological assessment and research and, in addition, in-depth training in psychotherapy. Social workers have specialized training in linking patients to community and institutional resources, in addition to elements of psychological assessment and psychotherapy. Marriage-Family Therapists have specific training and experience working with relationships and family issues. A Licensed Professional Counselor (LPC) generally has special training in career, mental health, school, or rehabilitation counseling to include evaluation and assessments as well as psychotherapy. Many of the wide variety of training programs are multi-professional, that is, psychiatrists, psychologists, mental health nurses, and social workers may be found in the same training group. Consequently, specialized psychotherapeutic training in most countries requires a program of continuing education after the basic degree, or involves multiple certifications attached to one specific degree.

Specific schools and approaches

In practices of experienced psychotherapists, therapy will not represent pure types, but will draw aspects from a number of perspectives and schools.

Psychoanalysis

Psychoanalysis was developed in the late 1800s by Sigmund Freud. His therapy explores the dynamic workings of a mind understood to consist of three parts: the hedonistic *id* (German: *das Es*, "the it"), the rational *ego* (*das Ich*, "the I"), and the moral *superego* (*das Überich*, "the above-I"). Because the majority of these dynamics are said to occur outside people's awareness, Freudian psychoanalysis seeks to probe the unconscious by way of various techniques, including dream interpretation and free association. Freud maintained that the condition of the unconscious mind is profoundly influenced by childhood experiences. So, in addition to dealing with the defense mechanisms employed by an overburdened ego, his therapy addresses fixations and other issues by probing deeply into clients' youth.

Other psychodynamic theories and techniques have been developed and used by psychotherapists, psychologists, psychiatrists, personal growth facilitators, occupational therapists and social workers. Techniques for group therapy have also been developed. While behavior is often a target of the work, many approaches value working with feelings and thoughts. This is especially true of the psychodynamic schools of psychotherapy, which today include Jungian therapy and Psychodrama as well as the psychoanalytic schools. Other approaches focus on the link between the mind and body and try to access deeper levels of the psyche through manipulation of the physical body which gave rise to various *body movement* based psychotherapeutic approaches such as neo-Reichian Alexander Lowen's Bioenergetic analysis, Peter Levine's Somatic Experiencing, Jack Rosenberg's integrative body psychotherapy, Pat Ogden's sensorimotor psychotherapy etc. They are not to be confused with alternative medicine body-work which seeks primarily to improve physical health because despite the fact that bodywork techniques (for example Alexander Technique, Rolfing, and the Feldenkrais Method) affect the emotions, they are not overtly designed to work on psychological issues.]

Gestalt Therapy

Gestalt Therapy is a major overhaul of psychoanalysis. In its early development it was called "concentration therapy" by its founders, Frederick and Laura Perls. However, its mix of theoretical influences became most organized around the work of the gestalt psychologists; thus, by the time 'Gestalt Therapy, Excitement and Growth in the Human Personality' (Perls, Hefferline, and Goodman) was written, the approach became known as "Gestalt Therapy."

Gestalt Therapy stands on top of essentially four load bearing theoretical walls: phenomenological method, dialogical relationship, field-theoretical strategies, and experimental freedom. Some have considered it an existential phenomenology while others have described it as a phenomenological behaviorism. Gestalt therapy is a humanistic, holistic, and experiential approach that does not rely on talking alone, but facilitates awareness in the

various contexts of life by moving from talking about situations relatively remote to action and direct, current experience.

Group Psychotherapy

The therapeutic use of groups in modern clinical practice can be traced to the early years of the 20th century, when the American chest physician Pratt, working in Boston, described forming 'classes' of fifteen to twenty patients with tuberculosis who had been rejected for sanatorium treatment. The term group therapy, however, was first used around 1920 by Jacob L. Moreno, whose main contribution was the development of psychodrama, in which groups were used as both cast and audience for the exploration of individual problems by reenactment under the direction of the leader. The more analytic and exploratory use of groups in both hospital and out-patient settings was pioneered by a few European psychoanalysts who emigrated to the USA, such as Paul Schilder, who treated severely neurotic and mildly psychotic out-patients in small groups at Bellevue Hospital, New York. The power of groups was most influentially demonstrated in Britain during the Second World War, when several psychoanalysts and psychiatrists proved the value of group methods for officer selection in the War Office Selection Boards. A chance to run an Army psychiatric unit on group lines was then given to several of these pioneers, notably Wilfred Bion and Rickman, followed by S. H. Foulkes, Main, and Bridger. The Northfield Hospital in Birmingham gave its name to what came to be called the two 'Northfield Experiments', which provided the impetus for the development since the war of both social therapy, that is, the therapeutic community movement, and the use of small groups for the treatment of neurotic and personality disorders.

Medical and Non-Medical Models

A distinction can also be made between those psychotherapies that employ a medical model and those that employ a humanistic model. In the medical model the client is seen as unwell and the therapist employs their skill to help the client back to health. The extensive use of the DSM-IV, the diagnostic and statistical manual of mental disorders in the United States, is an example of a medically-exclusive model.

The humanistic model of non medical in contrast strives to depathologise the human condition. The therapist attempts to create a relational environment conducive to experiential learning and help build the client's confidence in their own natural process resulting in a deeper understanding of themselves. An example would be gestalt therapy.

Some psychodynamic practitioners distinguish between more uncovering and more supportive psychotherapy. Uncovering psychotherapy emphasizes facilitating the client's insight into the roots of their difficulties. The best-known example of an uncovering psychotherapy is classical psychoanalysis. Supportive psychotherapy by contrast stresses strengthening the client's defenses and often providing encouragement and advice. Depending on the client's personality, a more supportive or more uncovering approach may be optimal. Most psychotherapists use a combination of uncovering and supportive approaches.

Cognitive Behavioral Therapy

Cognitive behavioral therapy refers to a range of techniques which focus on the construction and re-construction of people's cognitions, emotions and behaviors. Generally in CBT the therapist, through a wide array of modalities, helps clients assess, recognize and deal with problematic and dysfunctional ways of thinking, emoting and behaving.

Behavior Therapy

Behavior therapy focuses on modifying overt behavior and helping clients to achieve goals. This approach is built on the principles of learning theory including operant and respondent conditioning, which makes up the area of applied behavior analysis or behavior modification. This approach includes acceptance and commitment therapy, functional analytic psychotherapy, and dialectical behavior therapy. Sometimes it is integrated with cognitive therapy to make cognitive behavior therapy. By nature, behavioral therapies are empirical (data-driven),

contextual (focused on the environment and context), functional (interested in the effect or consequence a behavior ultimately has), probabilistic (viewing behavior as statistically predictable), monistic (rejecting mind-body dualism and treating the person as a unit), and relational (analyzing bidirectional interactions).[10]

Expressive Therapy

Expressive therapy is a form of therapy that utilizes artistic expression as its core means of treating clients. Expressive therapists use the different disciplines of the creative arts as therapeutic interventions. This includes the modalities dance therapy, drama therapy, art therapy, music therapy, writing therapy, among others. Expressive therapists believe that often the most effective way of treating a client is through the expression of imagination in a creative work and integrating and processing what issues are raised in the act.

Narrative Therapy

Narrative therapy gives attention to each person's "dominant story" by means of therapeutic conversations, which also may involve exploring unhelpful ideas and how they came to prominence. Possible social and cultural influences may be explored if the client deems it helpful.

Integrative Psychotherapy

Integrative Psychotherapy represents an attempt to combine ideas and strategies from more than one theoretical approach. These approaches include mixing core beliefs and combining proven techniques. Forms of integrative psychotherapy include multimodal therapy, the transtheoretical model, cyclical psychodynamics, systematic treatment selection, cognitive analytic therapy, Internal Family Systems Model, multitheoretical psychotherapy and conceptual interaction. In practice, most experienced psychotherapists develop their own integrative approach over time.

Hypnotherapy

Hypnotherapy is therapy that is undertaken with a subject in hypnosis. Hypnotherapy is often applied in order to modify a subject's behavior, emotional content, and attitudes, as well as a wide range of conditions including dysfunctional habits, anxiety, stress-related illness, pain management, and personal development.

Adaptations for children

Counseling and psychotherapy must be adapted to meet the developmental needs of children. Many counseling preparation programs include courses in human development. Since children often do not have the ability to articulate thoughts and feelings, counselors will use a variety of media such as crayons, paint, clay, puppets, bibliocounseling (books), toys, board games, et cetera. The use of play therapy is often rooted in psychodynamic theory, but other approaches such as Solution Focused Brief Counseling may also employ the use of play in counseling. In many cases the counselor may prefer to work with the care taker of the child, especially if the child is younger than age four.

Criticisms and questions regarding effectiveness

Within the psychotherapeutic community there has been some discussion of empirically-based psychotherapy, e.g. Virtually no comparisons of different psychotherapies with long follow-up times have been carried out. The Helsinki Psychotherapy Study is a randomized clinical trial, in which patients are monitored for 12 months after the onset of study treatments, of which each lasted approximately 6 months. The assessments are to be completed at the baseline examination and during the follow-up after 3, 7, and 9 months and 1, 1.5, 2, 3, 4, 5, 6, and 7 years. The final results of this trial are yet to be published since follow-up evaluations will continue up to 2009.

There is considerable controversy over which form of psychotherapy is most effective, and more specifically, which types of therapy are optimal for treating which sorts of problems. The dropout level is quite high; one meta-analysis of 125 studies concluded that the mean dropout rate was 46.86%. The high level of dropout has raised some criticism about the relevance and efficacy of psychotherapy.

Psychotherapy outcome research—in which the effectiveness of psychotherapy is measured by questionnaires given to patients before, during, and after treatment—has had difficulty distinguishing between the success or failure of the different approaches to therapy. Those who stay with their therapist for longer periods are more likely to report positively on what develops into a longer-term relationship. This suggests that some "treatment" may be open-ended with concerns associated with ongoing financial costs.

As early as 1952, in one of the earliest studies of psychotherapy treatment, Hans Eysenck reported that two thirds of therapy patients improved significantly or recovered on their own within two years, whether or not they received psychotherapy.

Many psychotherapists believe that the nuances of psychotherapy cannot be captured by questionnaire-style observation, and prefer to rely on their own clinical experiences and conceptual arguments to support the type of treatment they practice.

In 2001 Bruce Wampold of the University of Wisconsin published "The Great Psychotherapy Debate". In it Wampold, a former statistician who went on to train as a counseling psychologist, reported that

1. Psychotherapy is indeed effective,
2. The type of treatment is *not* a factor,
3. The theoretical bases of the techniques used as well as the strictness of adherence to those techniques are both *not* factors,
4. The therapist's strength of belief in the efficacy of the technique *is* a factor,
5. The therapist as a person is a *large* factor,
6. The alliance between the patience and the therapist (meaning affectionate and trusting feelings toward the therapist, motivation and collaboration of the client, and empathic response of the therapist) is a *key* factor.

Wanpold therefore concludes that "we do not know why psychotherapy works".Although the Great Psychotherapy Debate dealt primarily with data on depressed patients, subsequent articles have made similar findings for post-traumatic stress disorder and youth disorders.

Some report that by attempting to program or manualize treatment psychotherapists may actually be reducing efficacy, although the unstructured approach of many psychotherapists cannot appeal to patients motived to solve their difficulties through the application of specific techniques different from their past "mistakes."

Critics of psychotherapy are skeptical of the healing power of a psychotherapeutic relationship. Since any intervention takes time, critics note that the passage of time alone, without therapeutic intervention, often results in psycho-social healing. Social contact with others is universally seen as beneficial for all humans and regularly scheduled visits with anyone would be likely to diminish both mild and severe emotional difficulty.

Many resources available to a person experiencing emotional distress—the friendly support of friends, peers, family members, clergy contacts, personal reading, research, and independent coping—-present considerable value. Critics note that humans have been dealing with crises, navigating severe social problems and finding solutions to life problems long before the advent of psychotherapy. Of course, it may well be something in the patient that does not develop these "natural" supports that requires therapy.

