NATIONAL OPEN UNIVERSITY OF NIGERIA

SCHOOL OF EDUCATION

COURSE CODE: EGC 812

COURSE TITLE: BEHAVIOUR MODIFICATION

COURSE GUIDE

Course Code **EGC 812**

Course Title **BEHAVIOUR MODIFICATION**

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EGC 812: EGC 812 is a semester, two credit unit course. It is a course for students who offer Masters degree in education guidance and counselling programme however, it is also a suitable course of study for anyone who wants to acquire some knowledge of how to live a normal and stress free life.

The Course

This course is made up of three modules. Each module comprises five units and in all, there are 15 units. As a master Degree student, one of the courses central to your profession is behaviour modification. This is because at the heart of guidance and counselling is your knowledge of how to correct abnormal behaviours in human organisms. Therefore, you need to equip yourself with major facts and how you can function effectively in this helping profession. You need to study it with all seriousness.

This Course Guide is a window into the course because it tells you briefly what the course is about, what course materials you will be using and how you can work your way through the materials. It suggests some general guidelines for the amount of time you should spend on each study unit of the course in order to complete it successfully. It also gives you some guidance on your tutor marked assignments (TMAs). Detailed information on TMAs is similarly made available. There are regular tutorial classes that are linked to the course. Though tutorial classes are not compulsory, but you are advised to attend these sessions.
Happy study.

What you will learn in this Course

This course EGC 812, titled Behaviour Modification, has been specifically designed to equip you with the knowledge of how to help and correct abnormal behaviour in human organisms and to the point that you should be able to discuss confidently on issues concerning behavior modifications in humans, especially in educational school environment and other situations.

In this regard, the course would highlight the importance of investigations and research in resolving issues and challenges in the study of Psychology through various theories.

- You will learn about the various methods of investigation in beahaviour modification which researchers adopt.
- You will learn about the different topics in behavior modification.
- You will learn about the causal factors in behavior modification in human organisms.
- More importantly you will be exposed to methods of conducting behaviour modification in human organisms.

Course Aims

It is hoped that after your degree, you will rise to certain influential leadership position as a counsellor in the education sector, therefore the major aims of this course are:

1) To refresh your memory on the concept of behaviour modification;
2) Deepen your understanding of behaviour modification;
3) Prepare you to be able to discuss coherently on any issues or matter relating to behaviour modification or its application in school environments or other situations.

Course Objectives

In order to achieve the aims set out above, some carefully stated overall objectives must be considered. In addition, each study unit also has specific objectives. The study unit objectives are always included at the beginning of a study unit; you should read them before you start working through the study unit. You may want to refer to the objectives as you go through each unit to check on your progress. You should always look at the study unit objectives after completing a study unit. In this way, you can be sure that you have done what was required of you by the study unit. Set out below are also the wider objectives of the course as a whole. By meeting these objectives, you should have achieved the aims of the course. On successful completion of the course, you should be able to:

1. Define the concept of behaviour,
2. Explain types of behaviour,
3. Explain development and acquisition of behaviour,
4. Discuss the notion of behaviour modification,
5. Explain personality and human behaviour,
6. Discuss why people seek therapy,
7. Discuss who provides psychotherapeutic services,
8. Explain the process of measuring in psychotherapy,
9. Analyze therapeutic approaches,
10. Discuss biological approaches in behaviour modification,

11. Discuss behaviour therapy
12. Discuss cognitive, humanistic, and psychodynamic therapies.

Working through This Course

To complete this course you are required to read the study units carefully and other relevant materials stated in the section on further reading. Each study unit contains Tutor Marked Assignments (TMAs) and at each point in the course you are required to submit assignments for assessment purposes. At the end of the course is a final examination. You will also find listed, all the components of the course, what you have to do and how you should allocate your time to each study unit in order to complete the course successfully and in good time.

Course Materials

Major components of the course are:

1) Course Guide
2) Study Units
3) References
4) Presentation Schedule

Study Units

The study units in this course (EGC 812) are as follows:

MODULE 1

Unit 1: The Concept of Behaviour

Unit 2: Types of Behaviour

Unit 3: Development and acquisition of behaviour

Unit 4: The notion of behaviour modification

Unit 5: Personality and human behaviour

MODULE 2

Unit 1: Why do people seek therapy?

Unit 2: Who provides psychotherapeutic services?

Unit 3: Measuring success in psychotherapy

Unit 4: Therapeutic approaches: An Overview

Unit 5: Biological approaches

MODULE 3

Unit 1: Behaviour therapy

Unit 2: Cognitive and Cognitive – Behavioural therapy

Unit 3: Humanistic – Experiential therapies

Unit 4: Psychodynamic Therapies

Unit 5: Marital and family therapy

Presentation Schedule

The presentation schedule included in this course material gives you the important dates of this year for the completion of tutor-marked assignments and for attending tutorials.

Remember, you are required to submit all your assignments by the due date. You should guard against falling behind in your work.

Assessment

There are three aspects in the assessment of the course. First is a set of Self – Assessment Exercises (SAEs), second is a set of tutor-marked assignments (TMAs), and third is a written end of semester examination. In tackling the assignments, you are expected to be sincere in attempting the exercises; you are expected to apply the information, knowledge and techniques gathered during the course. The assignments must be submitted to your tutor against formal deadlines stated in the presentation schedule and the assignment file. The work you submit to your tutor for assessment will make up 40% (post graduate) of your total course mark. At the end of the course, you will need to sit for a final written examination of two hours' duration. This examination will make up the remaining 60% (postgraduate) of your total course mark.

Tutor-Marked Assignments (TMAs)

Assignment questions referred as TMA (Tutor Marked Assignments) for each study units in this course are stated . You will be able to complete your assignments from the information and materials contained in your reading, and study units. However, it is desirable for you to demonstrate that you have read and researched more widely than the required minimum. Using other references will give you a broader viewpoint and may provide a deeper understanding of the subject.

When you have completed each assignment, send it together with a TMA (tutor-marked assignment) form to your tutor. Make sure that each assignment reaches your tutor on or before the deadline given in the presentation schedule and assignment file. If, for any reason, you cannot complete your work on time, contact your tutor before the assignment is due to discuss the possibility of an extension. Extensions of time will not be granted after the due date unless in exceptional circumstances. You are encouraged to submit all assignments.

Final Examination and Grading

The final examination for this course will be for two hours' duration and it has a value of 60% of the total course grade. The examination will consist of questions, which reflect the type of self-testing, practice exercises and tutor-marked assignments (tutor-attended- to problems) you have previously encountered in this study material.

Use the time between finishing the last study unit and sitting for the examination to revise the entire course. You might find it useful to review your self-tests, tutor-marked assignments and tutor comments on them before the examination. The final examination covers information from all parts of the course.

Course Marking Structure

The following table lays out how the actual course marking is done.

Table I: Course Marking Structure

Stages of Assessment	Percentage of Scores
Assessments	40% (Postgraduate)
Final Examination	60% (Postgraduate)
Total	100% of Course Marks

Course Overview

The next table brings together the study units, the number of weeks you should take to complete them, and the assignments that follow.

Table II: Course Organiser

Unit	Title of work	Weekly Activity	Assessment (end of Unit)
1	The concept of behaviour	1	Assignment 2
2	Differences between adaptive and maladaptive behaviour	1	Assignment 3
3	Causes of behaviour development	1	Assignment 3
4	Process of assessing human behaviour	1	Assignment 3
5	Psychoanalytic perspectives of personality	1	Assignment 2
6	Psychosocial view points on abnormal behaviour	1	Assignment 2
7	Reasons why people seek therapy	1	Assignment 2
8	Professionals who provides in psychological distress	1	Assignment 3
9	Approaches to measure treatment success in psychotherapy	1	Assignment 4
10	Therapeutic approaches in treating maladaptive behaviour	1	Assignment 3
11	Disorders that can be treated with antipsychotic drugs	1	Assignment 3

12	Processes in systematic desentization	1	Assignment 3
13	Differences between rational emotive behaviour therapy and cognitive therapy	1	Assignment 3
14	Techniques in Rogers' theory	1	Assignment 2
15	Freud's therapeutic techniques	1	Assignment 3
Total no of weeks		15	

How to Get the Most from This Course

In Open and Distance Learning (ODL), the study units replace the University Lecturer. This is one of the great advantages of ODL. You can read and work through specially designed study materials at your own pace, and at a time and place that suit you best. Think of it as reading the lecturer. In the same way that the lecturer might set you some reading to do, the study units tell you when to read your other materials. Just as a lecturer might give you an in-class exercise, your study units provide exercise, for you to do at the appropriate points. Each of the study units follows a common format. The first item is an introduction to the subject matter of the study unit and how a particular study unit is integrated with the other study units and the course as a whole. Next is a set of learning objectives. These objectives let you know what you should be able to do by the time you have completed the study unit. You should use these objectives to guide your study. When you have finished the study unit, you must go back and check whether you have achieved the objectives or not. If you make a habit of doing this, you will significantly improve your chances of passing the course.

The main body of the study unit guides you through the required reading from other sources. This will usually be either from a reading section or some other sources. You will be directed when there is need for it.

Self- Assessment Exercise (SAEs) are stated throughout the study units. Working through these SAEs will help you to achieve the objectives of the study units and prepare you for the assignments and examination.

You should do every SAE as you come to it in the study unit. There will also be numerous examples given in the study units. Work through these when you come to them too.

The following is a practical strategy for working through the course. If you run into any trouble, telephone your tutor immediately. Remember that your tutor's job is to help you. When you need help, don't hesitate to call and ask your tutor to provide necessary guidance. You are encouraged to take note of the following tips:

1.Read this course guide thoroughly.

2. Organise a study schedule. Refer to the course overview for more details. You should note that it is expected of you to devote at least 2 hours per week for studying this course. The number of hours to be devoted for intensive study stated above is outside other need driven academic activities like self help, group discussion and instructional facilitation. Note the time you are expected to spend on each unit and how the assignments relate to the study units. Important information e.g. details of your tutorials, and the date of the first day of the semester is available. You need to gather together all these information in one place, such as in your diary or a wall calendar. Whatever method you choose to use, you should write in your own dates for working on each unit.

3. Once you have created your own study schedule, do everything you can to stick to it. The major reason why students fail is that they get behind with their course work. If you get into difficulties with your schedule, please let your tutor know before it is too late for him to help you.

4. Turn to unit 1, read the introduction and the objectives for the unit.

5. Assemble the study materials. Information about what you need for a unit is given in the table of content at the beginning of each unit. It will be helpful for you to always read both the study unit you are working on and one of the materials for further reading on your desk at the same time.

6.Work through the Unit.The content of the unit itself has been arranged to provide a sequence for you to follow. As you work through the unit,you will be instructed to read sections from other sources. Use the unit to guide your reading.

7.Keep in mind that you will learn a lot by doing all your assignments carefully. They have been designed to help you meet the objectives of the course and, therefore, will help you pass the examination. Submit all assignments not later than the due date.

8. Review the objectives for each study unit to confirm that you have achieved them. If you feel unsure about any of the objectives, review the study materials or consult your tutor.

9. When you are confident that you have achieved a unit's objectives, you can then start on the next unit. Proceed unit by unit through the course and try to pace your study so that you keep yourself on schedule.

10.When you have submitted an assignment to your tutor for marking, do not wait until you get it back before starting on the next unit. Keep to your schedule. When the assignment is returned, pay particular attention to your tutor's comments, both on the tutor-marked

assignment form and also as written on the assignment itself. Consult your tutor as soon as possible if you have any questions or problems.

11. After completing the last unit, review the course and prepare yourself for the final examination. Check that you have achieved the unit objectives (listed at the beginning of each unit) and the course objectives (listed in the course guide).

Tutors and Tutorials

There are 15 hours of tutorials provided in support of this course. You will be notified of the dates, times and location of these tutorials together with the name and phone number of your tutor as soon as you are allocated a tutorial group.

Your tutor will mark and comment on your assignments. He will also keep a close watch on your progress or any difficulties you might encounter and provide assistance to you during the course. You must mail your tutor-marked assignments to your tutor well before the due date (at least two working days are required). They will be marked by your tutor and returned to you as soon as possible. Do not hesitate to contact your tutor by telephone, e–mail, or discussion board if you need help. The following might be circumstances in which you would find help necessary. Contact your tutor if: You do not understand any part of the study units or the assigned readings. You have difficulty with the self – assessment exercises. You have a question or problem with an assignment, with your tutor's comments on an assignment or with the grading of an assignment. You should try your best to attend the tutorials. This is your only chance to have a face-to-face academic contact with your tutor and to ask questions on problems encountered in the course of your study. To gain the maximum benefit from course tutorials, prepare a question list before attending them. You will learn a lot from participating in discussions actively.

Summary

Upon completing this course, you will be required to have acquired basic knowledge on Behaviour modification. You will be able to answer questions like these ones.

- Define the concept of behaviour
- Explain the basic principles and assumptions of behaviourists, psychoanalytic and humanistic psychologists on behaviour
- Differentiate between adaptive and maladaptive behaviour
- Explain the meaning of deviance as proposed by both scientific and humanistic perspective

- List and explain causes of behavioural development
- Discuss the concept of behaviour acquisition
- List and explain the process of assessing factors controlling human behaviour
- Discuss the methods used by psychologists in behaviour modification

Explain the processes involved in building behaviour capabilities

- What is personality ?
- Examine the psychoanalytic perspectives of personality
- What is projective test?
- Write short note on MMPI
- List and explain reasons why people seek therapy
- What kinds of professional provide help to people in psychological distress?
- In what kind of setting does treatment occur?
- What factors are important in determining how well patients do in therapy?
- What kinds of disorders can be treated with antipsychotic drugs? How do these drugs help patients? What are their drawbacks?
- Do the clinical advantages of ECT out weight its disadvantages?
- Explain the processes in systematic desensitization
- List and explain the processes in behaviour modification

Differentiate between operant conditioning and token economy

COURSE CODE: EGC 812

COURSE TITLE: BEHAVIOUR MODIFICATION

COURSE DEVELOPER: Dr. Okoza J.

MODULE 1

Unit 1: The Concept of Behaviour

Unit 2: Types of Behaviour

Unit 3: Development and acquisition of behaviour

Unit 4: The notion of behaviour modification

Unit 5: Personality and human behaviour

MODULE 2

Unit 1: Why do people seek therapy?

Unit 2: Who provides psychotherapeutic services?

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MODULE 3

Unit 1: Behaviour therapy

Unit 2: Cognitive and Cognitive – Behavioural therapy

Unit 3: Humanistic – Experiential therapies

Unit 4: Psychodynamic Therapies

Unit 5: Marital and family therapy

MODULE 1

Unit 1: The Concept of Behaviour

Unit 2: Types of Behaviour

Unit 3: Development and acquisition of behaviour

Unit 4: The notion of behaviour modification

Unit 5: Personality and human behaviour

UNIT 1: THE CONCEPT OF BEHAVIOUR

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1.0 Introduction

2.0 Objectives

3.0 Main Content

3.1 The meaning of Behvaiour

3.2 Basic principles and Assumptions by Psychologists on Behaviour

4.0 Conclusion

5.0 Summary

6.0 Tutor-Marked Assignment

7.0 References/Further Readings

1.0 INTRODUCTION

Psychologists to a large extent acknowledge that the human person is a very complex being in this world. His complex nature arises from the fact that he acts differently at various times, in same or similar situations and uniquely too. The extent to which he is understood depends largely to the extent to which his behaviour is known and predictable. However, since he as a being is a complex phenomenon, knowing him and predicting his actions are no easy tasks. The reason is that “human behaviour involves all aspects of human operations such as personal and covert thought processes including a configuration of chains of complex human information processing such as perception, conception, thinking, remembering, memory processes and even creativity. There are the dynamic emotional aspects of human behaviour which are equally complex convert behaviour patterns interacting very intricately with human cognitive processes and action” (Akinboye, 1984 as cited in Adomeh, 2005).

Such behavioural pattern which is shaded from the external observer can only be inferred from the overt behaviour of the individual. And it takes a professional psychologist to do that. Both psychologists and sociologists are not just concern with understanding and predicting human behaviour. Their ultimate aim is to manage and control adaptive behaviour in human organism. The management and control of adaptive behaviour in human persons lead us to the concept of behaviour.

2.0 OBJECTIVES

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

- Explain the meaning of behaviour
- Explain basic principles and assumptions about behaviour by psychologists

3.0 MAIN CONTENT

3.1 The Concept of Behaviour

Among psychologists there is the consensus that psychology is the science of human behaviour and mental processes. Psychologists use the scientific method, and this in essence means that they rely on careful, systematic and objective observation. To the extent that poets, novalists, playwrights, artists and philosophers use other non scientific methods of study, they are no psychologists. This does not mean, of course, that they have nothing of value to say about human behaviour.

The psychologist studies individual behaviour, while most sociologists study group behaviour. Many psychologists are interested in how the behaviour of others affects the individual, but their focus is on the individual, not the group per se. let us now look at some definitions of behaviour.

According to Colman (2003), behaviour is the physical activity of an organism, including overt bodily movements and internal glandular and other physiological processes, constituting the sum total of the organism's physical responses to its environment. The term also denotes the specific physical responses of an organism to particular stimuli or classes of stimuli. Santrock (2000) defined behaviour as everything we do that can be directly observed.

Strictly speaking, behaviour refers to directly observable responses like pushing a button, kicking someone or talking. However, since such responses may be used to infer subjective events (goals, thoughts, and feelings for example), and since subjective experience is what many psychologists are really most interested in, the subject matter of psychology include virtually anything the individual does or experiences (Adomeh, 2005). The word behaviour tends to be restricted to relatively large, global responses and is generally not applied to the more minute, specific phenomenon that interest most biologists. Many psychologists are certainly interested in the body's physiological functioning, but they are unlikely to spend much more time studying the embryological development of the respiratory system, the formation of blood clots, or the stages in the division of liver.

Because of this specific interest of the individual psychologist, (Akinboye 1984 as cited in Adomeh, 2005) noted that while there is a general consensus among psychologists on behaviour as the subject matter of psychology as mentioned earlier, there is no such consensus among psychologists as to the precise meaning of the word behaviour. Consequently, definition of behaviour ranges from the most general to the most specific depending on the point of view of those defining the concept or their area of emphasis.

Thus, some psychologists who are concerned with conduct, behaviour is the activities organisms engage in. Put simply, observable activities are sometimes used to infer subjective events like goals, thoughts and feelings. In other words, behaviour is the activities perform by organism on regular basis. In relation to man therefore, behaviour is the activity than man performs. Any form of expression in which man shows forth what he is could be considered his behaviour, since his activities cannot be separated from him as a human organism.

According to some other psychologists who wish to emphases the neurological foundation of human behaviour it is the response of the neuromotor system to perceived stimuli. What this means is that behaviour does not occur in a vacuum. It is a reaction of the organism to some perceived environmental contingencies. For a human being or any other organism for that matter to engage in any activity that could be termed behaviour, something must precede it or he must be prompted to act. Such environmental contingencies could either be internal or external to the human person or organism. Such a reaction to stimulus

is considered a unit of behaviour. Hence to behave the organism must do something, that is, engage in activity.

As an activity, behaviour is considered one, albeit very important, function of the physical structure of individual organisms. It is literally the action of muscles and glands caused most immediately by the coordinated effort of various structures in the central nervous system. For behavioural scientists, however, behaviour must be defined in terms of its function as an activity of the organism that changes in an orderly way with certain variables, whether the orderly relationship can be demonstrated or not. When scientists study the function of behaviour, their first task, as in other natural sciences, is to discover basic unit of functional analysis. They do this, as Darwin did concerning the various life forms he encountered on his travels abroad the H.M.S. Beagle by asking about function (Schlinger, 2002 as cited in Adomeh, 2005).

Schlinger (2002), is also of the view that behavioural scientists have made great in road in functional unit of behaviour in the last one hundred years. Notable among such scholars are Parlov, Thorndike and Skinner, who each discovered unit of functional behaviour which they referred to as respondents, operant and discriminated operants respectively. There are different principles and assumptions about behaviour. This we now turn to discuss. Be attentive and learn more.

3.2 Basic Principles and Assumption about Behaviour by Psychologists

The basic principles and assumptions about behaviour will be treated from behaviourist approach, psychoanalytic approach, humanistic approach and cognitive approach.

Behaviourist Approach

Behaviourists emphasise the role of environmental factors influencing behaviour, to the near exclusion of innate or inherited factors. This amounts essentially to a focus on learning. The key form of learning is conditioning, either classical (Pavlovian or respondent), which formed the basis of Watson's behaviourism, or operant (instrumental), which is at the centre of Skinner's radical behaviourism.

Behaviourism is often referred to as 'S – R' psychology ('S' standing for stimulus and 'R' for 'response'). Both classical and operant conditioning explain observable behaviour (responses) in terms of environmental events (stimuli), but they define the stimulus and response in fundamentally different ways. Only in classical conditioning is the stimulus seen as triggering a response in a predictable automatic way, and this is what is conveyed by 'S – R' psychology.

Both types of conditioning are forms of associative learning, whereby associations or connections are formed between stimuli and responses that did not exist before learning takes place. The mechanisms proposed by a theory should be as simple as possible. Behaviourists stress the use of operational definitions (defining concepts in terms of observable, measurable events).

Finally, the aim of a science of behaviour is to predict and control behaviour (Gross, 2010).

Psychoanalytic Approach

According to Freud, much of our behaviour is determined by unconscious thoughts, wishes, memories, and so on. What we are consciously aware of at any one time represents the tip of an iceberg: most of our thoughts and ideas are either not accessible at that moment (preconscious) or are totally inaccessible (unconscious). These unconscious thoughts and ideas can become conscious through the use of special techniques, such as free association, dream interpretation and transference, the cornerstones of psychoanalysis. You will learn more about this concept later under psychotherapy.

Much of what is unconscious has been made so through repression, whereby threatening or unpleasant experiences are ‘forgotten’. They become inaccessible, locked away from our conscious awareness. This is a major form of ego defence. Freud singled out repression as a special cornerstone on which the whole structure of psychoanalysis rests. It is the most essential part of it. Freud’s theory though criticized as unscientific, contains some profound observations and understanding of human behaviour. These must be incorporated into any adequate human psychology not only its theory but also its methods.

Humanistic Approach

Both the psychoanalytic and behaviourist approaches are deterministic (Gross, 2010). People are driven by forces beyond their control, either unconscious forces from within (Freud) or reinforcement from outside (Skinner). Humanistic psychologists believe in free will and people's ability to choose how they act. A truly scientific psychology must treat its subject matter as fully human, which means acknowledging individuals as interpreters of themselves and their world. Behaviour, therefore, must be understood in terms of the individuals subjective experience, from the perspective of the actor.

Maslow, a humanistic psychologist argued that Freud supplied the 'sick half' of psychology, through his belief in the inevitability of conflict, neurosis, innate self-destructiveness and so on, while he (and Rogers) stressed the 'healthy half'. Maslow saw self-actualisation at the peak of a hierarchy of needs, while Rogers talked about the actualizing tendency, an intrinsic property of life, reflecting the desire to grow, develop and enhance our capabilities. A fully functioning person is the ideal of growth. Personality development naturally moves towards healthy growth (unless it is blocked by external factors) and should be considered the norm (Gross, 2010).

Cognitive Approach

Despite its undoubted influence within psychology as a whole, it is most difficult to define the boundaries of cognitive psychology compared with the other major approaches. Its identity is not as clearly established, and it cannot be

considered to be a specific, integrated set of assumptions and concepts. It has several contemporary forms, with many theories, research programmes and forms of psychotherapy having a cognitive tilt (Nye, 2000).

Looking at the various psychological principles and assumptions our aim is to prepare your knowledge foundation on what you will learn when we shall discuss the different forms of psychotherapy.

4.0 CONCLUSION

You have learnt so far that behaviour is a physical activity of the organism. There is no consensus among psychologists as to the precise definition of behavior. There are different approaches to behaviour and hence we have different basic principles and assumptions among behaviourists, psychoanalytic, humanistic and cognitive psychologists.

5.0 SUMMARY

In this unit, you have learnt about the concept of behaviour. You also learned about the Pavlovian conception that states associations or connections are formed between stimuli and responses. The psychoanalytic believed that our behaviour is influenced by our unconscious thoughts, while the humanistic believes in the subjectivity of the human organism.

6.0 TUTOR-MARKED ASSIGNMENT

- Define the concept of behaviour
- Explain the basic principles and assumptions of behaviourists, psychoanalytic and humanistic psychologists on behaviour

7.0 REFERENCES/FURTHER READINGS

Adomeh, I. O. C. (2005). Principles of behaviour modification (Unpublished). Research, Department of Educational Foundations and Management, Ambrose Alli University, Ekpoma, Nigeria

Colman, A. M. (2003). Oxford dictionary of psychology. Oxford University Press, Britain

Gross, R. (2010). Psychology (6th Ed.). Hodder Education, UK.

Nye, R. D. (2000). Three Psychologies: Perspectives from Freud, Skinner and Rogers (6th edition). Belmonth, CA: Wadsworth/Thomson Learning.

UNIT 2: TYPES OF BEHAVIOUR

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1.0 Introduction

2.0 Objectives

3.0 Main Content

- 3.1 Types of behaviour
- 3.2 The meaning of Deviant Behaviour
- 3.3 Deviance as classified by Scientific sociologists
- 3.4 Deviance as classified by humanistic sociologists

4.0 Conclusion

5.0 Summary

6.0 Tutor-Marked Assignment

7.0 References/Further Reading

1.0 INTRODUCTION

In the last unit, you learn about the concept of behaviour. It was defined in different perspectives. It was also remarked that psychologists define, behaviour from different point of view and hence there is no consensus amongst them as to the definite meaning of behaviour. In all, behaviour is what you can observe as a response from the living organisms.

In this unit, you will learn about types of behaviour, the meaning of deviant behaviour, deviance as intrinsically real, deviance as an objective fact and deviance as determined behaviour.

2.0 OBJECTIVES

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

- List and explain types of behaviour
- Discuss deviant behaviour
- Explain deviance as classified by scientific sociologists
- Analyse deviance as classified by humanistic sociologists

3.0 MAIN CONTENT

3.1 Types of Behaviour

Since behaviour is an activity of an organism, and it does not occur in a vacuum but is prompted by a stimulating event or a combination of events, which could be internal or external to the organism, it means that the classification of behaviour must be done in relation to other organisms. In classifying behaviour,

therefore, we must look at it from the point it affects other human organisms and the society in general.