Further critiques have emerged from feminist, constructionist and discursive sources. Key to these is the issue of power. In this regard there is a concern that clients are persuaded—both inside and outside of the consulting room—to understand themselves and their difficulties in ways that are consistent with therapeutic ideas. This

means that alternative ideas (e.g., feminist, economic, spiritual) are sometimes implicitly undermined. Critics suggest that we idealize the situation when we think of therapy only as a helping relation. It is also fundamentally a political practice, in that some cultural ideas and practices are supported while others are undermined or disqualified. So, while it is seldom intended, the therapist-client relationship always participates in society's power relations and political dynamic

Module 7: Coaching in Counseling

Coaching is a method of directing, instructing and training a person or group of people, with the aim to achieve some goal or develop specific skills. There are many ways to coach, types of coaching and methods to coaching. Direction may include motivational speaking. Training may include seminars, workshops, and supervised practice.

Origins of Coaching

Today coaching plays an important role in human resource development (HRD) and life help, and the field of coaching as a distinct area of study is rapidly gaining ground. Although the role of coach has changed over time, some examples of research papers on business coaching show that between the late 1930s and the late 1960s, some forms of internal coaching in organizations were already present; i.e. managers (or supervisors) also acted as coaches to their staff (cf. Zeus & Skiffington, 2002; Grant, 2003a; 2006). Gorby (1937) specified how older employees were trained to coach new employees regarding methods of waste reduction.

The evolution of this formal discipline has been influenced by and enhanced through the incorporation of pertinent maxims from other fields of study including personal development philosophies, adult education practices, elements of psychology (sports, clinical, developmental, organizational, social and industrial) and other organizational or leadership principles. Since the mid 1970's, coaching has developed into a more independent discipline and has a set of training standards (Davidson & Gasiorowski, 2006).

It is important for future clients to distinguish between coaches who are professionally trained and/or accredited and those who "hang their name plate" out as a coach. Professional coaching skills are transferable across the variety of areas in which a coach may be employed. Whitworth, et al. (1998) stated that "the coaches experience is confined to the coaching process. The coaches job is to help clients articulate their dreams, desires and aspirations, help them clarify their mission, purpose and goals, and help them achieve that outcome" (p.5) in any area of life (i.e. personal, professional, relationship, health etc.)

Recent practices in performance coaching for non-sporting environments focus on non-directive questioning, provocation and helping clients to analyze and solve their own challenges, rather than offering advice or direction.

Kinds of Coaching

Life Coaching

Life coaching is a practice with the aim of helping clients determine and achieve personal goals. Life coaches use multiple methods that will help clients with the process of setting and reaching goals. Coaching is not targeted at psychological illness and coaches are neither therapists nor consultants.

Life coaching has its roots in executive coaching, which itself drew on techniques developed in management consulting and leadership training. Life coaching also draws inspiration from disciplines including sociology, psychology, positive adult development, career counseling, mentoring and other types of counseling. Contemporary life coaching can also be traced to the teachings of Benjamin Karter, a college football coach turned motivational speaker of the late seventies and early eighties The coach may apply mentoring, values assessment, behavior modification, behavior modeling, goal-setting and other techniques in helping their clients.

Government bodies have not found it necessary to provide a regulatory standard for life coaching, nor does any state body govern the education or training standard for the life coaching industry; the title of "coach" can be used by any service provider. Multiple coaching schools and training programs are available, allowing for many options (and sometimes causing confusion) when an individual decides to gain "certification" or a "credential" as they apply to the coaching industry. Multiple certificates and credential designations are available within the industry.

Some assert that life coaching is akin to psychotherapy without restrictions, oversight or regulation. The State legislature of Colorado, after holding a hearing on such concerns, disagreed, asserting that coaching is unlike therapy because it does not focus on examining nor diagnosing the past. Instead coaching focuses on effecting change in a client's current and future behavior. Additionally, life coaching does not delve into diagnosing mental illness or dysfunction.

According to a survey of coaching clients, "sounding board" and "motivator" were the top roles selected for a coach. Clients are looking for a coach "to really listen to them and give honest feedback." The top three issues in which clients seek help are time management, career and business.

Business Coaching

Business coaching is the practice of providing positive support and positive feedback while offering occasional advice to an individual or group in order to help them recognize ways in which they can improve the effectiveness of their business. Coaching is an excellent way to attain a certain work behavior that will improve leadership, employee accountability, teamwork, sales, communication, goal setting, strategic planning and more. It can be provided in a number of ways, including one-on-one, group coaching sessions and large scale [seminars]. Many corporations are instilling the practice of 360 degree coaching, which permits employees to utilize their own life or professional experiences in a positive way to create team participation attitudes even with superiors. Professional Business Coaches are often called in when a business is perceived to be performing badly, however many businesses recognize the benefits of business coaching even when the organization is successful. Business coaches often specialize in different practice areas such as executive coaching, corporate coaching and leadership coaching.

At least two organizations, the International Coaching Council (ICC) and the Worldwide Association of Business Coaches (WABC) provide a membership-based association for professionals involved in business coaching. The ICC and WABC also provide an accrediting system for business coach training programs. The ICC currently has over 1,500 members from over 50 countries. WABC has created the only international accreditation programs for business coach training providers and international certification programs for business coaches that are designed exclusively for business coach trainers and coaches, built around business coaching competencies and conferred by a business coach association. Business coaching is not the same as mentoring. Mentoring involves a developmental relationship between a more experienced "mentor" and a less experienced partner, and typically involves sharing of advice. A business coach can act as a mentor given that he or she has adequate expertise and experience. However, mentoring is not a form of business coaching. A good business coach need not have specific business expertise and experience in the same field as the person receiving the coaching in order to provide quality business coaching services. Business coaching needs to be more structured and formal than mentoring.

Business coaches often help businesses grow by creating and following a structured, strategic plan to achieve agreed upon goals. Multiple organizations train professionals to offer business coaching to business owners who may not be able to afford large coaching firm prices.

Coaching is not a practice restricted to external experts. Many organizations expect their senior leaders and middle managers to coach their team members toward higher levels of performance, increased job satisfaction, personal growth, and career development. Those that do back up their expectations with training in coaching skills, access to feedback tools, and/or specific coaching behaviors described in their leadership competency models. Few link coaching activities to compensation, however, resulting in less coaching by managers.

Personal Coaching

Personal coaching is a relationship which is designed and defined in a relationship agreement between a client and a coach. It is based on the client's expressed interests, goals and objectives.

A professional coach may use inquiry, reflection, requests and discussion to help clients identify personal and/or business and/or relationship goals, develop strategies, relationships and action plans intended to achieve those goals. A coach provides a place for clients to be held accountable to themselves by monitoring the clients' progress towards implementation of their action plans. Together they evolve and modify the plan to best suit the client's needs and environmental relationships. Coaches often act as human mirrors for clients by sharing outside and unbiased perspectives. Coaches may teach specific insights and skills to empower the client toward their goals.

Clients are responsible for their own achievements and success. The client takes action, and the coach may assist, but never leads or does more than the client. Therefore, a coach cannot and does not promise that a client will take any specific action or attain specific goals.

Professional coaching is not counseling, therapy or consulting. These different skill sets and approaches to change may be adjunct skills and professions.

Health Coaching

In the world of health and wellness, a health coach is an emerging new role. Health coaching is becoming recognized as a new way to help individuals "manage" their illnesses and conditions, especially those of a chronic nature. In both sports and health, a "coach" is a person who observes, gives objective feedback, teaches, helps to develop a plan of action and holds another responsible for their actions and commitments. The coach will use special techniques, personal experience, expertise and encouragement to assist the coachee in bringing his/her behavioral changes about.

Sports Coaching

In sports, a coach or manager is an individual involved in the direction, instruction and training of the operations of a sports team or of individual sportspeople. This type of coach gets involved in all the aspects of the sport, including physical and mental player development. Sports coaches train, develop and mentor their athletes to become better at the physical components of the game. The coach is assumed to know more about the sport, and have more previous experience and knowledge. The coach’s job is to transfer as much of this knowledge and experience to the players to develop the most skilled athletes.

Combining these aspects of the sport, the coach is accountable for the overall performance and results of the team or player.

Dating Coaching

Dating coaches are coaches whose job is to direct and train people to improve their success in dating and relationships. A dating coach directs and trains his/her clients on various aspects of meeting and attracting long-term partners and meeting more compatible prospects. The focus of most programs is on confident and congruent communication. Dating coaches may focus on topics important to the art of dating: interpersonal skills, flirting, psychology, sociology, compatibility, fashion and recreational activities. Neil Strauss in *The Game: Penetrating the Secret Society of Pickup Artists* also focuses on neuro-linguistic programming (NLP), theories of persuasion, history and evolutionary biology, body language, humor and street smarts

Conflict Coaching

Conflict coaching may be used in an organizational context, for matrimonial and other relationship matters and is one of many conflict management tools for helping people improve their conflict management skills and abilities. Like many other techniques of this nature, it is premised on the view that conflict provides an opportunity to improve relationships, to create mutually satisfactory solutions and attain other positive outcomes when differences arise between and among people.

Transformational Coaching

A Transformational Life Coach incorporates many modalities available in meeting the needs of the client, from business best practices to personal growth to even spiritual matters. This help may increase awareness and success in transforming one's life. The new millennium has brought massive economic shifts for many people, creating a need for redefining their lives. People in transition often want to address deeper convictions about what they want out of life; they want more self awareness and self improvement. A transformational coach aims to bring together and highlight all the possibilities that will help mold and shape the visioneering process for clients as they create a plan and execute the daily, weekly, monthly and yearly details.

Call Center Coaching

One specialized form of Business Coaching is the coaching that is done for employees in call centers. This deserves a special call out because unlike other parts of an organization where business coaching may or may not be practiced on a regular basis, monitoring and coaching agents is often the centerpiece of the call center improvement strategy.

In call centers, agents are typically monitored and evaluated by members of a Quality Assurance (QA) team, but can also be monitored by their coach or manager. To effectively evaluate the agent, it is essential for the monitor to know how the call is supposed to be handled and to have a standardized form for assessing the agent's performance on the call. Either the monitor or the agent's coach will then give the agent feedback, while, ideally, listening to a recorded version of the call the agent was evaluated on to avoid disputes over how something was done.

Call Center Coaching, especially when it is part of a broader performance management system that includes elements such as performance metrics and an incentive programs can help individuals to improve their performance. If the agent is motivated to do well, the feedback should help the agent refine his or her performance.

However, Call Center Coaching as an organizational effectiveness strategy also has its weaknesses. One example of this weakness is that it relies on hope. The monitor/coach hopes the agent 1) remembers the feedback, say to be sure to tell customers to remove personal software before returning the game box and 2) does what he/she was coached on during the next call. An example of a stronger approach would be some kind of fail-safe or poka yoke to ensure the agent does not skip the step that reminds the customer to remove their software.

Another factor which limits the utility of call center coaching as an organizational effectiveness strategy is the high turnover in call centers. Call Center turnover fluctuates with the local and national economies, but it is not uncommon to see turnover in the thirty percent range. When turnover is high, your process improvement investment is walking out the door (quitting) every day. If the turnover is high enough, the coaching investment will either produce no discernible benefits or the benefits produced will have no Return on Investment.

Coaching Ethics and Standards

One of the challenges in the field of coaching is upholding levels of professionalism, standards and ethics. To this end, many of the coaching bodies and organisations have codes of ethics and member standards and criteria

according to which they hold their members accountable in order to protect coaching clients' interests. Examples of Codes of Ethics, include: ICF (International Coach Federation)http://www.coachfederation.org/Ethics/ AC (Association of Coaching)"Ethics" EMCC (European Mentoring and Coaching Council)"Ethics" WABC (World Association of Business Coaches)"Ethics" COMENSA (Coaches and Mentors of South Africa) "Code of Ethics"

Module 8: Mentorship in Counseling

Mentorship refers to a developmental relationship in which a more experienced or more knowledgeable person helps a less experienced or less knowledgeable person—who can be referred to as a **protégé**, or **apprentice** -- to develop in a specified capacity. (The coined word "mentee" is now the most widely used term, for example by mentornet.com. This word annoys purists but is found in dictionaries, all over the internet and in thousands of scholarly articles; "mentee" is the term that appears to communicate most readily.)

There are several definitions of mentoring in the literature. Foremost, mentoring involves communication and is relationship based. In the organizational setting, mentoring can take many forms. One definition of the many that has been proposed, is "Mentoring is a process for the informal transmission of knowledge, social capital, and the psychosocial support perceived by the recipient as relevant to work, career, or professional development; mentoring entails informal communication, usually face-to-face and during a sustained period of time, between a person who is perceived to have greater relevant knowledge, wisdom, or experience (the mentor) and a person who is perceived to have less (the protege)" (Bozeman, Feeney, 2007).