The view that behaviour that are learnt or learnable brings us to the consideration of types of behaviour. Broadly speaking, there are two types of behaviour, namely, adaptive behaviour and maladaptive behaviour. Adaptive behaviours are those human activities and responses through which he satisfies his needs and relates to the other members of the society in morally and accepted way, which does not infringe on the rules and regulations of either his immediate environment or the larger society. Any other behaviour that does not fulfill all of the above conditions even if it helps the inidivudal to adapt to environmental contingencies is considered maladaptive behaviour (Adomeh, 2005).

Maladaptive behaviour means that such a conduct departs from the normal. At that point of deviation we can refer to it as deviant behaviour. Since it is this type of conduct that requires to be managed and restored to the point of departure, we shall learn more on deviant behaviour and their types. Exercise patience and learn more.

3.2 The meaning of Deviant Behaviour

Like behaviour itself, a lot of controversies abound in the definition deviant behaviour. These controversies are not peculiar to the lay people in behaviour modification, even among sociologists themselves. It is therefore important to

state some of these professional definitions before attempting a synthesis as did Thio (1978: 4 as cited in Adomeh, 2005).

Consequently, Thio stated that Parsons defined deviant behaviour as a situation or when one exhibit a conduct that is contrary to societal expectations. In the same way, a student of Talcoth Parsons, Robert Merton, opined that "Deviant behaviour refers to conduct that departs significantly from the norms set for people in their social statuses…when a man acts 'like a child' or a layman acts 'like a physician', he engages in deviant".

For Albert Cohen, deviant behaviour does not only mean violation of expectations about our social statuses and roles; it refers to violation of any rule anywhere as long as the violation attracts some disapproval, anger or indignation. Cohen went further to list crime, dishonesty, betrayal, cutting corners, immorality, corruption, wickedness and sin as examples of deviant behaviour. Since such deviant behaviour as suicide and mental illness will not excite disapproval, anger or indignation. Cohen went further to list crime, dishonesty, betrayal, cutting corners, immorality, corruption, wickedness and sin as examples of deviant behaviour. Since such deviant behaviours as suicide and mental illness will not excite disapproval, anger, or indignation, Cohen excludes then from his list. But John Lofland includes them in his. To Lofland, deviants are persons toward whom there is experienced fear, hate, threat and defensiveness and on occasion, compassion, concern and hope of redemption. While other sociologists restrict deviant behaviour to the act of violating normative rules, Sagarin's definition includes both rule breakers and people who have committed

not deviant acts. The latter group includes the crippled, the mentally retarded, the spastic, the leprous, the blind, the deaf and mute. Although these people have not broken social rules, they are similar to physically normal people who have, in that they are held in low social esteem. That notwithstanding, most sociologists limit the use of the term deviance to what the public considers objectionable behaviour.

The tern objectionable used by most sociologists to quality behaviour had lead to classifying deviant behaviour into two main groups, namely, the scientific and the humanistic perspectives. Those sociologists that define deviance from the scientific perspective are known as scientific sociologists and they make three main assumptions, namely (i) that deviance is intrinsically real, (2) deviance is objective fact, and (3) deviance is determined behaviour. Now, we are going to learn more about these classifications of scientific sociologists.

3.3 Deviance as classified by scientific sociologists

i. Deviance as intrinsically real: The first assumption of the scientific sociologists is that deviance is intrinsically real. What this means is that a deviant possesses some characteristics that distinguish it from conforming behaviour. According to the scientific sociologists it is possible to distinguish deviant persons from conforming persons. They tend to view deviant behaviour as an attribute that is inherent in the individual yet relative to a given norm, time and/or society. It must also possess the ability to affect other person's disagreeably. Examples of deviant acts that affect others

disagreeably are murder, rape, robbery and of course mugging. Thus deviance by any other name or label is real just as rose by any other label will smell as sweet.

ii. Deviance as Objective Fact: The second assumption of the scientific sociologists is about the nature of deviance as an objective fact. In other words deviance an object of observation, perception and/or thought right out there and not something of one's imagination. In assuming deviant behaviour as something out there with an objective nature, and treating the deviant person as if he or she were an object, scientists have attempted to observe and study deviant behaviour and deviant person objectively.

Since personal bias places a role in a sociologists outlook, they no longer pass moral judgement on deviant behaviour, but instead they prefer to study the subject matter precisely as it is. By this sociologists are very objective about the nature of deviant behaviour. Consequently, value loaded and subjective notions like maladjustment, moral failing, debauchery, demoralization, sickness, pathology and abnormality are no longer in vogue. Replacing outmodeled notions are such concepts as innovation, retreatism, ritualism, rebellion, culture conflict, subcultural behaviour, reinforced behaviour and so on.

iii. Deviance as determined behaviour: The third scientific perspective is that deviant behaviour is something that is determined or caused by some other things, events, occurrences, or phenomena in the environment. Implicit in this determinist or causal view is that a given thing cannot simply appear out

of nothing or nowhere. If a person is thought to will or determine his or her own behaviour then it does not make sense to say that that behaviour is caused by something else. If a murderer is thought to will or determine a murderous act, then it does not make sense to say that the murderous act is caused by such other things as the individual's physical or mental condition, family background, or various social experiences in the society. Therefore in defending their scientific principle of determinism, the early sociologists stuck to their denial of free will. For them the causes of deviance can be located in the social environment, namely "broken home, unhappy homes, lower-class background, economic deprivation, social disorganization, rapid social change, differential association, differential reinforcement and so on.

Conclusively, the scientific perspective on deviance, which is anchored on three related assumptions can be summed up three sentences; namely, first deviant behaviour is intrinsically real, second it is an objective fact, and third it is determined by other things.

3.4 Deviance as Classified by Humanistic Sociologist

The second major group's view on deviance is the humanistic perspective. This group set out to challenge the scientific sociologists. Like the latter the humanistic made three assumptions, namely, deviance is a label, subjective experience and a voluntary act. We now explain them as follows:

i. Deviance as a label – The first assumption of the humanistic is that deviance is a label apportioned to a particular type of behaviour. The humanistic

perspective therefore holds that deviant behaviour by itself does not have any intrinsic characteristics unless it is thought to have those characteristics. The so called intrinsically deviant characteristics do not come from the behaviour itself; they come instead from people's mind. Furthermore, since laws vary from one state to the other, the same type of behaviour may be defined as criminal in one state but no so in another. There is then a relativity principle in deviant behaviour; behaviour gets defined as deviant relative to a given norm, standard of behaviour, or the way people react to it.

ii. Deviance as subjective experience. Since according to the humanistic deviance is a label, which like beauty is in the eye of the beholder, they proceeded to state their second assumption as follows: "that the supposedly deviant behaviour is a subjective experience and the supposedly deviant person is a conscious, feeling, thinking and reflective subject." As a result of their subjective and emphatic approach, humanists often present an image of deviant as basically the same as conventional people. This implies that the so-called conventional behaviour, should not be controlled by society.

iii. Deviance as voluntary act. The third assumption of the humanists holds that the deviant behaviour is a voluntary act or an expression of human volition, will, or choice. To deny human free will is to make them robots, senseless and purposeless machines who merely react to environmental contingencies. For the humanists, human beings possess free will and choice making ability, determine or cause their own behaviour.

By the above three assumption the humanists carefully turned the table against the scientists and set the stage for an antithesis, which of course needs a synthesis. This precisely what Thio (1978: 24) integrated perspective is all about. According to him, the scientific and humanistic perspectives can be integrated into a larger perspective that sees deviant behaviour as an act that can be located at a point on a continuum of maximum and minimum public consensus regarding the deviant nature of the act. More concretely, according to this integrated view, deviant behaviour is divided into two major types. One is referred to as higher consensus deviance, which is generally serious enough to earn a comparatively great amount of public consensus that is really deviant. The type is more fitting for scientific investigation. The other is called lower – consensus deviance, which is generally less serious and thus receives a lesser degree of public consensus on its deviant reality. This type is more appropriate for humanistic analysis.

4.0 CONCLUSION

You have learned about the meaning and types of deviant behaviour. We also learn that some behaviour are adaptive and some are maladaptive. You have a better background now to learn about maladaptive behaviours later in this course that requires modification.

5.0 SUMMARY

In this unit, you learned something about the types of behaviour and the meaning of deviant behaviour. Furthermore you learn about sociological classification of behaviour into scientific and humanistic perspectives. The

scientific sociologists classified deviant behaviour into three namely, behaviour as intrinsically real, as objective fact and as a determined behaviour. The opposing group the humanistic classified deviant behaviour into three namely, behaviour as intrinsically real, as objective fact and as a determined behaviour. You also learn about the synthesis of both perspective as attempted by Thio (1978 as cited in Adomeh, 2005).

6.0 TUTOR-MARKED ASSIGNMENT

- Differentiate between adaptive and maladaptive behaviour
- Explain the meaning of deviance as proposed by both scientific and humanistic perspective

7.0 REFERENCES/FURTHER READINGS

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(Unpublished). Research, Department of Educational Foundations and Management, Ambrose Alli University, Ekpoma, Nigeria

UNIT 3: DEVELOPMENT AND ACQUISITION OF BEHAVIOUR

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main Content

3.1 Behavioural development

3.2 Behaviour acquisition

4.0 Conclusion

5.0 Summary

6.0 Tutor-Marked Assignment

7.0 References/Further Reading

1.0 INTRODUCTION

In the last unit, you learn about types of behaviour, the meaning of deviant behaviour, deviant as classified by both scientific and humanistic sociologists. In this unit you will learn about how organisms develop their behaviour pattern and how it influences the way they behave. Put simply, you will learn about behavioural development and behaviour acquisition.

2.0 OBJECTIVES

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

- explain the concept of behavioural development
- Discuss behaviour acquisition

3.0 MAIN CONTENT

3.1 Behaviour Development

Pelaez (2002 as cited in Adomeh, 2005) in her write on behavioural development decided to toe the path of what causes such development. She used the examples of Aristotle, namely, efficient, material, formal and final causes. Let us now discuss each of these elements listed.

Efficient causes: According to Pelaez, efficient causes are the elicitors of behaviour change. These are the stimuli in the environment that trigger or elicit a change or a response. The efficient causes are identified in early behaviour development because they make the early components essentials for later developmental outcomes. In early human development, one of a neonate's greatest strengths for survival is starting with a full set of useful reflexes. These involuntary and automatic responses to stimuli originally have a clear adaptive value to the infant in terms of the automatically sucking the breast when placed in its mouth. Some infantile reflexes either disappear or become operant responses in later life.

Material causes: material causes are the substances, machinery or material components that can be identified as forming the behaviour. Geneticists use the genes and DNA strings as explanations for behaviour and development once their location has been identified. For instance, one important genetic disease produced by a dominant gene is Huntington's disease, a condition that causes gradual deterioration of the nervous system leading to a progressive decline in behavioural abilities and ultimately death. Person who carry the dominant gene for the Huntington's chorea may enjoy good health for most of their lives. The disease start with involuntary twitching of the head, limbs and body and goes on to degenerative changes in the nervous system, loss of mental and physical powers and death. The age of onset of this disease, i.e. the age at which it becomes first noticeable varies from infancy to old age.

It is virtually certain that some persons who are carriers of the gene for this disease die of other causes before they develop any symptoms of Huntington's chorea. The gene may, then, be said to have an incomplete penetrance. Its expressivity is also variable. When the victim of the disease dies young before producing children, the gene may be said to have a lethal effect. When the victim dies in the midst of the reproductive period of life, the gene acts as a semilethal or a sub vital. When incapacitation and death occur in old age, after the close of reproductive period, the gene is not lethal at all. Health or disease in old age are, however, not under direct control of natural selection in the evolutionary process (Colman, 2003).

Often times, there are some reductionistic explanations of behaviour that are inaccessible to the observer. The reason is that such explanation may be based on either concomitant or outcomes of another more fundamental process or cause in which a different, more molar, level of analysis would be required, in which behaviour would be seen as emerging from the organism contingent upon interactions with the environment (Pelaez, 2002 as cited in Adomeh, 2005).

Formal causes: These types of causes are referred to as models, paradigms, equations, or formulars used to explain behaviour. In behavioural psychology, the matching law is an example. The formula states that relative responding matches the relative reinforcement produced by that responding. The matching law summarise organism performances on a variety of schedules of reinforcement. Another example is the schematic model of information processing system. The store model explains how information flows through a series of separate but interrelated sets of processing units, or stores. It attempt to attribute the functions of memory retrieval, and problem solving to this schematic, theoretical model.

Final causes: These categories of causes are also known as functional causes in the sense that they are the functional explanations of behaviour change. Consequently developmental psychologists attempt to provide answers to the following: what is the purpose of behaviour? What is behaviour development supposed to do or ultimately accomplish? On classification we can conceive of two types of final causes, namely, proximal and ultimate causes. Example of proximal cause is reinforcement, whereas survival of the fittest is an

example of ultimate cause. The study of human development is concerned with the proximate as well as the ultimate causes of behaviour.

3.2 Behaviour Acquisition

Having accepted the definition of human behaviour as the activity which man engages in, it is now necessary to consider how man in the first place come to engage in a such a behaviour which had come to become part and parcel of live. Philosophers and even psychologists have 100 years engage themselves in unending debate in an attempt to explain how man come to behave the way he does.

Jocke Locke (1690 – 1939) is of the view that at birth, the human mind is a tabula rasa (blank sheet). All knowledge therefore comes from experience. In order words, as a man grows he acquires behaviour based on his daily experiences. John Locke therefore proposed that to properly shape behaviour, parents and significant others should praise children when they display good behaviour and simply ignore bad behaviour.

Jean Jacques Rousseau on his part speaks of inherent goodness. “Everything” he says is good as it comes from the hands of the maker of the world (God) but degenerates once it gets into the hands of man”. The only way to save the situation is to give education to the child and offer instruction when the child needs it.

The positions of these two philosophers introduce us to the first form of acquisition of behaviour namely learnt behaviour.

Learnt behaviour: It is possible to group behaviour into two, namely voluntary and involuntary behaviours. Apart from involuntary acts which are either reflex or elicited behaviours, others are operant behaviours and are governed by their consequences. Operant behaviour is any response by an organism that is not directly caused by a stimulus but is freely emitted behaviour (Colman, 2003).

Operant behaviours can be further divided into desirable and undesirable behaviours, such behaviours are learnt behaviours.

On how this learning takes place, Locke says it is through experience. Rousseau is of the view that it can be acquired through proper education, and Pavlov and Watson proposed that it is through classical conditioning. Skinner settles for operant conditioning; while Bandura sees anticipatory control as the basis of all human behaviour. In all, there is a general agreement among these scholars that human beings learn to behave the way do. What is probably the major difference is how they come to acquire the various forms of behaviour, which of course could be the reason why some behaviours are adaptive and others are said to be maladaptive.

Modeling through observation and imitation

Freud is of the opinion that this is a form of identification that occurs indirectly. It all begins when the child attempts to resolve a conflict he finds himself. That is the hidden conflict between his desire and fear.

However, the social learning theorists on their part, completely disagreed with Freud on how children come to adopt adults' roles. For them it is just a matter of observation and imitation. The children having seen what the adult and older children do, they try to be like them by imitating their actions. In other words, environmental contingencies help to shape children's behaviours.

Bandura (1986) described four main processes that are involved in observational learning: attention, retention (memory), motor reproduction and reinforcement (motivation). How does these factors affects learning? Let us now discuss them.

1. Attention: The behaviour to be acquired must be made present in the person's immediate environment either directly or indirectly
2. Retention: Observation will only have lasting effect on a person if he remembers what he had observed.
3. Motor reproduction: since observation tells the person which form of behaviour he should imitate a complex behaviour might not only be difficult for the child to imitate, he might not be interested in it, but what is important is the child's ability to mentally reproduce his experience.
4. Motivation: Unless an observer of a model is motivated by some anticipated gains if he imitate the model, he will not be interested in it.

Research findings have shown that both parents and significant others do not only make models available for their young ones to imitate, they sometimes reward them for what they considered appropriate sex role. Similarly, they even punish inappropriate sex role in order to discourage them.

4.0 CONCLUSION

You have learned about development and acquisition of behaviour. What causes behaviour was explained and we now know that human organisms either learn behave or acquire it.

5.0 SUMMARY

In this unit, the following important points are worthy of note

- Behavioural development are caused by efficient, material, formal and final causes
- Behaviour acquisition can occur through learnt behaviour or through operant
- Behaviour acquisition can also occur through modeling based on observation/imitation

6.0 TUTOR-MARKED ASSIGNMENT

- List and explain causes of behavioural development
- Discuss the concept of behaviour acquisition

7.0 REFERENCES/FURTHER READINGS

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UNIT 4: THE NOTION BEHAVIOUR MODIFICATION

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main Content

3.1 The meaning of behaviour modification

3.2 Methods used by psychologists in behaviour modification

3.3 Behaviour Management

4.0 Conclusion

5.0 Summary

6.0 Tutor-Marked Assignment

7.0 References/Further Reading

1.0 INTRODUCTION

In the last unit, you learned about behaviour development and behaviour acquisition in human organisms. The concept of deviant behaviours were analyzed. In this unit, you will learn about the meaning of behaviour modification, methods used by psychologists in behaviour modification, issue of behaviour

management, and building behavioural capabilities. Be attentive and learn with interest this very important topic.

2.0 OBJECTIVES

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

- Explain the concept of behaviour modification
- List and explain the methods used by psychologists in behaviour modification
- Discuss the issue of behaviour management

3.0 MAIN CONTENT

3.1 The Meaning of Behaviour Modification

Any attempt made by man to manage human or other animals conduct for the good of the individual concern or the common good is known as behaviour modification (Adomeh, 2005).

In attempting such behaviour management, various procedures could be used either singly or several methods could be adopted depending on the extent of deviation from societal accepted standard. Akinboye (1992 cited in Adomeh, 2005) has rightly pointed out that a single behaviour change strategy may not be adequate in restoring persons lost adaptive behaviour of people. This means that just as maladaptive behaviours are not acquired overnight, the restoration back to the point of departure is a tedious task. This is why the scientific discipline of psychology that has accepted the task of studying and managing behaviour for the greatest good normally adopt the scientific method in carrying out its

objectives. Behaviour modification therefore becomes the scientific management of behaviour in a way that individuals and groups are made more effective in their daily activities.

It is important to remark that behaviour modification does not begin and end with maladaptive behaviours only. It also concerns itself with adaptive behaviours. In fact, psychologists who are trained professional therapists extend their services to persons who are functioning within the normally acceptable limits so that they can constantly remain at that level. Such services are generally described as preventive measures.

Another group that behaviour therapists concern themselves with are those whose behaviours have been successfully managed and restored to the point of earlier departure. Such persons need treatment so that they will be prevented from acquiring some or other undesirable behaviours as they encounter conflicts and life problems in their daily living. Now let us move a step further and learn about methods used by psychologists in behaviour modification.

3.2 Methods used by psychologists in behaviour modification

Psychologists who engage in behaviour modification normally employ different scientific methods for people with maladaptive behaviour, adaptive behaviour and those whose behaviours have been managed and restored to the point of earlier departure. In order to effectively meet the needs of the different groups the scientific method requires the therapist to adopt the following methods.

1. Engage in constant research
2. Establish the target behaviour to be acquired
3. Development of treatment programme(s)
4. Utilization of the treatment package, and
5. Evaluation of the treatment programme(s)

The scientific procedure employed by professional therapists differentiates behaviour modification from traditional behaviour influence. In other words, behaviour modification sets a goal for itself and takes definite step towards achieving its set objectives. At this point we now move into the major method used by psychologists in behaviour modification. This brings us to a concept known as behaviour therapy.

Behaviour Therapy

According to Colman (2003) behaviour therapy means a collection of psychotherapeutic techniques aimed at altering maladaptive or unwanted behaviour patterns, especially through the application of principles of conditioning and learning, the basic assumptions being that most forms of mental disorder can be interpreted as maladaptive patterns of behaviour, that these patterns result from learning processes, and that the appropriate treatment involves the unlearning of these behaviour patterns and the learning of new ones. Another name for behaviour therapy is behaviour modification. Behaviour modification is a concept that originated in United States of America. It is very important to quickly explain the concept of therapy.

Therapy according to Colman (2003) is any form of treatment for a disorder by a method other than surgery. A good example is psychotherapy. And what is psychotherapy? We need an answer to this important question in the study of behaviour modification.

What is psychotherapy?

Psychotherapy is the process used by mental health professional to help individuals recognize, define, and overcome their psychological and interpersonal difficulties and improve their adjustment. Psychotherapist use a number of strategies to accomplish these goals: talking, interpreting, listening, rewarding and modeling, for example (Santrock, 2000). Colman (2003) defined psychotherapy as the treatment of mental disorder and allied problem by psychological methods. You will learn more about psychotherapy in module 2 and 3. Let us come back once more and discuss the concept of behaviour therapy.

Therapy is a treatment programme which involves the definition of a particular problem or concern, its treatment and the evaluation of the entire programme in order to determine its effectiveness or otherwise. Behaviour therapy therefore involves the application of the aforementioned programme in behaviour management. As a programme of activity or process of change, it involves at least two persons or two groups of persons. The first set is the therapist who had seen the needs of the other set of person(s) and had therefore developed the treatment programme in order to help the person(s) in need out of difficulties. The second group of persons are those who are experiencing the difficulties and consequently need the treatment package.

Some individuals are unique even in similar situations and as a result the programme or treatment package needs to be constantly evaluated and adapted to meet their specific needs. These constant evaluation and adaptation makes the programme scientific and relevant in clinical practice. As a programme of events, behaviour therapy according to Akinboye (1992 as cited in Adomeh, 2005) makes seven basic assumptions:

1. It is the currently overt behaviour that needs treatment not past experiences
2. Both desirable and undesirable behaviours are learnt
3. For therapy to be effective both research and treatment should be carried out simultaneously
4. It is possible to use generated psychological principles in the management of behaviour
5. Behaviour therapy sets precise treatment goals
6. Treatment procedures and techniques are adapted to specific situation and problems, and
7. There is room for empirical testing of the treatment programme

3.3 Behaviour Management

Behaviour therapists aim at accessing factors controlling human behaviour in order to modify them for the greater good. To enable the therapist do this he must proceed in a specific manner, namely:

1. Assess the environmental contingencies that are maintaining the problem(s). This can be done through observation, interviews, use of checklist, rating scales and sociometric technique.
2. Assess the target behaviour. That is the problem behaviour you want to change. Is the client confused, neurotic, psychotic, sick, quarrelling? What does he lack?
3. Establishment of baseline. This is crucial to modern counseling. Baseline describe pre-treatment or pre-therapy and record observations that allow for later evaluation of treatment programme
4. Indicate the desired behaviour you want to achieve. This could be stated in short term or long term basis
5. Develop the treatment plan for handling the problem. This plan should be related to the nature of the problem assessed. It should also be related to the therapists preference, competence, comfort and also the client's comfort. Thus the development of a treatment plan should be original.
6. Evaluation the programme for efficiency. The one question to ask at the end of the treatment is have I reached my set goal? Or ask the client how he/she feels now or check if there is deviation in the chart or seek comments from interested parties. Sometimes a follow up is necessary to see whether there is retention of gain or a lapse.

Behaviour that could be found during assessment

There are four types of behaviour that could be found during assessment. These are:

1. Deficit Behaviours: These are more or less absent behaviours which do not appear in the baseline. That is the situation with mentally retarded children. In order to make them appear in the baseline and rise, something closed to them should be used.
2. Excess behaviours. These are behaviours that are above normal level. Aggression for example would rise in the baseline. Treatment should therefore aim at reducing it.
3. Weak behaviours. Unlike deficit behaviours, these behaviours are present in the repertoire only that their manifestations are not only low but are unstable. Treatment should therefore aim at stabilizing them and make them rise to appreciable levels.
4. Cognitive – physiological behaviour: Some clients may display these types of behaviours. Although they are health related problems that may not be charitable, they are qualitative.

Whenever any of these behaviours is found in a client, there are possible ways of trying to manage them in order to restore it to the point of departure. However, since the first three types of behaviours are the most commonly manifested among clients, their management procedures shall be discussed below briefly. The procedures are:

Building Behavioural capabilities

Deficit behaviours need to be acquired through building new behaviour capabilities. A number of methods can be used to acquire such absent behaviour

anew. Such methods include, shaping, chaining, modeling, fading and prompting. Let us learn more about these method.

Shaping: Since deficit behaviour means absent behaviour, the therapist has to differentiate aspects of existing behaviour in the client that closely approximate the desired behaviour. After such differentiation, it is then consistently, contingently, continuously and generously reinforced until the desired behaviour manifest. This process is called shaping.

Chaining: Since behaviours are normally linked together, behaviour chaining involves shaping, stimulus control and the operation of conditioned reinforcement.

Modeling: This is the provision of a vicarious experience for the client to imitate

Prompting: This is the provision of signals (e.g. instructions, directions, advise, example etc) aimed at enhancing the acquisition of behaviour.

Fading: This is the gradual elimination of factors of behaviour.

1. Increasing the frequency of weak behaviour

Sometimes the weak manifestation of behaviour adversely affect the client. When this is the case, what is needed to be done is to strength the weak manifested behaviour. The possible methods of doing this are positive reinforcement, negative reinforcement and stimulus control. A brief explanation of these concept is important.

i. Positive reinforcement: This is the process where a manifestation of a desired behaviour is promptly followed by a positive reinforcer in order to encourage the person to manifest such a behaviour again.

ii. Negative reinforcement: This is an eliminative process through which painful stimulus which blocks the emission of desirable behaviour are removed so that the client will be able to emit the required behaviour.

iii. Stimulus control: This is a process whereby specific cues or signals in the environment are initiated in order to increase desired behaviour.

2. Eliminating Excess Behaviour

Excess behaviours means the manifestation of those behaviours that are socially unacceptable since their consequences entrap the client and makes him a social misfit. A kleptomaniac for instance is a social misfit, who is manifesting a failing character or behaviour. Other failing behaviours include depression, fear, delinquency, truancy, frustration, anxiety, etc. Unless these excess behaviours are eliminated in our society, we will continue to have social misfits around us. Among the suggested techniques with which we will be able to do so are punishment and extinction. What is punishment and extinction? Below are explanation of these concepts.