History of Mentorship

The roots of the practice are lost in antiquity. The word itself was inspired by the character of Mentor in Homer's *Odyssey*. Though the actual Mentor in the story is a somewhat ineffective old man, the goddess Athena takes on his appearance in order to guide young Telemachus in his time of difficulty.

Historically significant systems of mentorship include traditional Greek pederasty, the guru - disciple tradition practiced in Hinduism and Buddhism, Elders, the discipleship system practiced by Rabbinical Judaism and the Christian church, and apprenticing under the medieval guild system.

Typology in mentorship

There are two types of mentoring relationships: formal and informal. Informal relationships develop on their own between partners. Formal mentoring, on the other hand, refers to assigned relationships, often associated with organizational **mentoring programs** designed to promote employee development or to assist at-risk children and youth. Formal relationships can be seen as being forced as they are assigned relationships. As stated by Murray, "Formal dyads are assigned by a third party...and informal ones evolve spontaneously" (Buell, 2004). The formal mentoring relationship is structured in a fashion that can be better managed by a particular organization.

There are formal mentoring programs that are values-oriented, while social mentoring and other types focus specifically on career development. Some mentorship programs provide both social and vocational support. In well-designed formal mentoring programs, there are program goals, schedules, training (for both mentors and protégés), and evaluation. Mentoring is an activity that can potentially promote spiritual development.

There are many kinds of mentoring relationships from school or community-based relationships to e-mentoring relationships. These mentoring relationships vary and can be influenced by the type of mentoring relationship that is in effect. That is whether it has come about as a formal or informal relationship. Also there are several models have been used to describe and examine the sub-relationships that can emerge. For example, Buell (2004) describes how mentoring relationships can develop under a cloning model, nurturing model, friendship model and apprenticeship model. The cloning model is about the mentor trying to "produce a duplicate copy of him or her self." The nurturing model takes more of a "parent figure, creating a safe, open environment in which mentee can both learn and try things for him-or herself." The friendship model are more peers "rather than being involved in a

hierarchical relationship." Lastly, the apprenticeship is about less "personal or social aspects... and the professional relationship is the sole focus" (Buell, 2004). [1]

In 1990, MENTOR created *The Elements of Effective Practice*, a tool for state and local mentoring organizations matching mentors and youth protégés in formal mentoring relationships of all kinds. Revised and updated several years later with a companion toolkit, *The Elements* guidebook reflects the latest in mentoring research, policies, and practices.

New-hire Mentorship

For example, in some programs, newcomers to the organization (protégés) are paired with more experienced people (mentors) in order to obtain information, good examples, and advice as they advance. These programs are structured features designed to help train these less experienced individuals. It is considered that new employees who are paired with a mentor are twice as likely to remain in their job than those who do not receive mentorship.

There are many benefits of these mentorships. One is that networking occurs more easily and is a possible reason that those mentored tend to do well in organizations. As Pompper and Adams (2006) state, "joining a mentor's network and developing one's own is central to advancement." These mentoring relationships provide much substance for career growth, and benefits both the mentor and the mentee. For example, the mentor gets to show leadership by giving back and perhaps being refreshed about their own work. The person being mentored networks, becomes integrated easier in an organization, gets experience and advice along the way. The actual organization receives an employee that is being gradually introduced and shaped by the organization's culture and operation because they have been under the mentorship of an experienced member (Pompper, Adams, 2006).

As mentioned earlier, in the organizational setting mentoring usually "requires unequal knowledge"(Bozeman, Feeney, 2007). The process of mentorship can differ. However, Bullis (1989) describes the mentoring process in the forms of phase models. Initially, the "mentee proves himself or herself worthy of the mentor's time and energy." Then cultivation occurs which includes the actual "coaching...a strong interpersonal bond between mentor and mentee develops." Next, under the phase of separation " the mentee experiences more autonomy." Ultimately, there is more of equality in the relationship termed by Bullis as Redefinition (1989).

High-potential Mentorship

In other cases, mentoring is used to groom up-and-coming employees deemed to have the potential to move up into leadership roles. Here the employee (protégé) is paired with a senior level leader (or leaders) for a series of career-coaching interactions. A similar method of high-potential mentoring is to place the employee in a series of jobs in disparate areas of an organization, all for small periods of time, in anticipation of learning the organization's structure, culture, and methods. A mentor does not have to be a manager or supervisor to facilitate the process.

Mentorship in Education

In many secondary and post-secondary schools, mentorship programs are offered to support students in program completion, confidence building and transitioning to further education or the workforce. There are also many mentoring programs designed specifically to bring under-represented populations into science and engineering. One example is that of MentorNet-.

Blended Mentoring

The blended mentoring is a mix of on-site and online events, projected to give to career counselling and development services the opportunity to adopt mentoring in their ordinary practice. The use of this mentoring is the core objective of the EMPIRE project. In fact, Career guidance services have the potential to contribute significantly to the development of human capital. Nonetheless researches and policy reports (Career Guidance in

Europe's Public Employment Services, commissioned in 2005 by European Commission Directorate-General for Employment, Social Affairs and Equal Opportunities) have expressed concern that occupational information alone and traditional matching of people and jobs are not enough. Advances in the use of technology (cyber-counseling) and the introduction of new methodologies like mentoring could enrich the career counseling profession's contributions to individual development and expand access to a broader range of customers.

Reverse Mentoring

In the reverse mentoring situation, the mentee has more overall experience (typically as a result of age) than the mentor (who is typically younger), but the mentor has more knowledge in a particular area, and as such, reverses the typical constellation. Examples are when young internet or mobile savvy Millennial Generation teens train executives in using their high end Smart Phones. They in turn sometimes offer insight in business processes.

Module 9: Career Counseling

Career counseling may include provision of occupational information, modeling skills, written exercises, and exploration of career goals and plans. Career counseling can also involve the use of personality or career interest assessments, such as the Myers-Briggs Type Indicator or the Strong Interest Inventory, which makes use of Holland's theory.

- Counseling
- Clinical Behavioral Counseling Professional practice of behavior analysis

Career Counseling and career coaching are similar in nature to traditional counseling (Kim, Li, Lian, 2002). However, the focus is generally on issues such as career exploration, career change, personal career development and other career related issues (Swanson, 1995). Typically when people come for career counseling they know exactly what they want to get out of the process, but are unsure about how it will work (Galassi, Crace, Martin, James, and Wallace, 1992).

Guidance counselors offer students guidance—the discussion and information students need to make wise decisions regarding educational and career opportunities. Guidance counselors also offer students counseling—the help and support students need in dealing with personal stress and problems of adjustment. Although it is useful for purposes of description

Career counselors work with people from all walks of life such as adolescents looking to explore career options or with experienced professionals looking for a career change. Career counselors typically have a background in psychology, vocational psychology, or industrial/organizational psychology (Swanson & Parcover, 1998). The approach of career counseling varies by practitioner, but generally they include the completion of one or more assessments (Swanson & Parcover, 1998). These assessments typically include: interest inventories, cognitive ability tests, and personality assessments.

Challenges of career counseling/guidance

One of the major challenges associated with career counseling is encouraging participants to engage with it. For example in the UK 70% of under 14s say they have had no careers advice while 45% over 14s have had no or very poor/limited advice. Another issue is the spread of careers advice opportunities. For example, 40% of doctors in training found it difficult to get appropriate careers advice.

In a related issue some client groups tend to reject the interventions made by professional career counselors preferring to rely on the advice of peers or superiors within their own profession. Jackson et al found that 44% of doctors in training felt that senior members of their own profession were best placed to give careers advice. Furthermore it is recognized that the giving of career advice is something that is widely spread through a range of

formal and informal roles. In addition to career counselors it is also common for teachers, managers, trainers and HR specialists to give formal support in career choices. Similarly it is also common for people to seek informal support from friends and family around their career choices and to bypass career professionals altogether. Today increasingly people rely on career web portals to seek advice on resume writing and handling interviews; as also to research on various professions and companies.

Vocational Theories in career counselling

There are several types of theories of vocational choice and development. These types include trait factor theories, social cognitive theories, and developmental theories. Two examples of trait factor theories, also known as person-environment fit- are Holland's theory and Theory of Work Adjustment. Holland hypothesized six vocational personality/interest types and 6 work environment types: realistic, investigative, artistic, social, enterprising, and conventional. When a person's vocational interests match his or her work environment types, this is considered congruence. Congruence has been found to predict occupation and college major. The theory of work adjustment (TWA), as developed by Dawis and Lofquist, hypothesizes that the correspondence between a worker's needs and the reinforcer systems predicts job satisfaction, and that the correspondence between a worker's skills and a job's skill requirements predicts job satisfactoriness. Job satisfaction and satisfactoriness together should how long one remains at a job. When there is a discrepancy between a worker's needs or skills and the job's needs or skills, then change needs to occur either in the worker or the job environment.

Social Cognitive Career Theory (SCCT) has been proposed by Lent, Brown and Hackett. The theory takes Albert Bandura's work on self-efficacy and expands it into interest development, choice making, and performance. Person variables in SCCT include self-efficacy beliefs, outcome expectations, personal goals. The model also includes demographics, ability, values, and environment. Efficacy and outcome expectations are theorized to interrelate and influence interest development, which in turn influences choice goals, and then actions. Environmental supports and barriers also affect goals and actions. Actions lead to performance and choice stability over time.

Career development theories propose vocational models that include changes throughout the lifespan. Super's model proposes a lifelong five stage career development process. The stages are growth, exploration, establishment, maintenance, and disengagement. Throughout life, people have many roles that may differ in terms of importance and meaning. Super also theorized that career development is an implementation of self-concept. Gottfredson also proposed a cognitive career decision-making process that develops through the lifespan. The initial stage of career development is hypothesized to be the development of self-image in childhood, as the range of possible roles narrows using criteria such as sex-type, social class, and prestige. During and after adolescence, people take abstract concepts into consideration, such as interests.

Module 10: Rehabilitation Counseling

This focuses on helping people who have disabilities achieve their personal, career, and independent living goals through a counseling process. Rehabilitation Counselors can be found in private practice, in rehabilitation facilities, universities, schools, government agencies, insurance companies and other organizations where people are being treated for congenital or acquired disabilities with the goal of going to or returning to work.

Initially, rehabilitation professionals were recruited from a variety of human service disciplines, including public health nursing, social work, and school counseling. Although educational programs began to appear in the 1940s, it was not until the availability of federal funding for rehabilitation counseling programs in 1954 that the profession began to grow and establish its own identity.

Historically, rehabilitation counselors primarily served working-age adults with disabilities. Today, the need for rehabilitation counseling services extends to persons of all age groups who have disabilities..

Rehabilitation Counseling Careers

Many rehabilitation counselors work in a variety of arenas. The predominant placement of rehabilitation counselors are state rehabilitation programs as Vocational Counselors, social service agencies as Clinicians, and at the collegiate level as Disability Counselors/Specialists.

State Rehabilitation Programs: The predominant need for rehabilitation counselors is within federal/state funded vocational rehabilitation programs. The Veteran's Administration has its own vocational rehabilitation program. Federal/State Vocational Rehabilitation Programs are funded and regulated by Rehabilitation Services Administration (RSA), a division of the U.S Department of Education. Although policies vary from state to state, rehabilitation counselors who work in the federal/state systems typically must hold a masters degree in rehabilitation counseling, special education or a related field. Counselors in the federal/state Vocational Rehabilitation programs are required to be certified or be eligible to sit for the certification examination. People accepting employment in the federal/state Vocational Rehabilitation programs do so with the agreement they will meet these qualifications by a specified date to maintain employment.

College Disability Counselors/Specialists: By law all community colleges, colleges and universities are required to make reasonable accommodations for students with disabilities. To satisfy this requirement most collegial settings have a Disability Resources Center, a Special Needs Coordinator or a similar office. Staff are responsible for coordinating services that *may* include but are not limited to: Advocacy/liaison, Computer access, Counseling (academic, personal, vocational), Equipment loan, Information/referral services, In-service awareness programs, Notetakers, On campus orientation and mobility training for visually impaired students, Priority registration assistance, Readers, Scribes, Shuttle (on-campus), Sign language interpreters, Test proctoring/testing Accommodations, and Tutors.