Punishment: Punishment as a means of eliminating undesirable ehaviour does not mean the process of corporal punishment such as using rod or slapping. What is implied is the administration of aversive stimulus which results in a decrease of in the manifestation of the target behaviour. Akinboye (1992) opined that punishments are effective in controlling excess behaviour based on the following reasons:

1. They are contingently applied after the manifestation of excess behaviour
2. Every episode of excess behaviour is punished

3. Application is at a maximum intensity, and
4. The client is aware of the degree of aversive consequences

Extinction: This is mainly a disconnection of a prior link between a behaviour and its consequences. The effectiveness of extinction as a strategy of eliminating excess behaviour is sometimes enhanced when the individual is informed of the probability of losing reinforcers if he manifests excess behaviour. Another method of extinction as a process of behaviour management is to explore to the full the elimination of factors of behaviour.

4.0 CONCLUSION

You have learned in this unit the meaning of behaviour therapy or behaviour modification. For us to have a safe and peaceful society, behaviour modification is an essential service that must be rendered to clients who are in need of it.

5.0 SUMMARY

In this unit, you have learned the following facts.

1. Behaviour modification involves both maladaptive and adaptive behaviour
2. Behaviour modification requires the use of scientific approach
3. Behaviour therapy and behaviour modification are used interchangeably
4. Psychotherapy is the process used by mental health professionals to help individuals in need of adjustment in their behaviour

5. That behaviour therapists aim to assess factors controlling behaviour in order to modify them
6. Behaviour capabilities could be built through shaping, chaining, modeling, prompting and fading

6.0 TUTOR-MARKED ASSIGNMENT

- List and explain the process of assessing factors controlling human behaviour
- Discuss the methods used by psychologists in behaviour modification
- Explain the processes involved in building behaviour capabilities

7.0 REFERENCES/FURTHER READINGS

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UNIT 5: PERSONALITY AND HUMAN BEHAVIOUR

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main Content

- 3.1 What is personality?
- 3.2 How do the psychoanalytic perspectives portray personality?
- 3.3 What do the behavioural and social cognitive perspective
- 3.4 How do the humanistic perspectives describe personality?
- 3.5 What is the trait perspective on personality?
- 3.6 What are some ways personality can be assessed?

4.0 Conclusion

5.0 Summary

6.0 Tutor-Marked Assignment

7.0 References/Further Reading

1.0 INTRODUCTION

In the last unit, you studied the concept of behaviour modification, how behaviour can be assessed and the process of building behaviour capabilities. You also learn how to decrease excess behaviour.

In this unit, you will learn about the concept of personality and the different psychological perspectives and the unit will be concluded by ways in which personality can be assessed.

2.0 OBJECTIVES

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

- Explain the concept of personality
- Discuss the different perspectives on personality
- State the ways personality can be assessed

3.0 MAIN CONTENT

3.1 What is personality?

Personality is one of those concepts that we think we know what it is but when we try to express what it is verbally it can be quite difficult. According to Santrock (2000), definition of personality includes enduring characteristics and adaptation: Personality consists of enduring, distinctive thoughts, emotions, and behaviours that characterize the way an individual adapt to the world.

We will be discussing a number of theoretical perspectives on personality. They ask why individuals react to the same situation in different ways. For

example, why is Olu so talkative and gregarious, and Okolie so shy and quiet when they meet someone for the first time? Why is Joan so confident and Mary so insecure about upcoming job interviews? Some theorists believe that biological and genetic factors are responsible; others argue that life experience are more important. Some theorists claim that the way we think about ourselves is the key to understanding personality, while others stress that the way we behave toward each other is more important (Freidman & Schustack, 1999). Let us now learn about the different perspectives on personality.

3.2 Psychoanalytic Perspectives

Psychoanalytic perspectives view personality as primarily unconscious (that is, beyond awareness) and as occurring in stages. Most psychoanalytic perspectives emphasise that early experiences with parents play an important role in sculpting personality. Psychoanalytic theorists believe that behaviour is merely a surface characteristic and that to truly understand someone's personality we have to explore the symbolic meanings of behaviour and the deep inner workings of the mind. These characteristics are highlighted by the original architect of psychoanalytic theory: Sigmund Freud. You have learnt about this theory in abnormal psychology. In this course, your interest should be what the perspective state about personality and behaviour. It is in this light we shall look at other perspectives. Personality is a full course of its own in psychology.

Jung's Analytical psychology: Freud's contemporary Carl Jung (1875 – 1961) shared an interest in the unconscious, but he believed Freud underplayed

the unconscious mind's role in our personality. Jung believed that the roots of personality go back to the dawn of human existence. Read more about this in any good psychology textbook.

Adler's Individual Psychology. Alfred Adler (1870 – 1937) was another of Freud's contemporaries. In Adler's individual psychology, people are motivated by purposes and goals, being creators of their own lives. They are seen as responsible for their own lives. Unlike Freud who believed in the power of the unconscious mind, Adler argued that people have the ability to consciously monitor their lives. He also believed that social factors are more important in shaping personality than sexual motivation (Silverman & Corsini, 1984).

3.3 Behavioural and Social Cognitive Perspectives

The behavioural and social cognitive perspectives emphasize the importance of studying environment experiences and people's observable behaviour to understand their personality. Social cognitive theory emphasizes person/cognitive factors in personality. Out of the behavioural tradition grew the belief that personality is observable behaviour, learned through experiences with the environment. The two main versions of the behavioural and social cognitive perspectives are (i) behaviourism and (2) social cognitive theory. Briefly, our focus will be on Skinner's behaviorism and Albert Bandura's social cognitive theory.

Skinner's Behaviourism

B. F. Skinner's approach to learning is known as operant conditioning. Skinner concluded that personality is the individual's behaviour, which is determined by the external environment. Skinner believed that we do not have to resort to biological or cognitive processes to explain personality (behaviour)

Behaviourists counter that you cannot pinpoint where personality is or how it is determined. In Skinner's view, personality simply consists of the collection of the person's observed, overt behaviours. It does not include internal traits or thoughts. Skinnerian's believe that consistency in behaviour comes from consistency in environmental experiences. However, Skinner stressed that our behaviour always has the capacity for change if new experiences are encountered. Since behaviourists believe that personality is learned and often change according to environmental experiences and situations, it follows that by rearranging experiences and situations the individual's personality can be changed.

Social Cognitive Theory

Social cognitive theory states that behaviour, environment, and person/cognitive factors are important in understanding, personality. Albert Bandura (1986, 1997, 1998) and Walter Mischel (1973, 1995) are the architects of social cognitive theory's contemporary version. Bandura says that behaviour, environment, and person/cognitive factors interact in a reciprocal manner. Thus, in Bandura's view, the environment can determine a person's behaviour (which matches up with Skinner's view), but there is much more to consider. The person

can act to change the environment. Person/cognitive factors can influence a person's behaviour and vice versa. Person/cognitive factors include self-efficacy (a belief that one can master a situation and produce positive outcome), plans, and thinking skills. We now turn to another perspective of personality – Humanistic perspectives.

3.4 Humanistic perspectives

The humanistic perspectives stress the person's capacity for personal growth, freedom to choose one's own destiny, and personal qualities. Humanistic psychologists believe each of us has the ability to cope with stress, control our lives, and achieve what we desire. Each of us has the ability to break through and understand ourselves and our world. In this humanistic perspectives, a brief discussion on Carl Rogers (1902 – 1987) and Abraham Maslow (1908 – 1970) will be conducted.

Carl Roger's Approach

Rogers (1902 – 1987) began his inquiry about human nature with people who were troubled. Rogers (1961) examined the conditioned, controlling world that kept them from having positive self-concept and reaching their full potential as human beings. Rogers believed that most people have considerable difficulty accepting their own true feelings, which are innately positive. As we grow up, people who are central to our lives condition us to move away from these positive feelings. Our parents, siblings, teachers and peers place constraints and contingencies on our behaviour. These constraints and negative feedback

continue during our adult lives. The result tends to be that our relationships either carry the dark cloud of conflict or we conform to what others want. As we struggle to live up to society's standards, we distort and devalue our true self. The self-concept is a central theme in Rogers' and other humanists views; self concept refers to individuals' overall perceptions of their abilities, behaviour, and personality. In Roger's view, a person who has an inaccurate self-concept is likely to be maladjusted. The next discourse is on Maslow's approach.

Maslow's Approach

Maslow proposed that we are motivated by a hierarchy of needs. If our physiological needs are met, we become concerned with personal safety; if we achieve a sense of security, we then seek to love, to be loved, and to love ourselves; with our love needs satisfied, we seek self-esteem. Having achieved self-esteem, we ultimately seek self-actualization, the process of fulfilling our potential.

Maslow (1970) developed his ideas by studying healthy, creative people rather than troubled clinical cases. He based his decription of self-actualization on a study of those who seemed notable for their rich and productive lives (Myers, 2004).

Interest in the self led to the belief that self esteem is an important aspect of personality. Self-esteem is the evaluative and affective dimension of self-concept. Self-esteem is also referred to as self-worth (Santrock, 2000). The next perspective is the trait perspectives.

3.5 Trait Perspectives

Trait theories state that personality consists of broad dispositions, called traits, that tend to lead to characteristics responses. In order words, people can be described in terms of the basic ways they behave, such as whether they are outgoing and friendly or whether they are dominant and assertive. People who have a strong tendency to behave in these ways are described as high on the traits; those who have a weak tendency in these ways are described as low in the traits. While trait theorists sometimes differ on which traits make up personality, they all agree that traits are the fundamental building blocks of personality (Cloninger, 1996; Matthew & Dreary, 1998). At this point, let us discuss the views of psychologists on the trait perspectives.

Allport's trait theory

Allport (1961) defined personality as: the dynamic organization within the individual of those psychological systems that determine his characteristic behaviour and thoughts.

He identified two basic kinds of traits:

1. Common traits: basic modes of adjustment applicable to all members of a particular culture, ethnic or linguistic background

2. Individual traits: a unique set of personal dispositions and ways of organizing the world, based on life experiences. Individual traits can take the one of three forms:

cardinal, central or secondary. A brief discuss of these three forms of individual traits follows.

Three kinds of individual traits

1. Cardinal traits are so all-pervading that they dictate and direct almost all of an individual's behaviour, such as someone who is consumed by greed, ambition or lust. However, such traits are quite rare, and most people do not have on predominant trait.
2. Central traits are the basic building blocks that makes up the core of personality and which constitute the individuals characteristic ways of dealing with the world (e.g. honest, loving, happy go lucky). A surprisingly small number of these is usually sufficient to capture the essence of a person.
3. Secondary traits are less consistent and influential than central traits, and refer to tastes, preferences, political persuasion, reactions to particular situations, and so on (Gross, 2011).

The existence and nature of individual traits make it very difficult to compare. Any given individual is a unique creation of the forces of nature. There was never a person just like him and there never will be again (Allport, 1961).

Eysenck's Dimension of Personality: Hans Eysenck (1967) also tackled the task of determining the basic traits of personality. He gave personality tests to large numbers of people and analysed each person's responses. Eysenck said that three main dimensions were needed to explain personality (i) introversion extraversion, (2) stable – unstable (known as the neurotism dimension), and (3) psychotism.

In terms of the introversion – extraversion dimension, an introverted person is quiet, unsociable, passive, and careful; an extraverted person is active, optimistic, sociable, and outgoing. In terms of the stable – unstable dimension, a stable person is calm, even-tempered, carefree and has leadership possibilities, an unstable person is moody, anxious, restless, and touchy.

Eysenck believed that various combinations of these dimensions result in certain personality traits. For example, a person who is extraverted and unstable is likely to be impulsive. The third dimension, psychotism, reflects the degree in which people are in contact with reality, control their impulses and are cruel or caring toward others.

The Big Five Factors: Considerable interest continues to be generated in determining what the key factors of personality really are. Since the 1980s, there has been a vast amount of research to discover a small but comprehensive number of basic trait dimensions that can account for the structure of personality and individual differences.

There is a growing consensus that personality can be adequately described by five broad constructs or factors, the five factor model (often referred to as the Big Five (Costa & McCrae, 1992; Digman, 1990).

The Five major personality traits or factors (commonly abbreviated to NEOAC or OCEAN) are neurotism (or emotional stability), extraversion, openness to experience, agreeableness and conscientiousness.

Research on the big five factors includes the extent to which the factors appear in personality profiles in different cultures, how stable the factors are over time, and the role the factors might play in predicting physical and mental health. The last in this unit is personality assessment.

3.6 Personality Assessment

Clinical and school psychologists assess personality to better understand an individual's psychological problems; they hope the assessment will improve their diagnosis and treatment of the individual. Before we describe some specific personality tests, two important points need to be noted about the nature of personality assessment. First, the kinds of tests chosen by psychologists frequently depend on the psychologist's theoretical belief. And second, most personality tests are designed to assess stable, enduring characteristics, free of situational influence (Hy & Loeviger, 1996). The personality assessments to be discussed are: projective tests, self-report test and behavioural and cognitive assessment.

Projective Tests

A projective test presents individuals with an ambiguous stimulus and then asks them to describe it or tell a story about it. Projective tests are based on the assumption that the ambiguity of the stimulus allows individuals to project into it their feelings, desires, needs, and attitudes. The test is especially designed to elicit the individual's unconscious feelings and conflicts, providing an assessment that goes deeper than the surface of the personality. (Auerback, 1999; Handler,

1999). Projective tests attempt to get inside of your mind to discover how you really feel and think, going beyond the way you overtly present yourself. Let us now discuss some projective tests.

The Rorschach Inkblot Test. The Rorschach Inkblot test, developed in 1921 by the Swiss psychiatrist Hermann Rorschach, is a widely used **projective test;** it uses an individual's perception of inkblots to determine his or her personality. The test consists of ten cards, half in black and white in colour, which are shown to the individual one at a time. The person taking the Rorschach test is asked to describe what he or she sees in each of the inkblots. For example, an individual may say, "That looks like two people fighting". After the individual has responded to all ten inkblots, the examiner presents each of the inkblots again and inquires about the individual's earlier response. For example, the examiner might ask, "where did you see the two people fighting?" and "what about the inkblot made the two people look like they were fighting?" Besides recording the responses, the examiner notes the individual's mannerisms, gestures and attitudes (Santrock, 2000).

The Thematic Apperception Test (TAT). The Thematic Apperception Test, which was developed by Henry Murray and Christina Morgan in the 1930s, is an ambiguous projective test designed to elicit stories that reveal something about an individual's personality. The TAT consists of a series of pictures, each on an individual card. The person taking the TAT is asked to tell a story about each of the pictures, including events leading up to the situation described, the characters' thoughts and feelings, and how the situation turns out. It is assumed

that the person projects her own unconscious feelings and thoughts into the story she tells. In addition to being used as a projective test in clinical practice, the TAT is used in research of achievement motivation (Cramer, 1999). Several of the TAT cards stimulate the telling of achievement related stories, which enables the researcher determine the person's need for achievement. There are many other projective tests used in clinical assessment. Let us now turn to another personality assessment which is self-report tests.

Self Report Tests

Self report tests, also called objective tests or inventories, directly ask people whether items (usually true/false or agree/disagree) describe their personality traits or not. Self report tests are questionnaires that include a large number of statements or questions. You respond with a limited number of choices (yes or no; true or false; agree or disagree. Let us now discuss the most widely used empirically keyed personality test.

The Minnesota Multiphasic Inventory (MMPI). The Minnesota Multiphasic Personality Inventory (MMPI) is the most widely used and researched self report personality test. MMPI initially was constructed to assess "abnormal" personality tendencies and improve the diagnosis of individuals with a mental disorder. A thousand statements were given to both mental patients and apparently normal people. How often individuals agreed on each item was calculated; only the items that clearly differentiated the psychiatric patients from normal individuals were retained. For example, a statement might be included on the depression scale of the MMPI of patients diagnosed with a

depressive disorder agreed with the statement significantly more than did normal individuals.

The MMPI eventually was streamlined to 550 items, each of which can be answered true, false or cannot say. The MMPI includes four validity scales in addition to the ten clinical scales. The validity scales were designed to indicate whether an individual is lying, careless, defensive, or evasive when answering the test items.

For the first time in its approximately 40 year history, the MMPI was revised in 1989. The revision is called the MMPI – 2. It has a number of new items (for a total of 567 items), but the 10 clinical scales were retained as were several of the validity scales. The MMPI -2 continuous to be widely used around the world to assess personality and it has been translated into more than 20 languages. Not only it is used by clinical psychologists to assess a person's mental health, it also is used to predict which individuals will make the best job candidates or which career an individual should pursue (Santrock, 2000). The next focus is on behavioural and cognitive assessment of personality.

Behavioural and Cognitive Assessment

Behavioural assessment attempt to obtain more objective information about an individual's personality by observing the individual's behaviour directly. Instead of removing situational influences from personality as projective tests and self report measures do, behavioural assessment assumes that personality cannot be evaluated apart from the environment. Behaviour modification is an attempt to apply learning principles to change maladaptive behaviour. Behaviour assessment of personality

emerged from this tradition. For example, recall that the observer often will make baseline observations of the frequency of the individual's behaviour. This might be accomplished under controlled laboratory conditions or in more naturalistic circumstances. The therapists then will modify some aspect of the environment such as getting parents and the child's teacher to stop giving the child attention when he engages in aggressive behaviours. After a specified period of time, the therapist will observe again to determine if the changes in the environment were effective in reducing the maladaptive behaviour.

The influence of social cognitive theory has increased the use of cognitive assessment in personality evaluation. The strategy is to discover what thoughts underlie the individual's behaviour; that is, how do individuals think about their problems? What kinds of thoughts precede maladaptive behaviour, occur during its manifestation and follow it? Cognitive processes such as expectations, planning, and memory are assessed, possibly by interviewing the individual or asking him or her to complete a questionnaire.

4.0 CONCLUSION

In this unit, You learned about different theories of personality and learned also that psychologists use a wide variety of tests and measures to assess personality. These measures often are tied to psychologists theoretical perspectives. Personality tests basically were designed to measure stable, enduring aspects of personality.

5.0 SUMMARY

In this unit, you have learned the following: the meaning of personality which involves our enduring thoughts, emotions, and behaviours that characterize the way we adapt to the world. You also learned about the psychoanalytic, behavioural/cognitive, and humanistic perspectives of personality. Furthermore, you learned about the methods of assessing personality which included projective tests, self-report tests and behavioural/cognitive assessment.

6.0 TUTOR-MARKED ASSIGNMENT

- What is personality ?
- Examine the psychoanalytic perspectives of personality
- What is projective test?
- Write short note on MMPI

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MODULE 2: AN OVERVIEW OF DIFFERENT THERAPIES OF HUMAN BEHAVIOUR

Unit 1: Why do people seek therapy?

Unit 2: Who provides psychotherapeutic services?

Unit 3: Measuring success in psychotherapy

Unit 4: Therapeutic approaches: An Overview

Unit 5: Biological approaches

UNIT 1: WHY DO PEOPLE SEEK THERAPY?

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main Content

- 3.1 Why Do People Seek Therapy?
  - i. Stressful current life circumstances
  - ii. People with long-standing problems
  - iii. Reluctant Clients

iv People who seek personal growth

4.0 Conclusion

5.0 Summary

6.0 Tutor-Marked Assignment

7.0 References/Further Reading

1.0 INTRODUCTION

In module one, you learned about the concept of behaviour, types of behaviour, development and acquisition of behaviour, the notion of behaviour modification and personality and behaviour. In this unit, you will learn about the reasons why people seek therapy. The belief that people with psychological problems can change – can learn more adaptive ways of perceiving, evaluating and behaving is the conviction underlying all psychotherapy. Achieving these changes is by no means easy. Sometimes a person's view of the world and his or her self concept are distorted from pathological early relationships reinforced by years of negative life experiences. In other instances, environmental factors such as an unsatisfying job, an unhappy marriage, or financial stresses must be a focus of attention in addition to psychotherapy. Because change can be hard, people sometimes find it easier to bear their present problems than to challenge themselves to chart a different life course. Therapy also takes time. Even the highly skilled and experiences therapist cannot undo a person's entire past history and prepare him or her to cope adequately with difficult life situations

within a short time. Therapy offers no magical transformations. Nevertheless, it holds promise even for the most severe mental disorders (Carson et al, 2011 et al., 2011).

2.0 OBJECTIVES

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

- Explain the reasons why people seek therapy

3.0 MAIN CONTENT

3.1 Why do people seek therapy? People seek therapy because of these listed factors:

i. Stressful current life circumstances
ii. People with long-standing problems
iii. Reluctant Clients
iv. People who seek personal growth

Let us examine these factors briefly.

Stressful current life circumstances. People who seek therapy vary widely in their problems and in their motivation to solve them. Perhaps the most obvious candidates for psychological treatment are people experiencing sudden and highly stressful situations such as a divorce or unemployment, people who feel so overwhelmed by a crisis that they cannot manage on their own. These people often feel quite vulnerable and tend to be open to psychological treatment because they are motivated to alter their present intolerable mental states. In

such situations, clients may gain considerably, in a brief time, from the perspective provided by their therapists.

People with long-standing problems. Other people entering therapy have experienced long- term psychological distress and have lengthy histories of maladjustment. They may have had interpersonal problems such as an inability to be comfortable with intimacy, or they may have felt susceptible to low moods that are difficult for them to check. Chronic unhappiness and the inability to feel confident and secure may finally prompt them to seek outside help. These people seek psychological assistance out of dissatisfaction and despair. They may enter treatment with a high degree of motivation, but as therapy proceeds, their persistent patterns of maladaptive behaviour may generate resistance with which a therapist must contend.

Reluctant clients: Some people enter therapy by a more indirect route. Perhaps they had consulted a physician for their headaches or stomach pains, only to be told that nothing was physically wrong with them. After they are referred to a therapist, they may at first resist the idea that their symptoms are emotionally based. Motivation to enter treatment differs, widely among psychotherapy clients. Reluctant clients may come from many sources, for example, an alcoholic whose spouse threatens “either therapy or divorce,” (Carson et al, 2011). In general, males are more reluctant to enter therapy than females.

People who seek personal growth: A final group of people who enter therapy have problems that would be considered relatively normal. That is, they appear to have achieved success, have financial stability, have generally accepting and loving families, and have accomplished many of their life goals. They enter therapy not out of personal despair or impossible interpersonal involvements, but out of a sense that they have not lived up to their own expectation and realized their own potential. These people, partly because their problems are more manageable than the problems of others, may make substantial gains in personal growth.

Psychotherapy, however, is not just for people who have clearly defined problems, high levels of motivation, and an ability to gain ready insight into their behaviour. Psychotherapeutic interventions have been applied to a wide variety of chronic problems. Even severely disturbed, psychotic client may profit from a therapeutic relationship that takes into account his or her level of functioning and maintains therapeutic subgoals that are within the clients present capabilities (Kendler, 1999b as cited in Carson at al, 2011).

4.0 CONCLUSION

It should be noted from these brief descriptions that there is no “typical client”. Neither is there a “model” therapy. No currently used form of therapy is applicable to all types of clients. Most authorities agree that client variables such as motivation to change and the severity of symptoms are important to the

outcome of therapy. Therefore therapist must take into consideration the characteristics of a particular client.

5.0 SUMMARY

In this unit, you learned about the reasons why people seek therapy. They were listed as:

i. Stressful current life circumstances
ii. People with long-standing problems
iii. Reluctant Clients
iv. People who seek personal growth

6.0 TUTOR-MARKED ASSIGNMENT

- List and explain reasons why people seek therapy

7.0 REFERENCES/FURTHER READINGS

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UNIT 2: WHO PROVIDE PSYCHOTHERAPEUTIC SERVICES?

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main Content

3.1 Who provides psychotherapeutic services?

3.2 The Therapeutic Relationship

4.0 Conclusion

5.0 Summary

6.0 Tutor-Marked Assignment

7.0 References/Further Reading

1.0 INTRODUCTION

In the last unit, you learned about the reasons why people seek therapy. The reasons given were (i) as a result of stressful life circumstances, people with long standing problems. etc. In this unit, you will learn about who provides psychotherapeutic services and the relationship involved.

2.0 OBJECTIVES

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

- Explain who provides psychotherapeutic services
- Discuss the relationship in therapy

3.0 MAIN CONTENT

3.1 Who provides psychotherapeutic services?

Members of many different professions have traditionally provided advice and counsel to individuals in emotional distress. Physicians, in addition to caring for their patients' physical problems, often become trusted advisers in emotional matters as well. Many physicians are trained to recognize psychological problems that are beyond their expertise and to refer patients to psychological specialists or to psychiatrists.

Another professional group who deals extensively with emotional problems is the clergy. A minister, priest, or rabbi is frequently the first professional to encounter a person experiencing an emotional crisis. Although some clergy are trained mental health counselors, most limit their counseling to religious matters and spiritual support and do not attempt to provide psychotherapy. Rather, like general-practice physicians, they are trained to recognize problems that require professional management and to refer seriously disturbed people to mental health specialists (Carson, et al, 2011). You have learn about the role of physicians and men of God in psychotherapy. Our focus now will be on trained professionals in the field of psychotherapeutic service – called mental health professionals.

The three types of mental health professionals who most often administer psychological treatment in mental health settings are clinical psychologists, psychiatrists, psychiatric social workers, and guidance and counselling trained personnel. In addition to their providing psychotherapy, the medical training and licensure qualifications of psychiatrists enable them to prescribe psychoactive medications and also to administer other forms of medical treatment such as electroconvulsive therapy. In the United States of America, appropriately supervised psychologists and other clinical specialists may now prescribe medications if they have received additional training. In Nigeria presently, we have not developed to this status. Although every health professional differs to some degree in his or her training and approach to treatment, generally, psychiatrists differ from psychologists in their predilection for treating mental disorders with a biological approach (i.e. medications), whereas psychologists generally treat patients' psychopathology by examining and in some cases changing their patients' behaviours and thoughts patterns (Carson, et al., 2011).

In a clinic or hospital (as opposed to an individual practice), a wide range of treatment approaches may be used. These range from the use of drugs, to individual or group psychotherapy, to home, school, or job visits aimed at modifying adverse condition in a clients life – for example, helping a teacher become more understanding and supportive to a child – client's needs. Often the latter is as important as treatment directed toward modifying the client's personality, behaviour, or both. The next focus will be the therapeutic relationship.

3.2 The therapeutic Relationship

The therapeutic relationship evolves out of what both the client and therapists bring to the therapeutic situation. The outcome of psychotherapy normally depends on whether the client and therapist are successful in achieving a productive working alliance. The client's major contribution is his or her motivation. Clients who are pessimistic about their problems and symptoms respond less well to treatment (Mussell et al., 2000 as cited in Carson et al., 2011). Let us now discuss two factors in therapeutic relationship, namely the therapeutic alliance and qualities that enhance therapy.