Some adaptive technological accommodations *may* include but are not limited to: Adaptive computer technology (including voice activated and speech output), Assistive listening devices, Films/videotapes about disabilities, Kurzweil personal reader, Large print software,Print enlargers (CCTV), Raised-line drawing kit, Tactile map of campus, Talking calculators, Tape recorders/APH Talking Book Machine, TDD for hearing impaired, Wheelchair, Wheelchair access maps.

Students who have documentation proving their disability status and the staff are trained to access or have knowledge of the necessary services according the students' unique need. As the college level is different from the primary school system, the same services that a student may have received within a special education program in high school may not be required at the collegiate level. A wide variety of students with disabilities can be served, some examples are individuals with: learning disabilities, sensorial disabilities (hearing loss, vision loss, etc.), physical disabilities (cerebral palsy, etc.) and psychological disabilities.

Module 11: Credit /Debt Counseling

Credit/Debt Counseling is a process of offering education to consumers about how to avoid incurring debts that cannot be repaid. This process is actually more debt counseling than a function of credit education.

Credit counseling often involves negotiating with creditors to establish a debt management plan (DMP) for a consumer. A DMP may help the debtor repay his or her debt by working out a repayment plan with the creditor. DMPs, set up by credit counselors, usually offer reduced payments, fees and interest rates to the client. Credit counselors refer to the terms dictated by the creditors to determine payments or interest reductions offered to consumers in a debt management plan.

Common features of Debt Management Programs

After joining a DMP, the creditors will close the customer's accounts and restrict the accounts to future charges. The most common benefit of a DMP as advertised by most agencies is the consolidation of multiple monthly payments into one monthly payment, which is usually less than the sum of the individual payments previously paid by the customer. This is because credit cards banks will usually accept a lower monthly payment from a

customer in a DMP than if the customer were paying the account on their own. Some DMPs advertise that payments can be cut by 50%, although a reduction of 10-20% is more common.

The second feature of a DMP is a reduction in interest rates charged by creditors. A customer with a defaulted credit card account will often be paying an interest rate approaching 30%. Upon joining a DMP, credit card banks sometimes lower the annual percentage rates charged to 5-10%, and a few eliminate interest altogether. This reduction in interest allows the counseling agencies to advertise that their customers will be debt free in periods of 3-6 years, rather than the 20+ years that it would take to pay off a large amount of debt at high interest rates.

A third benefit offered by credit counseling agencies is the process of bringing delinquent accounts current. This is often called "reaging" or "curing" an account. This usually occurs after making a series of on-time payments through the debt management program as a show of good faith and commitment to completion of the program. For example, a client with an account with a monthly payment of $50 which has not been paid in two months might be considered by the creditor to be 60 days past due. After joining the DMP and making three consecutive monthly payments, the creditor could reage the account to reflect a current status. Thereafter the monthly payment due on the statements would be the monthly payment negotiated by the DMP, and the account report as current to the credit bureaus. This process does not eliminate the prior delinquencies from the credit bureau reports. It merely gives a fresh start and an opportunity for the client to begin building a positive credit history. Like all derogatory credit information, the passage of time will lessen the impact of the negative marks when credit scores are calculated.

Many educational facilities have begun to incorporate credit practice into the curriculum. Schools have been incorporating the Charge Large Board Game. Players or students now learn and practice using credit paying-off in cash. The different level credit cards and upgrading system (in the Charge Large game) makes for an incentive for players to use their credit card and paying them off in full. It is said by 2011, the Charge Large Board Game will be in 70% of colleges practiced during orientation and in the classroom setting. In addition, by 2011, the Charge Large Board Game will be in 65% of high schools throughout the United States. Therefore, students receive credit counseling prior to receiving any form of credit.

Module 12: Mediation in counseling

Mediation is a form of alternative dispute resolution (ADR) or "appropriate dispute resolution",which aims to assist two (or more) disputants in reaching an agreement. The parties themselves determine the conditions of any settlements reached— rather than accepting something imposed by a third party. The disputes may involve (as parties) states, organizations, communities, individuals or other representatives with a vested interest in the outcome.

Mediation, in a broad sense, consists of a cognitive process of reconciling mutually interdependent, opposed terms as what one could loosely call "an interpretation" or "an understanding of". The German philosopher Hegel uses the term 'dialectical unity' to designate such thought-processes. This article discusses the legal communications usage of the term. Other Wikipedia articles, such as Critical Theory, treat other usages or "senses" of the term "mediation," as for example cultural and biological.

Mediators use appropriate techniques and/or skills to open and/or improve dialogue between disputants, aiming to help the parties reach an agreement (with concrete effects) on the disputed matter. Normally, all parties must view the mediator as impartial. Disputants may use mediation in a variety of disputes, such as commercial, legal, diplomatic, workplace, community and family matters. A third-party representative may contract and mediate between (say) unions and corporations. When a workers' union goes on strike, a dispute takes place, and the corporation hires a third party to intervene in attempt to settle a contract or agreement between the union and the corporation.

Mediation is the only way assisted by one third, which promotes freedom of choice of protagonists in a conflict.

Mediator Codes of Conduct

The application of a code of conduct to the practice of mediation becomes problematic — due in part to the diverse number and type of practitioners in the field. A tendency exists for professional societies to develop their own codes of conduct, which apply to their own members. Examples of this in Australia include the mediation codes of conduct developed by the Law Societies of South Australia and Western Australia and those developed by organisations such as Institute of Arbitrators & Mediators Australia (IAMA) and LEADR for use by their members. Other organizations such as the American Center for Conflict Resolution Institute ([www.accri.org]) have developed both classroom and distance learning courses which subscribe to its mission of promoting peace through education. The CPR/Georgetown Ethics Commission (www.cpradr.org), the Mediation Forum of the Union International des Avocats, and the European Commission have also promulgated codes of conduct for mediators.

Writers in the field of mediation normally espouse a code of conduct that mirrors the underlying principles of the mediation process. In this respect some of the most common aspects of mediator codes of conduct include:

- a commitment to inform participants as to the process of mediation.
- the need to adopt a neutral stance towards all parties to the mediation, revealing any potential conflicts of interest.
- the requirement for a mediator to conduct the mediation in an impartial manner
- within the bounds of the legal framework under which the mediation is undertaken any information gained by the mediators should be treated as confidential.
- mediators should be mindful of the psychological and physical wellbeing of all the mediations participants.
- mediators should not offer legal advice, rather they should direct participants to appropriate sources for the provision of any advice they might need.
- mediators should seek to maintain their skills by engaging in ongoing training in the mediation process.
- mediators should practice only in those fields in which they have expertise gained by their own experience or training.

Uses of Mediation

One core problem in the dispute-resolution process involves the determination of what the parties actually dispute. Through the process of mediation participants can agree to the scope of the dispute or issues requiring resolution. Examples of this use of mediation in the Australian jurisdiction include narrowing the scope of legal pleadings and its use in industrial and environmental disputes.

Definition of the nature of a dispute can often clarify the process of determining what method will best suit its resolution.

One of the primary uses of mediation involves parties using the mediation process to define the issues, develop options and achieve a mutually-agreed resolution.

Australia has incorporated mediation extensively into the dispute-settlement process of family law and into the latest round of reforms concerning industrial relations under the WorkChoices amendments to the Workplace Relations Act.

Where prospects exist of an ongoing disputation between parties brought on by irreconcilable differences (stemming from such things as a clash of religious or cultural beliefs), mediation can serve as a mechanism to foster communication and interaction.

Mediation can function not only as a tool for dispute resolution but also as a means of dispute prevention. Mediation can be used to facilitate the process of contract negotiation by the identification of mutual interests and the promotion of effective communication between the two parties. Examples of this use of mediation can be seen in recent enterprise bargaining negotiations within Australia.

Governments can also use mediation to inform and to seek input from stakeholders in formulation or fact-seeking aspects of policy-making. Mediation in wider aspect can also serve to prevent conflict or to develop mechanisms to address conflicts as they arise.

Mediation as a method of dispute resolution

In the field of resolving legal controversies, mediation offers an informal method of dispute resolution, in which a neutral third party, the mediator, attempts to assist the parties in finding resolution to their problem through the mediation process. Although mediation has no legal standing *per se*, the parties can (usually with assistance from legal counsel) commit agreed points to writing and sign this document, thus producing a legally binding contract in some jurisdiction specified therein.

Mediation differs from most other conflict resolution processes by virtue of its simplicity, and in the clarity of its rules. It is employed at all scales from petty civil disputes to global peace talks. It is thus difficult to characterize it independently of these scales or specific jurisdictions - where 'Mediation' may in fact be formally defined and may in fact require specific licenses. There are more specific processes (such as peace process or binding arbitration or mindful mediation) referred to directly in the text.

Mediator roles and functions

Mediator functions are classified into a few general categories, each of which necessitates a range of specific interventions and techniques in carrying out a general function.

Creating favorable conditions for the parties' decision-making

Mediators can contribute to the settlement of disputes by creating favorable conditions for dealing with them. This can occur through:

- Providing an appropriate physical environment- this is through selection of neutral venues, appropriate seating arrangements, visual aids and security.
- Providing a procedural framework- this is through conduct of the various stages of mediation process. As the chair of the proceedings, they can establish basic ground rules, provide order, sequence and continuity. The mediators opening statement provides an opportunity to establish a structural framework, including the mediation guidelines on which the process will be based.
- Improving the emotional environment- this is a more subtle function and varies among mediations and mediators. They can improve the emotional environment through restricting pressure, aggression and intimidation in the conference room by providing a sense of neutrality and by reducing anxiety among parties.

Assisting the parties to communicate

People in conflict tend not to communicate effectively and poor communication can cause disputes to occur or escalate. For mediators to encourage communication efficiently, they themselves must be good communicators and practice good speaking and listening skills, pay attention to non-verbal messages and other signals emanating from the context of the mediation.

Facilitating the parties' negotiations

Mediators can contribute expertise and experience in all models and styles of negotiation so that the parties are able to negotiate more constructively, efficiently and productively. This function is prominent after the problem-defining stages of mediation and involves mediators bringing direction and finesse to the negotiation efforts of the parties. Mediators can also act as catalysts for creative problem solving, for example by brainstorming or referring to settlement options generated in analogous mediation experiences.

Functions of the parties

The functions of the parties will vary according to their motivations and skills, the role of legal advisers, the model of mediation, the style of mediator and the culture in which the mediation takes place. Legal requirements may also affect their roles. In New South Wales the Law Society has published *A guide to the rights and Responsibilities of participants*.

Preparation

Whether parties enter mediation of their own volition or because legislation obligates them to do so, they prepare for mediation in much the same way they would for negotiations, save that the mediator may supervise and facilitate their preparation. Mediators may require parties to provide position statements, valuation reports and risk assessment analysis. The parties may also be required to consent to an agreement to mediate before preparatory activities commence.

Disclosure of information

Agreements to mediate, mediation rules, and court-based referral orders may have requirements for the disclosure of information by the parties and mediators may have express or implied powers to direct them to produce documents, reports and other material. In court referred mediations parties usually exchange with each other all material which would be available through discovery or disclosure rules were the matter to proceed to hearing. This would include witness statements, valuations and statement accounts.

Party Participation

The objectives of mediation, and its emphasis on consensual outcomes, imply a direct input from the parties themselves. The mediation system will expect that parties attend and participate in the mediation meeting; and some mediation rules require a party, if a natural person, to attend in person. However, the process assesses party participation in overall terms, so a party failing to participate in the initial stages may make up for this later in the process.

Module 13: Conflict-Management and resolution counseling

Society perceives conflict as something that gets in the way of progress, as a negative symptom of a relationship that one should cure as quickly as possible (Boulle, 2005, p. 87). However within the mediation profession conflict is seen as a fact of life and when properly managed it can have many benefits for the parties and constituents (Bagshaw, 1999, p. 206, Boulle, 2005, p. 87). The benefits of conflict include the opportunity to renew relationships and make positive changes for the future. Mediation should be a productive process, where conflict can be managed and expressed safely (Bradford, 2006, p. 148). It is the mediator's responsibility to let the parties express their emotions entailed in conflict safely. Allowing the parties to express these emotions may seem unhelpful in resolving the dispute, but if managed constructively these emotions may help towards a better relationship between the parties in the future.

Measuring the effectiveness of Conflict Management

The ADR field has felt a need to define the effectiveness of dispute-resolution in a broad manner, including more than whether there was a settlement (Boulle, 2005, p. 88). Mediation as a field of dispute resolution recognized there was more to measuring effectiveness, than a settlement. Mediation recognised in its own field that party satisfaction of the process and mediator competence could be measured. According to Boulle (2005, p.88) surveys of those who have participated in mediation reveal strong levels of satisfaction of the process.

Benefits of mediation may include:

- discovering parties' interests and priorities
- healthy venting of emotions in a protected environment
- an agreement to talk about a set agenda
- identifying roles of the constituents, such as relatives and professional advisors
- knowledge of a constructive dispute resolution for use in a future dispute

Conflict Resolution

Conflict resolution is a range of methods for alleviating or eliminating sources of conflict. The term "conflict resolution" is sometimes used interchangeably with the term dispute resolution or alternative dispute resolution. Processes of conflict resolution generally include negotiation, mediation, and diplomacy. The processes of arbitration, litigation, and formal complaint processes such as ombudsman processes, are usually described with the term dispute resolution, although some refer to them as "conflict resolution." Processes of mediation and arbitration are often referred to as alternative dispute resolution.

Methods

There are many tools available to persons in conflict. How and when they are used depends on several factors (such as the specific issues at stake in the conflict and the cultural context of the disputants). In such cases a conflict atlas is used to show the major issues, which led to the conflict. The list of tools available to practitioners include negotiation, mediation, community building, advocacy, diplomacy, activism, nonviolence, critical pedagogy, prayer, and counseling. In real world conflict situations, which range in scale from kindergarten bullying to genocide, practitioners will creatively combine several of these approaches as needed. Additionally, practitioners will often specialize in a particular scale (e.g. interpersonal, community, or international), or a particular variety of conflict (such as environmental, religious, or organizational), and repertoires of tools they find most useful

Module 14: Reconciliation and Peace Building

Conciliation is an alternative dispute resolution (ADR) process whereby the parties to a dispute (including future interest disputes) agree to utilize the services of a conciliator, who then meets with the parties separately in an attempt to resolve their differences. He does this by lowering tensions, improving communications, interpreting issues, providing technical assistance, exploring potential solutions and bringing about a negotiated settlement.

Conciliation differs from arbitration in that the conciliation process, in and of itself, has no legal standing, and the conciliator usually has no authority to seek evidence or call witnesses, usually writes no decision, and makes no award.

Conciliation differs from mediation in that the main goal is to conciliate, most of the time by seeking concessions. In mediation, the mediator tries to guide the discussion in a way that optimizes parties needs, takes feelings into account and reframes representations.

In conciliation the parties seldom, if ever, actually face each other across the table in the presence of the conciliator.

Module 15: HIV/AIDS Counselling

Basic HIV counselling principles

The advent of HIV/Aids in the world has forced all of us to accept a paradigm shift from curing towards caring. Because we have no cure for HIV/Aids, we have to focus our interventions on caring for the physical as well as the psychological welfare of the HIV?positive individual and his or her significant others.

The HIV positive individual needs to find ways to live a psychologically healthy life after diagnosis. The need for counsellors to assist HIV positive individuals and their loved ones are so great, that we need to equip everyone in the helping professions with the necessary skills to be effective HIV/Aids counsellors.

“The single most important requirement to be an HIV/Aids counsellor, is to have compassion for another person's struggle to live beyond the confines of a disease, and the willingness and commitment to walk the walk with this person and his or her significant others.” (Johnson, in Van Dyk, 2001.)

The aims of counselling or helping a client must always be based on the needs of the client. The purpose of counselling is twofold: (1) to help clients manage their problems more effectively and develop unused or underused opportunities to cope more fully, and (2) to help and empower clients to become more effective self helpers in the future (Egan, 1998). Helping is about constructive change and making a substantive difference to the life of the client. But only the client can make that difference: the counsellor is merely an instrument to facilitate that process of change.

Qualities of an effective HIV counselor

To be an effective HIV/Aids counselor, you need the following qualities or values:

1. Respect
The belief that every person is a worthy being who is competent to decide what he or she really wants, has the potential for growth, and has the abilities to achieve what he or she really wants from life.

A counsellor can show his or her respect to clients in the following ways:

- Accept the client by showing unconditional positive regard. This means that you as counsellor accept the client as he or she is, irrespective of the client's values or behaviour and of whether you as counsellor approve of those values and behaviour or not. A judgemental counsellor who condemns clients or who makes clients feel that their sexual behaviour is offensive to the counsellor, will not be able to facilitate healing, and will only do harm.
- Respect the client's rights. Individuals have a right to be who they are, a right to their own feelings, beliefs, opinions and choices.
- Respect the uniqueness of each client.
- Refrain from judgement. Counsellors are there to help their clients, not to judge or to blame them. Since HIV?infected individuals often already feel that they are “guilty” or “bad” before counselling even starts, only non?judgmental attitudes on the part of the counsellor will facilitate understanding and growth.
- Remain serene and imperturbable and never react with embarrassment, shock or disapproval when people discuss painful situations or their sexual practices with you.

2. Genuineness and congruence
Genuineness refers to being honest and transparent in the counselling relationship. A genuine or congruent counsellor demonstrates the following values or behaviour:

- Be yourself. Be real and sincere.
- Be honest with yourself and your clients.
- Don't be patronising or condescending.
- Keep the client's agenda in focus. Don't pursue your own agenda or inflict yourself on others.
- Don't be defensive. Know your own strengths and weaknesses.
- Strive towards achieving openness and self?acceptance because these qualities will enable you to accept people whose behaviour conflicts with your own personal values. Remember that it is impossible to hide negative feelings from clients. No matter how hard you try to conceal them, clients will sense your incongruence.
- When clients react negatively to you or criticise you, examine the behaviour that might have caused the clients to think negatively.

3. Empowerment and self responsibility
One of the values underlying counselling should be the desire to empower clients to take responsibility for themselves and to identify, develop and use resources that will make them more effective agents of change in the counselling sessions as well as in their everyday lives. The empowerment of clients should be based on the following values:

- Accept the principle that the client knows himself or herself better than anyone else, and that he or she is therefore in the best position to explore, expose and understand the self.
- Believe in the clients' ability to change if they choose to do so. Trust clients' ability to manage their lives more effectively. It is the task of the counsellor to help clients to identify and use their resources.
- Refrain from "rescuing" the client. This means that you should not take responsibility for another person's feelings, choices or actions. Allow the client to take responsibility for him or herself.
- Help clients to see counselling sessions as work sessions. Only the client can make change happen. The counsellor can merely make suggestions about how the client might change.
- Help clients to become better problem solvers in their daily lives.

4. Confidentiality
Confidentiality in the counselling context is non?negotiable. A counsellor may under no circumstances disclose the HIV status or any other information to anybody without the express permission of the client. Confidentiality is an expression of the counsellor's respect for the client.

Basic communication skills in HIV Counseling

Since counselling is a conversation or dialogue between the counsellor and client, the counsellor needs certain communication skills in order to facilitate change.

The counsellor needs the following basic communication skills to do effective counselling:

1. Attending
Attending refers to the ways in which counsellors can be "with" their clients, both physically and psychologically. Effective attending tells clients that you are with them and that they can share their world with you. Effective attending also puts you in a position to listen carefully to what your clients are saying. The acronym **SOLER** can be used to help you to show your inner attitudes and values of respect and genuineness towards a client (Egan.)

S: Squarely face your client. Adopt a bodily posture that indicates involvement with your client. (A more angled position may be preferable for some clients - as long as you pay attention to the client.) A desk between you and your client may, for instance, create a psychological barrier between you.

O: Open posture. Ask yourself to what degree your posture communicates openness and availability to the client. Crossed legs and crossed arms may be interpreted as diminished involvement with the client or even unavailability or remoteness, while an open posture can be a sign that you are open to the client and to what he or she has to say.

L: Lean toward the client (when appropriate) to show your involvement and interest. To lean back from your client may convey the opposite message.

E: Eye contact with a client conveys the message that you are interested in what the client has to say. If you catch yourself looking away frequently, ask yourself why you are reluctant to get involved with this person or why you feel so uncomfortable in his or her presence. Be aware of the fact that direct eye contact is not regarded as acceptable in all cultures.

R: Try to be relaxed or natural with the client. Don't fidget nervously or engage in distracting facial expressions. The client may begin to wonder what it is in himself or herself that makes you so nervous! Being relaxed means

that you are comfortable with using your body as a vehicle of personal contact and expression and for putting the client at ease.

Effective attending puts counsellors in a position to listen carefully to what their clients are saying or not saying.

2. Listening

Listening refers to the ability of counsellors to capture and understand the messages clients communicate as they tell their stories, whether those messages are transmitted verbally or nonverbally.

Active listening involves the following four skills:

- Listening to and understanding the client's verbal messages. When a client tells you his or her story, it usually comprises a mixture of experiences (what happened to him or her), behaviours (what the client did or failed to do), and affect (the feelings or emotions associated with the experiences and behaviour). The counsellor has to listen to the mix of experiences, behaviour and feelings the client uses to describe his or her problem situation. Also "hear" what the client is not saying.
- Listening to and interpreting the client's nonverbal messages. Counsellors should learn how to listen to and read nonverbal messages such as bodily behaviour (posture, body movement and gestures), facial expressions (smiles, frowns, raised eyebrows, twisted lips), voice?related behaviour (tone, pitch, voice level, intensity, inflection, spacing of words, emphases, pauses, silences and fluency), observable physiological responses (quickened breathing, a temporary rash, blushing, paleness, pupil dilation), general appearance (grooming and dress), and physical appearance (fitness, height, weight, complexion). Counsellors need to learn how to "read" these messages without distorting or over?interpreting them.
- Listening to and understanding the client in context. The counsellor should listen to the whole person in the context of his or her social settings.
- Listening with empathy. Empathic listening involves attending, observing and listening ("being with") in such a way that the counsellor develops an understanding of the client and his or her world. The counsellor should put his or her own concerns aside to be fully "with" their clients.

Active listening is unfortunately not an easy skill to acquire. Counsellors should be aware of the following hindrances to effective listening (Egan, 1998):

- Inadequate listening: It is easy to be distracted from what other people are saying if one allows oneself to get lost in one's own thoughts or if one begins to think what one intends to say in reply. Counsellors are also often distracted because they have problems of their own, feel ill, or because they become distracted by social and cultural differences between themselves and their clients. All these factors make it difficult to listen to and understand their clients.
- Evaluative listening: Most people listen evaluatively to others. This means that they are judging and labelling what the other person is saying as either right/wrong, good/bad, acceptable/unacceptable, relevant/irrelevant etc. They then tend to respond evaluatively as well.
- Filtered listening: We tend to listen to ourselves, other people and the world around us through biased (often prejudiced) filters. Filtered listening distorts our understanding of our clients.
- Labels as filters: Diagnostic labels can prevent you from really listening to your client. If you see a client as "that women with Aids", your ability to listen empathetically to her problems will be severely distorted and diminished.
- Fact?centred rather than person?centred listening: Asking only informational or factual questions won't solve the client's problems. Listen to the client's whole context and focus on themes and core messages.
- Rehearsing: If you mentally rehearse your answers, you are also not listening attentively. Counsellors who listen carefully to the themes and core messages in a client's story always know how to respond. The response may not be a fluent, eloquent or "practised" one, but it will at least be sincere and appropriate.
- Sympathetic listening: Although sympathy has it's place in human transactions, the "use" of sympathy is limited in the helping relationship because it can distort the counsellor's listening to the client's story. To sympathise with someone is to become that person's "accomplice". Sympathy conveys pity and even complicity, and pity for the client can diminish the extent to which you can help the client.

3. Basic empathy

- Basic empathy involves listening to clients, understanding them and their concerns as best as we can, and communicating this understanding to them in such a way that they might understand themselves more fully and act on their understanding (Egan, 1998).
- To listen with empathy means that the counsellor must temporarily forget about his or her own frame of reference and try to see the client's world and the way the client sees him or herself as though he or she were seeing it through the eyes of the client.
- Empathy is thus the ability to recognise and acknowledge the feelings of another person without experiencing those same emotions. It is an attempt to understand the world of the client by temporarily "stepping into his or her shoes".
- This understanding of the client's world must then be shared with the client in either a verbal or non-verbal way.