The therapeutic alliance: The establishment of an effective "working alliance" between client and therapists is seen by most investigators and practitioners as essential to psychotherapeutic gain. In a very real sense, the relationship with the therapist is therapeutic in its own right. There is much evidence that therapists' personal characteristics help determine therapeutic outcome. How well clients do in treatment is related to the strength of the alliance they have with their therapists. However, people who have a lot of problems often have very troubled interpersonal relationships. An important skill for any therapists therefore is the ability to foster good relationships with client who may present some challenges in this regard.

Other factors such as the level of expertise and experience of the therapists are important. Expert therapists have been shown to be better than either experienced or novice therapists in such skills as the ability to provide a

clear, coherent, and succinct account of a patient's problems. Although definitions of therapeutic alliance vary, its key elements are (i) a sense of working collaboratively on the problems, (ii) agreement between patient and therapist about the goals and tasks of therapy, and (iii) an affective bond between patient and therapist. Clear communication is also important. This is no doubt facilitated by the degree of shared experience in the backgrounds of client and therapist (Carson et al., 2011).

Qualities that enhance therapy

Clients motivation to change is a crucial element in determining the quality of therapeutic alliance and hence the level of success likely be achieved in the therapeutic effort. A wise therapist appropriately cautions about accepting an unmotivated client. Not all prospective clients regardless of their need for treatment, are ready for the temporary discomfort that effective therapy many entail. As already pointed in unit 1 of this module, many men, in particular, have trouble accepting the conditions that therapy may impose such as the need to report their innermost feelings. Even the motivation of self-referred clients may dissipate in the face of the painful confrontations with self and past experiences that good therapy may require.

Almost as important as motivation is a client's expectation of receiving help. This expectancy is often sufficient in itself to bring about substantial improvement (Fisher & Greenberg, 1997 as cited in Carson, et al. 2011); this may be because patients who expect therapy to be effective engage more in the process. Just as a placebo often lessens pain for someone who believe it will do so, a person who expects to be helped

by therapy is likely to be helped, almost regardless of the particular methods used by therapists. The downside of this fact is that if a therapy or therapists fails for whatever reason to inspire client confidence, the effectiveness of treatment is likely to be compromised.

To the art of therapy, a therapist brings a variety of professional skills and methods intended to help people see themselves and their situations more objectively – that is, to gain a different perspective. Besides helping provide a new perspective, most therapy situations also offer a client a safe setting in which he or she is encouraged to practice new ways of feeling and acting, gradually developing both the courage and the ability to take responsibility for acting in more effective and satisfying ways.

To bring about such changes, an effective psychotherapy must help the client give up old and dysfunctional behaviour patterns and replace them with new functional ones. Because clients will present varying challenges in this regard, the therapist must be flexible enough to use a variety of interactive styles. Effective therapy depends, at least to some extent, on a good match between client and therapist. For this reason, a therapist's own personality is an important factor in determining therapeutic outcomes, quite aside from his or her background and training at the particular formal treatment plan adopted.

4.0 CONCLUSION

In this unit, you learned about who provides psychotherapeutic services. You have now known that such services are not provided by lay people but by clinical psychologists, psychiatrists, psychiatric social workers and guidance

counselors. It is important that the characteristics of the clients must be noted by the therapist and the aspect of motivation of the clients must also be taken into consideration.

5.0 SUMMARY

In this unit, you studied about who provides psychotherapeutic services and you discovered that psychotherapy is provided by:

- General physician
- Religious men
- Clinical psychologists
- Psychiatrist
- Psychiatrists social workers, and
- Guidance counsellors

6.0 TUTOR-MARKED ASSIGNMENT

- What kinds of professional provide help to people in psychological distress?
- In what kind of setting does treatment occur?
- What factors are important in determining how well patients do in therapy?

7.0 REFERENCES/FURTHER READINGS

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UNIT 3: MEASURING SUCCESS IN PSYCHOTHERAPY

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main Content

- 3.1 Measuring Success in Psychotherapy
- 3.2 Changes Occurrence in therapy
- 3.3 Can therapy be Harmful?

4.0 Conclusion

5.0 Summary

6.0 Tutor-Marked Assignment

7.0 References/Further Reading

1.0 INTRODUCTION

In the last unit, you learned something about personnels that provides psychotherapeutic services and the relationship in psychotherapy. In this unit, you will learn about measuring success in psychotherapy, occurrence of changes in therapy and discuss the effects of therapy.

2.0 OBJECTIVES

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

- Explain how success is measured in psychotherapy
- Explain whether therapy can change human behaviour
- Determine whether therapy can be harmful

3.0 MAIN CONTENT

3.1 Measuring Success in Psychotherapy

According to Carson et al (2011), evaluating treatment success is not always as easy as it might seem. Attempts at estimating client's gains in therapy generally depend on one or more of the following sources of information (i) a therapist's impression of changes that have occurred (ii) a client's reports of change, (iii) reports from client's family or friends (iv) comparison of pretreatment and post-treatment scores on personality tests or on other instruments designed to measure relevant facets of psychological functioning, and (v) measures of change in selected overt behaviours. Unfortunately, each of these sources has its own limitations.

A therapist may not be the best judge of a client's progress, because any therapist is likely to be biased in favour of seeing himself or herself as competent and successful (after all, therapists are only human). In addition, the therapist typically has only a limited observational sample (the client's in-session behaviour) from which to make judgments of overall change. Furthermore therapists can inflate improvement averages by deliberately or subtly

encouraging difficult clients to discontinue therapy. The problem of how to deal with early dropouts from treatment further complicates many studies of therapy outcomes.

Also, a client is not necessarily a reliable source of information on therapeutic outcomes. Not only may clients want to believe for various personal reasons that they are getting better, they may report that they are being helped. In addition, because therapy often requires a considerable investment of time, money, and sometimes emotional distress, the idea that it has been useless is a dissonant one (lack of agreement). Relatives of the client may also be inclined to "see" the improvement they had hoped for, although they often seem to be more realistic than either the therapists or the client in their evaluations of outcome.

Clinical ratings by an outside, independent observer are sometimes used in research on psychotherapy outcomes to evaluate the progress of a client; these ratings may be more objective than ratings by those directly involved in the therapy. Another widely used objective measure of client change is performance on various psychological tests. A client evaluated in this way takes a battery of tests before and after therapy, and the differences in scores are assumed to reflect progress, or lack of progress, or occasionally even deterioration. However, some of the changes that such tests show may be artificial, as with regression to the mean (Speer, 1992 as cited in Carson et al., 2011), wherein very high (or very low) scores tend on repeated measurement to drift toward the average of their own distributions, yielding a false impression that some real changes has

been documented. You have learn how to measure success in psychotherapy. Now let us find out whether change can occur.

3.2 Changes Occurrence in Therapy

One important question to find answer to is, what happens to disturbed people who do not obtain formal treatment? In view of the many ways in which people can help each other, it is not surprising that improvement often occurs without professional intervention. Relevant here is the observation that treatment offered by therapists has not always been clearly demonstrated to be superior in outcome to non professionally administered therapies (Christensen & Jacobson, 1994 as cited in Carson et al., 2011). Moreover, some forms of psychopathology such as depressive episodes or brief psychotic disorder sometimes run a fairly short course without treatment. In other instances, disturbed people improve over time for reasons that are not apparent (Carson et al., 2011).

Even if many emotionally disturbed persons tend to improve without psychotherapy, psychotherapy can often accelerate improvement or bring about desired behaviour change that might not otherwise occur. Most researchers today would agree that psychotherapy is more effective than no treatment, and indeed the pertinent evidence, widely cited throughout the entire researches, confirms this strongly. The chances of an average client benefitting significantly from psychological treatment are overall, impressive. Research suggests that about 50 percent of patients show clinically significant change after 21 therapy

sessions. After 40 sessions, about 75 percent of patients have improved (Lambert et al., 2011 as cited in Carson et al., 2011).

3.3 Can Therapy be Harmful?

The outcomes of psychotherapy are not invariably either neutral (no effect) or positive. Some clients are actually harmed by their encounters with psychotherapists. According to one estimate, somewhere between 5 and 10 percent of clients deteriorate during treatment (Lambert & Ogles, 2004 as cited in Carson et al., 2011). Patients suffering borderline personality disorder and from obsessive compulsive disorder typically have higher rates of negative treatment outcomes than patients with other problems.

Obvious ruptures of the therapeutic alliance – what Binder and Strupp (1997 as cited in Carson, et al., 2011) refer to as “negative process” in which client and therapist become embroiled in a mutually antagonistic and downwardly spiraling course – account for only a portion of the failures. In other instances an idiosyncratic array of factors operate together (for example, the mismatch of therapist and client personality characteristics) to produce deteriorating outcomes. It should be noted that certain therapists, probably for reasons of personality, just do not do well with certain types of client problems. In the light of these intangible factors, it is ethically required that all therapists (i) to monitor their work with various types of clients to discover any such deficiencies, and (ii) to refer to other therapists those clients with whom they may be ill-equipped to work (APA, 2002).

A special case of therapeutic harm is the problem of sex between therapist and client, typically seduction of a client (or former client) by a therapist. This is highly unethical conduct. Given the frequently intense and intimate quality of therapeutic relationships, it is not surprising that sexual attraction arises. A prospective client seeking therapy needs to be sufficiently wary to determine that the therapist chosen is one of the large majority who are committed to high ethical and professional standards.

4.0 CONCLUSION

In this unit, it can be concluded that psychotherapy success is measurable. For a valid and reliable measurement, clinical ratings by independent observer and the use of tests are most appropriate. Therapy can be harmful if there is a soiled relationship between the therapist and client. It is therefore advisable for client to seek therapy from a professional who has high regard for ethical values.

5.0 SUMMARY

In this unit, you learned about the following:

- In measuring success in therapy, the role of the therapist, the client, family or friends are important
- Changes in behaviour occur during therapy
- Therapy can be harmful as a result of the characteristics of the therapist and the client.

6.0 TUTOR-MARKED ASSIGNMENT

- What approaches can be used to evaluate treatment success?
- Do people who receive psychological treatment always show a clinical benefit?

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UNIT 4: THERAPEUTIC APPROACHES – AN OVERVIEW

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main Content

- 3.1 Psychodynamic therapies
- 3.2 Humanistic therapy
- 3.3 Behaviour Therapy
- 3.4 Cognitive Therapies
- 3.5 Social approaches

4.0 Conclusion

5.0 Summary

6.0 Tutor-Marked Assignment

7.0 References/Further Reading

1.0 INTRODUCTION

In the last unit, you studied measuring success in psychotherapy, changes occurrence in therapy and the effect of therapy in human behaviour. In this unit, you will briefly learn about the different approaches in therapy. The aim is to

prepare you for the last module in this course which is module 3, where each of the approaches will be discussed elaborately.

2.0 OBJECTIVES

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

- Explain the meaning psychodynamic therapies
- Discuss humanistic therapy
- Examine behaviour therapy, and
- Explain cognitive therapies
- Discuss social approaches

3.0 MAIN CONTENT

3.1 Psychodynamic Therapies

Psychodynamic therapies focus on uncovering and resolving unconscious conflicts that drive psychological symptoms. The goal is to help clients recognize the maladaptive ways in which they have been trying to cope and the sources of their unconscious conflicts. These insights free clients from the grip of the past and give them a sense of agency in making changes in the present. (Vakoch & Strupp, 2000). Another goal is to help clients integrate aspect of their personality that have been split off or denied into a unified sense of self.

Sigmund Freud is the original founder of psychodynamic therapy. Psychoanalysis was his therapeutic technique. Freud believed the patient's free associations, resistance, dreams, and transferences and the therapist's

interpretations of them released previously repressed feelings, allowing the patient to gain self-insight. You will learn more about it in the last module.

3.2 Humanistic Therapy

The goal of humanistic therapy, often referred to as person-centered therapy, is to help the client discover his or her potentialities and place in the world and to accomplish self-actualisation through self-exploration. Person – centered therapies are unique in the extent to which they emphasise the self healing capacities of the person (Bohart, 1995). The job of the therapist in person centered therapy is not to act as an authority or expert who provides healing to the client. Rather, the therapist's job is to provide the optimal conditions for the client to heal him or herself. This therapy rests on the assumptions that the natural tendency for human is toward growth. Person centered therapists do not push clients to uncover pressed painful memories or unconscious conflicts. Instead, they believe that, when clients are supported and empowered to grow and self-actualize, they will eventually face their past when it is necessary for their further development (Bohart, 1995). The best known of these therapies is Carl Rogers' client – centered therapy (CCT).

3.3 Behaviour Therapies

Just as behaviour theories of psychopathology are radically different from psychodynamic and humanistic theories, behaviour therapies would seem to be the polar opposite of these other therapies. Whereas psychodynamic therapies focus on uncovering unconscious conflicts and relational issues that develop

during childhood and humanistic therapies focus on helping the client discover the inner self, behaviour therapies focus only on changing a person's specific behaviour in the present day.

The foundation for behaviour therapy is the behaviour assessment of the client's problem. The therapist works with the client to identify the specific circumstances that seem to elicit the client negative behaviour or emotional responses. What situations seem to trigger anxiety symptoms? When is the client most likely to begin heavy drinking? What types of interactions with other people make the client feel most distressed? The behaviour therapies are based on the theories classical conditioning of Ivan Pavlov and Operant conditioning of B. F. Skinner. You will learn more about it in the last module.