Some of the stumbling blocks to effective empathy are the following:

- Avoid distracting questions. Counsellors often ask questions to get more information from the client in order to pursue their own agendas. They do this at the expense of the client, i.e. they ignore the feelings that the client expressed about his or her experiences.
- Avoid using clichés. Clichés are hollow, and they communicate the message to the client that his or her problems are not serious. Avoid saying: "I know how you feel" because you don't.
- Empathy is not interpreting. The counsellor should respond to the client's feelings and should not distort the content of what the client is telling the counsellor.
- Although giving advice has its place in counselling, it should be used sparingly to honour the value of self?responsibility.
- To merely repeat what the client has said is not empathy but parroting. Counsellors who "parrot" what the client said, do not understand the client, are not "with" the client, and show no respect for the client. Empathy should always add something to the conversation.
- Empathy is not the same as sympathy. To sympathise with a client is to show pity, condolence and compassion - all well?intentioned traits but not very helpful in counselling.
- Avoid confrontation and arguments with the client.

4. Probing or questioning

Probing involves statements and questions from the counsellor that enable clients to explore more fully any relevant issue of their lives. Probes can take the form of statements, questions, requests, single word or phrases and non-verbal prompts.

Probes or questions serve the following purposes:

- to encourage non-assertive or reluctant clients to tell their stories
- to help clients to remain focussed on relevant and important issues
- to help clients to identify experiences, behaviours and feelings that give a fuller picture to their story, in other words, to fill in missing pieces of the picture
- to help clients to move forward in the helping process
- to help clients understand themselves and their problem situations more fully

Keep the following in mind when you use probes or questions:

- Use questions with caution.
- Don't ask too many questions. They make clients feel "grilled", and they often serve as fillers when counsellors don't know what else to do.
- Don't ask a question if you don't really want to know the answer!
- If you ask two questions in a row, it is probably one question too much.

- Although close-ended questions have there place, avoid asking too many close-ended questions that begin with “does”, “did”, or “is”.
- Ask open-ended questions - that is, questions that require more than a simple yes or no answer. Start sentences with: “how”, “tell me about”, or “what”. Open-ended questions are non-threatening and they encourage description.

5. Summarising

It is sometimes useful for the counsellor to summarise what was said in a session so as to provide a focus to what was previously discussed, and so as to challenge the client to move forward. Summaries are particularly helpful under the following circumstances:

- At the beginning of a new session. A summary of this point can give direction to clients who do not know where to start; it can prevent clients from merely repeating what they have already said, and it can pressure a client to move forwards.
- When a session seems to be going nowhere. In such circumstances, a summary may help to focus the client.
- When a client gets stuck. In such a situation, a summary may help to move the client forward so that he or she can investigate other parts of his or her story.

6. Integrating communication skills

Communication skills should be integrated in a natural way in the counselling process. Skilled counsellors continually attend and listen, and use a mix of empathy and probes to help the client to come to grips with their problems. Which communication skills will be used and how they will be used depends on the client, the needs of the client and the problem situation.

The eight commandments of emotional support

Pierre Brouard's eight commandments of emotional support can be applied by HIV/Aids counsellors.

1. Be non-judgemental
2. Be empathetic
3. Don’t give advice
4. Don’t ask why
5. Don’t take responsibility for the other person’s problems
6. Don’t interpret
7. Stick with the here and now
8. Deal with feelings first

Pre- and post- HIV test counseling

The HIV test is different from all other tests. It has phenomenal emotional, psychological, practical and social implications for the client.

- The HIV test is different from all other tests.
- It has phenomenal emotional, psychological, practical and social implications for the client.
- HIV testing should therefore never be done without thorough pre-test counseling.
- Pre-test counselling that is done in a proper and comprehensive way prepares the client and counsellor for more effective post-test counselling.
- Because clients are often too relieved or shocked to take much information in during post-test counselling, the health care professional should make use of the educational opportunities offered by pre-test counselling.
- Clients: although it may be difficult for you to go for pre-HIV test counselling, the psychological effects of being prepared by a professional for HIV testing far outweigh any possible “benefits” of privacy. Health care professionals are trained to do pre- and post-test counselling in a professional way and to keep all

information confidential. It is also your right as client to stay anonymous or to use a pseudo (or false) name when you go for testing.

According to the National Policy on Testing for HIV (published in August, 2000) nobody may be tested for HIV without their informed consent, and without proper pre- HIV test counselling.

Pre-HIV test counseling

The purpose of pre-test counselling is to provide you with information on the technical aspects of testing and the possible personal, medical, social, psychological, legal and ethical implications of being diagnosed as either HIV positive or HIV negative.

The purpose of pre-test counselling is further to find out why you want to be tested, the nature and extent of your previous and present high-risk behaviour, and the steps that need to be taken to prevent you from becoming infected or from transmitting HIV infection.

The counselor will usually follow the following guidelines in pre-test counseling:

1. Reasons for testing
The counselor will explore the reasons why you want to be tested:

Is it for insurance purposes, because of anxiety about lifestyle, or because you have been forced by somebody else to take the test? What particular behavior or symptoms are causing concern to you? Have you been tested before, and, if so, when? For what reason? And with what result?

These questions provide the counselor with an opportunity to ascertain your perceptions of your own high-risk behavior, and with allows you to assess whether you intend to be tested and whether your fears are realistic or if you are unnecessarily concerned. The following are some of the reasons that clients who want to be tested often give:

- Their partner has requested it.
- They want to determine their HIV status before starting a new relationship.
- They want to be tested prior to being married.
- They feel guilty and concerned about having multiple sex partners.
- They have had recent sexual encounters in which they did not use condoms.
- They are manifesting symptoms that are giving them cause for concern.
- They are been referred by a STI or TB clinic because the client has tuberculosis or a sexually transmitted infection.
- They have come to re-confirm a positive HIV test.
- Their current partner is HIV positive, or they were once involved with a partner who was HIV positive.
- They plan to become pregnant and want to check their HIV status before they do so.
- They have been raped or assaulted.
- They need to be tested after an occupational exposure (e.g. a needlestick).
- There are simply curious.

The reason why a client wants to be tested is important because it sets the scene for the rest of the pre-test counselling session.

2. Assessment of risk
The counsellor will assess the likelihood of whether you have been exposed to HIV by considering how much and how frequently you have been exposed to the following risk factors and lifestyle indicators:

- What is your sexual risk history in terms of frequency and type of sexual behaviour? Have you been involved in high-risk sexual practices such as vaginal or anal intercourse with more than one sex partner without the use of condoms? In the case of anal sex, was it anal-receptive or anal-insertive sex? Did you have sex with a sex worker (or prostitute) without a condom? Or is your sex partner HIV positive?
- Are there any other risks involved? Are you an intravenous drug user, a prisoner who is exposed to rape or unprotected sex in prison, a migrant worker, a refugee or a sex worker? Have your been raped or coerced to have sex with another person? Do you have another sexually transmitted infection or tuberculosis?
- Did you receive a blood transfusion or body products in a developing country where testing blood for HIV is not standard practice? Note: All blood supplies in South Africa are tested for HIV, and are very safe.
- Have you been exposed to possibly non-sterile invasive procedures such as tattooing, piercing or traditional invasive procedures such as male or female circumcision and scarification for the application of medicines?
- Have you been exposed to HIV-infected blood in the work situation? (E.g. injuries with large volumes of blood involved, or needlestick injuries.)

3. Beliefs and knowledge about HIV infection and safer sex

- The counsellor will determine exactly what you believe and know about HIV infection and Aids and he or she will correct errors or myths by providing accurate information about transmission and prevention.
- The counsellor may also ask you about your past and present sexual behaviour and provide information about safer sex practices and a healthier lifestyle. He or she should find out if you know how to practise safer sex and how to use a condom correctly. They will also supply you with condoms. Sex is natural and nothing to be ashamed of. Allow the counsellor to ask these questions, because that is the only way he or she can give you empowering information to enjoy sex safely.

4. Information about the test

The counsellor will ensure that you know exactly what the HIV test entails. The counsellor will explain the following points to you, and if he or she does not, you now know what questions to ask:

- There is a difference between being sero-positive and having Aids. The HIV antibody test is not a “test for Aids”. It indicates that a person has HIV antibodies in the blood and that the person is infected with HIV. It does not say when or how the infection occurred, or in what phase of infection the person is.
- The presence of HIV antibodies in the blood does not mean that the person is now immune to HIV. It means that he or she has been infected with HIV and that he or she can pass the virus on to others.
- The meaning of a positive and a negative test results.
- The meaning of the concept of the “window period”. The need for further testing will be emphasised if the person practises high-risk sexual behaviour and tests negative.
- The reliability of the testing procedures. A positive HIV antibody test result is always confirmed with a second test and the reliability of test results is usually high. False-positive or false-negative results may, however, occasionally occur despite the general reliability of HIV tests (e.g. a false negative test result because the person is in the window period).
- The testing procedure. Many clinics in South Africa use HIV antibody rapid tests, which means that the finger will be pricked to get a drop of blood. The results are available within 15 to 30 minutes. The counsellor will explain how blood is drawn for the Elisa test (if rapid testing is not available), where it is sent (if a rapid test is not used), when the results will be available and how the person will be informed of the outcome.

5. The implications of an HIV test result

The counsellor will discuss the possible personal, medical, social, psychological, ethical and legal implications of a positive test result with you prior to testing. He/she will inform you about all the advantages and disadvantages of testing. The following advantages can accrue from taking the test:

- Knowing the result may reduce the stress associated with uncertainty.
- One may begin to make rational plans for preparing oneself emotionally and spiritually to live with HIV.

- Symptoms can be confirmed, alleviated or treated.
- Prophylactic (preventative) treatment can be considered, for example for tuberculosis.
- Anti-retroviral treatment can be considered.
- Adjustments to one's lifestyle and sex life can protect oneself and one's sex partners from infection.
- One can make decisions about family planning and new sexual relationships.
- One can plan for future care of one's children.

The disadvantages that might accrue from taking an HIV test (especially if its result is positive) include:

- Possible limitations on life insurance and mortgages.
- Having to endure the social stigma associated with the disease.
- Possible problems in maintaining relationships and in making new friends.
- A possible refusal on the part of uninformed medical and dental personnel to treat an HIV-positive person. (A refusal to treat HIV-infected individuals of course goes against the provisions of the South African Constitution.)
- Possible dismissal from work (although it is illegal to dismiss people because they are HIV-positive).
- Possible rejection and discrimination by friends, family and colleagues.
- Emotional problems and a disintegration of one's life.
- Increased stress levels and uncertainty about the future.
- The stress and negative effects of maintaining a secret if the person decides not to disclose his or her test results.

The counsellor will tell you about medical treatments that are available which can help to keep you healthier for longer.

6. Anticipate the results

It is important to anticipate a positive HIV antibody result and to talk about how the client will deal with a positive test outcome. Anticipating a positive result helps the counsellor to ascertain the client's ability to deal with, and adjust to, a positive result. The counsellor also gains insight into some of the potential problems associated with a positive test outcome.

Preparation for the possibility of a positive test result, paves the way for more effective post-test counselling. In order to prepare you as client for the test result, the counsellor should ask the following questions:

- How would you feel if you tested negative? How would you feel if the test were to be negative but you were advised to be tested again because you may still be in the window period?
- What would your reactions and feelings be to a positive test? Would a positive test change your life? How? What negative changes would you anticipate? What positive changes can you imagine?
- Do you intend to tell others if you test positive? Who would you tell? Why that person? How would you tell them? Why would you tell them? Clients must be warned about people's possible reactions. Often those closest to the client cannot cope with such news. The counsellor must help clients to think not only of themselves but also of those who are to be told. (For example, if the client says to you: "The news will surely kill my old and frail mother", you may ask: "Why do you want your mother to know?"). Clients must also be warned that some people may not keep the information to themselves, and that this might have harmful effects for the client.
- How would you tell your sexual partner? If the test result is positive, the sexual partner also needs to be tested.
- How would a positive test result change the circumstances of your job, your family and your relationships? Would your relationships be improved or hindered by telling people you were HIV positive? What do you believe their reactions would be?
- Where would you seek medical help? How do you feel about a disease that requires a lot of care, lifestyle changes, commitment and discipline? Do you have members of your family or friends

who could help you to be disciplined about your health? Could you take medication every four hours if necessary?
- Who could provide (and is currently providing) emotional and social support (family, friends, others)?

The choice to be tested remains the client's prerogative. The advantages of testing can be explained to clients, but clients should not be forced to be tested if they feel that they will not be able to deal with the results. The mere knowledge of people's HIV status will not necessarily protect them, or their loved ones, from infection.

People who prefer not to be tested should, however, live as if they are infected and practise safer sex at all times. People who suspect they are HIV infected should also refrain from donating blood.

7. Confidentiality of test results
The counsellor should stress the confidentiality of test results. The client's right to confidentiality must be respected at all times. If individuals choose to remain anonymous, they must be reassured that no information will be communicated without their prior permission to anyone.

The client's consent must be obtained before anyone can pass on any information about his or her HIV status to any other health care professional who also treats the client. If the counsellor explains why other health care professionals need to know about the client's HIV status, most clients will consent to this information being given out.

8. Informed consent
The decision to be tested can only be made by the client and their informed consent must be obtained prior to testing. Consenting to medical testing or treatment has two elements: information and permission. Before an HIV test can be done, the client must understand the nature of the test, and he/she must also give verbal or written permission to be tested. A client may never be misled or deceived into consenting to an HIV test.

Note to health care professionals: According to the law, health care professionals may not do an HIV test on a person unless he or she clearly understands what the purpose of the test is, what advantages or disadvantages testing may hold for him or her as client, why the health care professional wants this information, what influence the result of such a test will have on his or her treatment, and how his or her medical protocol will be altered by this information.

9. Information about giving the results and ongoing support
The counsellor will explain to you when, how and by whom the results of the test will be given. The counsellor will assure you of personal attention, privacy, confidentiality and ongoing support and advice if needed.

10. The waiting period
Waiting for the results of an HIV antibody test can be an extremely stressful period for the client. This waiting period (in cases where the rapid HIV antibody test is not being used) can last from two to 14 days, depending on where the test was done (whether by a private practice, a governmental health service or a rural clinic).

The results of rapid HIV antibody tests are, of course, available within 30 minutes. However, if the client has to wait for the test results, the counsellor should anticipate this difficult waiting period by discussing the following points with the client:

- Find out the names of people whom the client might contact for moral support while he or she waits for the results.
- Encourage the client to contact you or a colleague if they have any questions.

- Counsel the client on how to protect sex partners (e.g. to use condoms) in the waiting period.
- Encourage the client to do something enjoyable to keep himself or herself occupied while waiting for the results (e.g. hiking, going to the movies or playing soccer with friends).

Note to counsellors: Pre-HIV test counselling is extremely important. It should not only be seen as a preparation for the HIV test, but as a golden opportunity to educate people about HIV/Aids and safer sex. Remember that this may be the one and only time that you will see the client because he or she might decide not to be tested, or not to come back for the test results after all.

Post-HIV test counselling

Not many things in life could be as stressful as going back for HIV test results. For many clients it feels as if the counsellor holds the key to the future in his or her hands.

Although the post-HIV test counselling interview is separate from the pre-test counselling interview, it is inextricably linked to it. The pre-test counselling interview should have given the client a glimpse of what to expect in post-test counselling. Pre- and post-test counselling should preferably be done by the same person because the established relationship between the client and counsellor provides a sense of continuity for the client. The counsellor will also have a better idea of how to approach the post-test counselling because of what he or she experienced in the pre-test counselling.

Counselling after testing will depend on the outcome of the test - which may be a negative result, a positive result or an inconclusive result.

The counsellor should always ask the client if he or she is prepared to receive the results. In the case of the rapid HIV antibody test - where the results are available within minutes - ask the client if he/she is ready to receive the results immediately. Some clients need time to prepare for the results.

Counselling after a negative HIV test result

- For both the client and the counsellor, a negative HIV result is a tremendous relief.
- A negative test result could however give someone, who is frequently involved in high-risk behaviour, a false sense of security. It is therefore extremely important for the counsellor to counsel HIV-negative clients in order to reduce the chances of future infection. Advice about risk reduction and safer sex must therefore be emphasised.
- If you practise high risk sex behaviour and test negative, it does not mean that you are “immune” to HIV and that precautions are therefore unnecessary. Nobody is immune to HIV and everyone risks being infected if they do not change their behaviour.
- The possibility that the client is in the “window period” or that the negative test result may be a false negative should also be pointed out. If there is concern about the HIV status of the person, he or she should return for a repeat test after about three months and ensure that appropriate precautions are taken in the meanwhile.

Note to councellors: Don’t underestimate the extreme importance of counselling a client who tested HIV negative. This may be your only chance to talk to this person about his or her sexual practices, potential drug abuse and other risk behaviours, and to educate him or her about safer sex practices. Free condoms can be given out at this session together with advice on how to use them and where to get more when needed. Use this counselling session to prevent a future situation where somebody else has to give the client a positive HIV test result!

Counselling after a positive HIV test result

To communicate a positive test result to a client is a huge responsibility. The way people react to test results depends to a large extent on how thoroughly the counsellor has educated and prepared them both before and after the test.

When a test is positive, the following guidelines for counselling may prove useful for counsellors:

1. Sharing the news with the client

- Positive (as well as negative) test results should be given to the client personally.
- Feedback should take place in a quiet, private environment and enough time should be allowed for discussion.
- The news of a positive result ought to be communicated openly, honestly and without fuss. Simple and straightforward language should be used. Do not give the individual false hopes and (alternatively) do not paint a hopeless scenario.
- Choose neutral words when conveying a positive HIV test result. Don't attach value to the news by saying "I have bad news for you" - because such an attitude reflects a hopelessness in the mind of the counsellor. Rather say: "Mr Peterson, the results of your HIV test came back, and you are HIV positive".
- A positive result is NOT a death sentence and the counsellor's task is to convey optimism and hope.
- There are a few Don'ts that we need to observe when sharing a positive HIV test result with a client.
    - Don't lie or dodge the issue.
    - Don't beat about the bush or use delaying tactics. Come to the point.
    - Don't break the news in a corridor or any other public place.
    - Don't give the impression of being rushed, distracted or distant.
    - Don't interrupt or argue.
    - Don't say that "nothing can be done" because something can always be done to ease suffering.
    - Don't react to anger with anger.
    - Don't say "I know how you feel" because you don't.
    - Don't be afraid to admit ignorance if you don't know something.

2. Client reaction to a positive HIV test result

- Clients' responses to the news usually vary from one person to another, and may include shock, crying, agitation, stress, guilt, withdrawal, anger and outrage - some clients may even respond with relief.
- The counsellor should allow clients to deal with the news in their own way and give them the opportunity to express their feelings.
- The counsellor should show empathy, warmth and caring.
- Maintain neutrality and respond professionally to outbursts. Don't show surprise or make value-laden comments such as "There is no need to be upset with me!" Because the loss of health is a bereavement, it manifests with all the components of denial, anger, bargaining, depression and acceptance. The counsellor must respect the personal nature of an individual's feelings.

3. Responding to client needs

- People's needs, when they receive an HIV positive test result, vary, and the counsellor has to determine what those needs are and deal with them accordingly.
- Fear of pain and death are often the most serious and immediate problems and these can be dealt with in various ways. Talking to clients about their fears for the future is one of the most important therapeutic interventions that the counsellor can make.
- Often it is enough for the counsellor just to be "there" for the client and to listen to him or her.
- One of the major concerns for HIV positive people is whom to tell about their condition and how to break the news. It is often helpful to use role-play situations in which the client can practise communicating the news to others.
- In responding to a client's needs, an attitude of non-judgmental empathic attentiveness is more important than doing or saying specific things. Listening is more important than talking; being with more important than doing.

4. Crisis intervention

- Crisis intervention is often necessary after an HIV positive test result is given
- Make sure that the person has support after he or she leaves your office. A person in crisis should never be left alone: he or she should have somebody with whom to share the burden.
- Ask the client where he or she is going after leaving your office. Let the person think about and verbalise his or her plans for the next few hours. Although it is better for the client not to be alone, personal needs should be taken into consideration: Some people prefer to be alone and work through a crisis all by themselves.
- Be sensitive to the possibility of suicide. If the client shows any suicidal tendencies, emergency hospitalisation should be arranged if a friend or family member cannot be with the client.
- Make sure that your client does not leave your office without support to help him or her through the first few days.
- Don't ever give an HIV-positive result on a Friday, because there are often no support systems available over weekends.

5. Follow-up visits

- When people hear that they are HIV positive, they usually experience so much stress that they absorb very little information.
- Follow-up visits are therefore necessary to give clients the opportunity to ask questions, talk about their fears and the various problems they encounter.
- Significant others, such as a lover, spouse or other members of the family, may be included in the session. During follow-up visits, clients should be offered a choice concerning their treatment.
- If health care professionals are not in a position to do follow-up counselling, information about relevant health services should be given. If there is a concern that the person might not return for follow-up counselling, information about available medical treatments such as anti-retroviral therapy, treatment of opportunistic infections, and social services for financial and ongoing emotional support should be given.
- Give the client a handout with whatever relevant information that he or she may need (such as the telephone numbers and addresses of Aids centres and other social services).

6. Support systems

- Find out what support systems are available to clients.
- Refer clients to support systems where people meet on a regular basis to talk about their difficulties or simply to relax and enjoy each other's company.
- Information about support systems such as the buddy system is usually available at the nearest Aids centre or from the offices of NGOs (non-governmental organisations) who work in the community.

7. Advice about health and sexuality

- Convey information about safer sex, infection control, health care in general and measures to strengthen the immune system.

8. Medical check-ups

- Encourage clients to go for regular medical check-ups to their family doctor or health clinic. Infections and opportunistic diseases can be prevented if treated in time.

Counselling after an indeterminate HIV test result

- In some cases an HIV test result can be "inconclusive", meaning that the result is ambiguous or indeterminate, and it is not possible at that stage to say if a person is HIV positive or not. (Explanation: A test result may be inconclusive because the test is cross-reacting with a non-HIV protein or because there has been insufficient time for full sero-conversion to occur since the person was exposed to HIV.)
- When a test result is inconclusive, other testing methods may be used to try to achieve a reliable result.

- The test can also be repeated after two weeks. If it is still inconclusive, it should be repeated at three, six and 12 months. If it is still inconclusive after one year, it should be accepted that the person is not infected with HIV.

Impact of HIV infection on affected significant others

The significant others in an HIV positive person's life often need help themselves to come to terms with (1) their own fears and prejudices and (2) the implications and consequences of their loved one's sickness and ultimate death.

The counsellor can play a tremendous role in counselling the lovers, friends and family of the HIV-positive person in the practicalities of physical and emotional care. Affected significant others experience more or less the same psycho-social feelings as do their HIV-positive loved ones – the same feelings of depression, loneliness, fear, uncertainty, anxiety, anger, emotional numbness and, at times, hope.

The impact of HIV infection on affected others can be summarised as follows:

- Affected others often experience fear and anxiety about their own risk of infection.
- They are often angry with the infected person for "bringing this onto them".
- They anticipate the loss of the HIV-positive person and issues of loss, bereavement and uncertainty are introduced into the relationship.
- They often feel unable to cope with the new demands that the infection place on them. They feel incompetent, unqualified and powerless in their interaction with the HIV-positive significant other.
- Responses to disclosure can range from involvement, caring and support on the one hand, to abandonment, indifference, and antagonism on the other.
- Affected others suffer in many ways as a result of untimely deaths. People who die of Aids are usually young (between 20 and 35 years old), and this leads to the "unnatural" situation where parents outlive their children. Grandparents who are preparing themselves for a quiet and contented old age now often find themselves forced to nurse and care for sick and dying children as well as grandchildren.
- Children suffer tremendously when their parents are infected, and the needs of children with infected parents are often neglected. There is no tradition of talking to children as equals and on an intimate basis in many African societies, and caregivers often report seeing "the suffering of children, who are too often hovering in the shadows of a sick room, seeing and hearing everything but never addressed directly".
- Significant others often have to fulfil a role for which they are not trained, namely that of caregiver. They have to look after serious ill loved ones.
- Neurological complications and deterioration in mental functioning in the client can be extremely disturbing to significant others. They may feel that they are already losing their loved ones and this can precipitate an early grieving process

Helping the infected person and affected significant others

The main function of the HIV/Aids counsellor is to be supportive of his of her infected and affected clients, to listen to their problems and to empower them to solve their problems and better their lives.

1. Support and empowerment

- Compile, with each client, a list of their problems, and let them reflect on what they want.
- Assist the client to identify possible solutions to these problems. Encourage clients to come up with their own solutions because clients will be more likely to implement solutions that they find feasible and practical.
- Ask the client to make a list of his or her good qualities and possible limitations. He or she should, for instance, list his or her coping skills, describe the level of his or her self-esteem, analyse his or her personality style, communication style, sense of humour - and any other strengths and weaknesses that may be important.

- Examine and discuss possible solutions to whatever problems the client may have identified. Assess each solution in terms of the client's actual capabilities and capacity. Refrain from giving advice and suggesting solutions.
- Ask the client to write down the answers to the following question: “Why must I go on living?” Once this has been done, encourage him or her to work toward those goals and to make new and longer-term goals along the way. Clients should set goals that will give them a sense of purpose and pride (goals such as “I want to see my children growing up”).
- Identify the ways in which clients have dealt successfully with their problems in the past and help them (if necessary) to develop new coping skills.
- Empower clients to make their own decisions and to take control over their lives wherever and whenever possible.
- Make a note of any relationship problems between the client and his or her loved ones, friends and family, as well as between the client and other health providers.
- Encourage the client to call on peer support (buddy systems) or self-help groups. The counsellor may also be able to put clients in touch with each other on an individual basis (with the consent of the individuals involved).

2. Peer support (buddy system)

Clients should be encouraged to become involved in support groups or to form their own groups if none exist in their communities. The following issues are usually dealt with in peer support groups:

- Learning to live with HIV infection. Many of the people involved in the peer support group, may have already gone through the process of living with HIV. They can describe the medical and psychological problems they have experienced and the interventions they found most useful.
- Helping caregivers and loved ones handle the daily pressure of caring for sick people.
- Reducing stress and avoiding conflict. Buddies can exchange practical advice on how to overcome anxiety, depression and other psychological problems that can lead to stress and conflict.
- Deciding how best to talk about HIV/Aids to loved ones, friend and colleagues. Disclosing a diagnosis of HIV can be particularly stressful, and buddies can share ideas on what to say, to whom, when and how.
- Dealing with feelings of loneliness, depression, powerlessness and suicide. The peer support group can provide help and mutual support. Advice from people who have actually experienced those feelings personally and who have coped with them successfully is more valuable than theoretical information.
- Advice about sexual relations and the implications of safer sex behaviour. Peer support groups can discuss all aspects of these problems and opportunities and give each other good advice about safer sex practices. Peer commitment to safer sex also helps to make these practices socially acceptable, attractive and sustainable.

Bereavement counselling

The bereavement experienced by a person who has lost a loved one and the bereavement experienced by a terminally ill or dying person are very similar.

Both people experience a grievous sense of loss: in the first case, one experiences the loss of a loved one, and in the second case, one experiences the loss of one’s future, one’s hopes, one’s loved ones, one’s health, self-esteem, well-being and one’s dignity as a human being. In either case, people are confronted with their own mortality.

Terminally ill persons are directly confronted by their own imminent death - the imminence of which becomes more pressing as the disease progresses – while persons who have lost a loved one are indirectly confronted with the possibility and spectacle of their own future death through the death of the loved one. It is therefore understandable that the process of bereavement is often very similar for both those who are dying and those who are forced to witness death.

In all cases where HIV-infected people are still leading relatively normal and healthy lives for extended periods, the counsellor needs to facilitate a process of reinvestment in life. This is also an important element in the counselling of a person who has lost or is in the process of losing a loved one.

Bereaved people should actively ***work through*** their grief in their own time. Bereavement is a process that cannot be rushed.

Kübler-Ross's stages of dying

Kübler-Ross identified the following "stages" of dying...

- **Denial and isolation:** *In this stage, the person denies that death is really going to take place.* This reaction is commonly associated with any kind of terminal illness. However, denial is usually only a temporary defence and is eventually replaced with increased awareness when the person is confronted with such matters as financial considerations, unfinished business and worry about surviving family members.
- **Anger:** *The dying person realises that denial can no longer be maintained, and very often, feelings of anger, resentment, rage and envy follow.* In this stage, the dying person wonders **"why"** he has to die. It can be difficult to care for a person in this stage since the anger can be displaced and projected onto the nurses, social worker, doctor, family member, etc. or even God. The realisation of loss becomes great, and those who symbolise life, energy, and competent functioning are especially salient targets of the dying person's resentment and jealousy.
- **Bargaining:** *In this phase, the dying person develops the hope that death can somehow be postponed or delayed.* Some persons enter into a bargaining or negotiation - often with God - as they try to delay their death. Psychologically the person is saying "Yes me, but...". In exchange for a few more days, weeks, or months of life, the person promises to lead a reformed life dedicated to God or to the service of others.
- **Depression:** *Here the dying person comes to accept the certainty of death.* This can be evident in several ways. The dying person may become silent, may refuse visitors, and may spend much of the time crying or grieving. This behaviour should be perceived as normal in these circumstances and is actually an effort to disconnect the self from all love objects. Efforts to cheer up the dying person at this stage should be discouraged, because the dying person has a need to contemplate impending death.
- **Acceptance:** *The dying person develops a sense of peace; an acceptance of one's fate; and, in many cases, a desire to be left alone.* In this stage, feelings and physical pain may be virtually absent. Kübler-Ross sees this stage as the end of the dying struggle, the final resting stage before death.

  Kübler-Ross never intended the stages to be an invariant sequence of steps toward death, and individual variation should be recognised.

The four tasks of mourning

According to Worden (1999) there are four tasks of mourning.

Accepting the reality of the loss: There are two aspects of death bereaved people must accept. The first one involves accepting that the person has died and will not come back. The second one involves facing the changes of the realities of life, brought about by the loss of a loved one.

Experiencing the pain of grief: Everyone who loses someone they love experiences the pain of grief. Sometimes society pressurises people who are in mourning to get on with their lives and not be preoccupied with the loss. This results in the bereaved feeling lonely, with no one to share the experiences - often complicating the grieving process. It is for this reason that the mental health provider must offer the bereaved a space to share their grief and to feel the pain.

Adjusting to an environment in which the deceased is missing: The bereaved can be assisted to living without the deceased person and to make decisions independently.

Emotionally relocating the loved one: The bereaved has to find a new place in his or her life for their lost loved one - a place that will allow him or her to move forward with life and form new relationships.

HIV/AIDS Counselling principles and procedures

Here are some useful counselling principles and procedures from Nefale (2001).

- Help the survivor **actualise** the loss
- Help the survivor to identify and express feelings
- Assist living without the deceased
- Facilitate emotional relocation of the deceased
- Provide time to grieve
- Interpret "normal" behaviour
- Allow for individual and cultural differences
- Provide continuing support
- Examine defences and coping styles
- Identify pathology and refer

Useful techniques in bereavement counselling

Counselling the loved ones of someone that has died from Aids or any terminal illness for that matter is a very difficult thing. Here are some useful techniques in bereavement counseling

Evocative language: The counsellor can use tough words to evoke language, e.g. "your son is dead" versus "you lost your son". This language will assist the client in perceiving the reality of the loss and can stimulate some of the painful feelings that need to be felt. Also speaking of the deceased in the past tense can be helpful.

The use of symbols: The counsellor can ask clients to bring photo's of the deceased to counselling sessions. This creates a sense of immediacy of the deceased and a concrete focus for talking **to** the deceased rather than talking **about** him/her. Letters written by the deceased can also be useful as well as audio/videotapes of the deceased. Articles of clothing and jewellery can also be used. The counsellor needs to be sensitive to the client's culture of doing things and deal with what the client is comfortable with.

Writing: The counsellor can ask the client to write a letter(s) to the deceased expressing thoughts and feelings. This can help take care of unfinished business by expressing things that need to be said to the deceased. Keeping a journal of one's grief experience or writing poetry can also facilitate the expression of feelings and lend personal meaning to the experience of loss.

Drawing: The counsellor can also ask the client to draw pictures that reflect his or her feelings as well as experiences held with the deceased. This works well with children, but can also be used with adults.

Role playing: The counsellor can assist the bereaved to role play various situations that they fear or feel awkward about, as one way to build coping skills. The counsellor can enter into the role play, either as a facilitator or to model possible new behaviours for the client.

Cognitive restructuring: The underlying assumption of the cognitive restructuring technique is that our thoughts influence our feelings, particularly covert thoughts and self-talk that constantly go on in our minds. By helping the client to identify these thoughts and reality test them for accuracy or overgeneralisations, the counsellor can help to lessen the dysphoric feelings triggered by certain irrational thoughts such as "no one will ever love me again".

Memory book: One activity a bereaved family can do together is to make a memory book of the lost family member. This book can include stories about family events and snapshots, poems and drawings made by various family members, including children. This activity can help the family to reminisce and eventually to mourn a more

realistic image of the dead person. In addition, children can go back to revisit this memory book in order to reintegrate the loss into their growing and changing lives.

Directed imagery: Helping the person to imagine the deceased, either with their eyes closed or visualising their presence in an empty chair and then encouraging them to say what they need to say to the deceased can be very powerful techniques. The power comes not from the imagery, but from being in the present and again, talking to the person, rather than talking about the person.

The purpose of all these techniques is to encourage the fullest expression of thoughts and feelings regarding the loss, including regrets and disappointment.

Voluntary Counseling and Testing

VCT for HIV usually involves two counseling sessions: one prior to taking the test known as "pre-test counseling" and one following the HIV test when the results are given, often referred to as "post-test counseling". Counseling focuses on the infection (HIV), the disease (AIDS), the test, and positive behavior change. VCT has become popular in many parts of Africa as a way for a person to learn their HIV status. VCT centers and counselors often use rapid HIV tests that require a drop of blood or some cells from the inside of one's cheek; the tests are cheap, require minimal training, and provide accurate results in about 15 minutes.

Circumcision and HIV

Over forty epidemiological studies have been conducted to investigate the **relationship between male circumcision and HIV infection**. Reviews of these studies have reached differing conclusions about whether circumcision could be used as a prevention method against HIV. Experimental evidence was needed to establish a causal relationship between lack of circumcision and HIV, so three randomized controlled trials were commissioned as a means to reduce the effect of any confounding factors. Trials took place in South Africa, Kenya and Uganda. All three trials were stopped early by their monitoring boards on ethical grounds, because those in the circumcised group had a lower rate of HIV contraction than the control group. The results showed that circumcision reduced vaginal-to-penile transmission of HIV by 60%, 53%, and 51%, respectively. A meta-analysis of the African randomised controlled trials found that the risk in circumcised males was 0.44 times that in uncircumcised males, and reported that 72 circumcisions would need to be performed to prevent one HIV infection. The authors also stated that using circumcision as a means to reduce HIV infection would, on a national level, require consistently safe sexual practices to maintain the protective benefit.

As a result of these findings, the WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) stated that male circumcision is an efficacious intervention for HIV prevention but should be carried out by well trained medical professionals and under conditions of informed consent (parents consent for their infant boys Both the WHO and CDC indicate that circumcision may not reduce HIV transmission from men to women, and that data is lacking for the transmission rate of men who engage in anal sex with a female partner. The joint WHO/UNAIDS recommendation also notes that circumcision only provides partial protection from HIV and should never replace known methods of HIV prevention.

Langerhans cells and HIV transmission

Langerhans cells are part of the human immune system. Three studies identified high concentrations of Langerhans and other "HIV target" cells in the foreskin and Szabo and Short suggested that the Langerhans cells in the foreskin may provide an entry point for viral infection. McCoombe, Cameron, and Short also found that the keratin is thinnest on the foreskin and frenulum. Van Howe, Cold and Storms criticised Szabo and Short's suggestion as "pure speculation. Fleiss, Hodges and Van Howe had previously stated a belief that the prepuce has an immunological function. Waskett criticized their specific hypothesis on technical grounds. A study published in 2007 by de Witte and others said that langerin, produced by Langerhans cells, is a natural barrier to HIV-1 transmission by Langerhans cells. Dowsett (2007) questioned why it was just males that were being encouraged to

circumcise: "Langerhans cells occur in the clitoris, the labia and in other parts of both male and female genitals, and no one is talking of removing these in the name of HIV prevention.

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African Population Institute
P. O. Box 10842, Kampala Uganda
Website: www.africapopulaation.net Email: info@africapopulation.net
Tel: +256-772/712/702-836998