Cognitive Therapies

Cognitive therapies focus on challenging people's maladaptive interpretations of events or ways of thinking and replacing them with more adaptive ways of thinking. Cognitive therapists also help clients learn more effective problem solving techniques to deal with the concrete problems in their lives.

One of the most widely used forms of cognitive therapy was developed by Aaron Beck (1976). Techniques in cognitive can be condensed into three main goals. The first goal is to assist clients in identifying their irrational and maladaptive thoughts and to consider alternative ways of thinking. The third question or set of questions the cognitive therapist might happen?" and "what

could you do if the worst get the client to face his or her worst fears about a situation and recognize ways the client could cope with even his or her fears. The next focus in this unit is the social approaches.

Social Approaches

Biologically based treatments focus on changing physical symptom. This will be discussed in unit 5 of this module. Psychological therapies focus primarily on changing the ways people think and behave. The social approaches to therapy view the individual as a part of the a larger system of relationships, influenced by social forces and culture, and view that this larger system must be addressed in therapy. Under the social approaches we have interpersonal therapy, family system therapy and group therapy. You will learn more about them.

4.0 CONCLUSION

In this unit, you have been introduced to the different therapeutic approaches. This is done to prepare your mind towards comprehending the different approaches involved in therapies. It is also important to state that just as we have different psychological perspectives in the study of psychopathology, personality assessment, so also we have different therapeutic approaches.

5.0 SUMMARY

In this unit, you have been introduced to the different therapeutic approaches in treating maladaptive behaviours. The psychodynamic therapy of

Sigmund Freud, humanistic theory of Carl Rogers, behavioural theory, cognitive therapies and the social approaches were briefly explained.

6.0 TUTOR-MARKED ASSIGNMENT

- List and explain 5 therapeutic approaches in treating maladaptive behaviour

7.0 REFERENCES/FURTHER READINGS

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UNIT 5: BIOLOGICAL APPROACHES

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main Content

- 3.1 Drug Therapies
- 3.2 Electroconvulsive therapy
- 3.3 Psychosurgery

4.0 Conclusion

5.0 Summary

6.0 Tutor-Marked Assignment

7.0 References/Further Reading

1.0 INTRODUCTION

In the last unit, you learned about the different therapeutic approaches in treating of maladaptive behaviours in human organisms. In this unit, you will learn about biological approaches in treating mental disorders. This unit will provide you with some important facts that will assist you to function as a competent and professionally trained guidance counselor.

2.0 OBJECTIVES

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

- Discuss drug therapies in treating maladaptive behaviours
- Explain the use of electroconvulsive therapy
- Examine the importance of psychosurgery

3.0 MAIN CONTENT

3.1 Drug Therapies

Under drug therapies, the major classes of medications that are now routinely used to help patients with a variety of mental disorders, as well as some additional treatment approaches (such as electroconvulsive therapy) will be discussed. The drug therapies under discussion are (i) antipsychotic drugs (2) antidepressant drugs, and (3) anti-anxiety drugs.

Antipsychotic Drugs

As their names suggests, antipsychotic drugs are used to treat psychotic disorders such as schizophrenia and psychotic mood disorders in abnormal psychology. The key therapeutic benefit of antipsychotics derives from their ability to alleviate or reduce the intensity of delusions or hallucinations. They do this by blocking dopamine receptors.

Antipsychotic medications are usually administered daily by mouth. However, some patients, particularly those with chronic schizophrenia, are often not able to remember to take their medication each day. In such cases, depot

neuroleptics can be very helpful. These are neuroleptics that can be administered in a long acting, injectable form. The clinical benefits of one injection can last for up to 4 weeks. We are not interested in learning about the names of these antipsychotics drugs because it is not the responsibility of a counselor to prescribe them for patients.

Antidepressant drugs

Antidepressant drugs lift people up from a state of depression. Most antidepressants work by increasing the availability of the neurotransmitters norepinephrine or serotonin, which elevate arousal and mood and appear scarce during depression. Consider fluozetine, which 38 million users worldwide have known as Prozac (Goode, 2000). Prozac and other serotonin – enhancing drugs have been prescribed not only to patients with depression but also to those with obsessive compulsive disorder (OCD).

Prozac partially blocks the reabsorption and removal of serotonin from synapses. Because they slow the synaptic vacuuming up of serotonin, Prozac, and its cousins Zoloft and paxil, are therefore called “selective serotonin – reuptake – inhibitor drugs (SSRIs). Other antidepressants work by blocking the reabsorption of both norepinephrine and serotonin or by inhibiting an enzyme that breaks down neurotransmitters such as serotonin. These drugs, though no less effective, have more potential side effects, such as dry mouth, weight gain, and hypertension or dizzy spells (Anderson, 2000; Mulrow, 1999). Myers (2004) remarked that one side effect of SSRI drugs can be decreased sexual appetite,

which has led to their occasional prescription to control sexual behaviour (Slater, 2000 as cited by Myers, 2004).

Antianxiety drugs

Like alcohol, antianxiety agents such as Xanax or Valium, depress central nervous system activity (and so should not be used in combination with alcohol). Used in combination with other therapy, an antianxiety drug can help a person learn to cope with frightening situations and fear triggering stimuli. These drugs appear to reduce the symptoms of anxiety without interfering substantially with an individual's ability to function in daily life. The most frequent use of benzo diazepines, accurately referred to us minor transquilizers, is as sleeping pills. Unfortunately, these drugs are highly addictive, and up to 80 percent of the people who take them for six weeks or more show withdrawal symptoms, including heart rate acceleration, irritability, and profuse sweating (Nolen – Hoeksema, 2004). The next focus now is electroconvulsive therapy.

Electroconvulsive therapy

An alternative to drug therapies in the treatment of some disorders is electroconvulsive therapy, or ECT. ECT was introduced in the early twentieth century, originally as a treatment for schizophrenia. Italian physicians Ugo Cerletti and Lucio Bini decided to experiment with the use of ECT to treat schizophrenia, reasoning that ECT can calm people with schizophrenia much as experiencing an epileptic seizures would calm and sedate people with epilepsy.

Eventually, clinicians found that ECT is not effective for schizophrenia, but it is effective for depression (Nolen – Hoeksema, 2004).

ECT consists of a series of treatments in which a brain seizure is induced by passing electrical current through the patient's brain. Patients are first anesthetized and given muscle relaxants, so that they are not conscious when they have seizure and so that their muscles do not jerk violently during the seizure. Metal electrodes are taped to the head and a current of 70 to 150 volts is passed through one side of the brain for about one-half of a second. Patients typically have a convulsive, which lasts about one minute. The full series of treatments consists of 6 to 12 sessions.

Although many mental-health professionals believe that ECT can be useful, it remains a controversial treatment. The idea of passing electrical current through the brain of a person to relieve psychiatric symptoms seems somewhat bizarre (Nolen-Hoeksema, 2004). And some critics argue that ECT still results in significant and permanent cognitive damage, even when done according to modern guidelines (Breggin, 1997). For some seriously depressed people who do not respond to medications, however, ECT may be the only effective alternative. The last important thing to learn in this unit is psychosurgery.

Psychosurgery

In the study of abnormal psychology you learnt about the theories that prehistoric peoples performed crude brain surgery, called trephining, on people with mental disorders in order to release the evil spirits causing the mental

disorders. In modern times, brain surgery did not really become a mode of treatment of mental disorders until early twentieth century. A Portuguese neurologists named Antonio de Egas Moniz introduced the procedure in 1935 in which the frontal lobes of the brain are severed from the lower centres of the brain of people suffering from psychosis. This procedure eventually developed into the procedure known as prefrontal lobotomy. Although Moniz won the Nobel Prize for his work, prefrontal lobotomies were eventually criticized as a cruel and ineffective means of treating psychosis (Valenstein, 1986). Patients would suffer severe permanent side effects, including either an inability to control impulses or a loss of the ability to initiate activity, extreme listlessness or loss of emotions, seizures, and sometimes even death (Nolen – Hoeksema, 2004).

By the 1950s, the use of psychosurgery had declined. These days, psychosurgery is used rarely, and only with people who have severe disorders that do not respond to other forms of treatment. Modern neurological assessment and surgical techniques make psychosurgery more precise and safe than it formerly was, although it remains highly controversial, even among professionals.

4.0 CONCLUSION

In this unit, you have seen that drug therapies such as antipsychotics, antidepressants and antianxiety drugs can help in the treatment of different mental disorders. You have also seen that electroconvulsive and psychosurgery are important approaches in the treatment of maladaptive behaviours. As

guidance counselors, you may not be competent to prescribed drugs because you do not have the professional competence to do so. But your knowledge of biological approach is an imperative. It will help you to make adequate referral when your psychological approaches fail.

5.0 SUMMARY

In this unit, you learned about drug therapies. Antipsychotic drugs were described as drugs used in treating psychotic disorders such as schizophrenia. Antidepressant drugs lift people from state of depression and antianxiety drugs helps to calm the central nervous system. Electroconvulsive therapy is alternative to disorders that defy medical treatment. Psychosurgery that started in a crude form in the ancient times is still being used today in a modernized way.

6.0 TUTOR-MARKED ASSIGNMENT

- What kinds of disorders can be treated with antipsychotic drugs? How do these drugs help patients? What are their drawbacks?
- Do the clinical advantages of ECT out weight its disadvantages?

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MODULE 3: PSYCHOLOGICAL APPROACHES

Unit 1: Behaviour therapy?

Unit 2: Cognitive and Cognitive – behavioural therapies

Unit 3: Humanistic – Experiential Therapies

Unit 4: Psychodynamic therapies

Unit 5: Marital and Family Therapy

UNIT 1: BEHAVIOUR THERAPY

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main Content

- 3.1 Behaviour Therapy
- 3.2 Behaviour modification
- 3.3 Operant conditioning
- 3.4 The token economy

4.0 Conclusion

5.0 Summary

6.0 Tutor-Marked Assignment

7.0 References/Further Reading

1.0 INTRODUCTION

In the last unit, you learned about the reasons why people seek therapy; who provides psycho-therapeutic services; measurement of success in psychotherapy therapeutic approaches, and biological approaches. In this unit, a detailed treatment will be given to behaviour therapy as a means of changing clients maladaptive behaviours. It is important for you to remain attentive as you learn now.

2.0 OBJECTIVES

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

- Discuss the concept of behaviour therapy
- Explain behaviour modification
- Analyse operant conditioning
- Explain the processes involved in token economy

3.0 MAIN CONTENT

3.1 Behaviour Therapy

Behaviour therapy refers to techniques based (primarily) on classical conditioning, developed by psychologists such as Eysenck and Wolpe. Wolpe (1958) defined behaviour therapy as 'the use of experimentally established principles of learning for the purpose of changing unadaptive behaviour'. To explain behaviour therapy properly, you will learn about (i) systematic desensitization (ii) implosion (implosive therapy) and flooding (iii) aversive therapy.

Systematic Desensitisation

The case little Peter represents the earliest example of any kind of behavioural treatment. Peter was a two – year-old living in a charitable institution. Jones was mainly interested in those children who cried and trembled when shown an animal (such as a frog, rat or rabbit). Peter showed an extreme fear of rats, rabbits, feathers, cotton wool, fur coats, frogs and fish, although in other respects he was regarded as well adjusted. It was not known how these phobias had arisen.

Jones, supervised by Watson, put a rabbit in a wire cage in front of Peter while he ate his lunch. After 40 such sessions, Peter ate his lunch with one hand and strokes the rabbit (now on his lap) with the other. In a series of 17 steps, the rabbit (still in the cage) had been brought a little closer each day, then let free in the room, eventually sitting on Peter's lunch tray (Jones, 1924). The methods used to remove his phobia of animals were later called systematic desensitization (SD) by Wolpe (1958). It represents a form of counter-

conditioning, and the key principle in SD is that of reciprocal inhibition. According to Wolpe (1969): “if a response inhibitory of anxiety can be made to occur in the presence of anxiety – evoking stimuli it will weaken the bond between these stimuli and the anxiety” (Wolpe, 1969). In other words, it is impossible for someone to experience two opposite emotions (e.g. anxiety and relaxation) at the same time. Accordingly, a patient or client with a phobia is first taught to relax through deep muscle relaxation. So, relaxation and fear of the object or situation ‘cancel each other out’ (this is the desensitization part of the procedure).

The systematic part of the procedure involves a graded series of contacts with the phobic object (usually by imagining it), based on a hierarchy of possible forms of contact, from the least of the most frightening. Starting with the least frightening, the client, while relaxing, imagines the object (e.g. the forthcoming examination) until this can be managed without feeling of any anxiety at all. Then, and only then, the next most feared contact will be dealt with, in the same way, until the most frightening contact can be imagined with no anxiety (the examination date and sitting down with question paper and answer booklet on the desk).

Implosion (implosive therapy) and flooding

Implosion is essentially about exposing the client to what, in systematic desensitization, would be at the top of the hierarchy. Instead of gradual exposure accompanied by relaxation, the client is thrown in at the deep end’ right from the

start. This is done by getting the client to imagine terrifying form of contact. How can we make this process to work?

The client's anxiety is maintained at such a high level that eventually some process of exhaustion or stimulus satiation takes place – the anxiety level can only go down. Extinction occurs by preventing the client from making the usual escape or avoidance response. Implosion (and flooding), therefore, represents a form of 'forced reality testing' (Yates, 1970).

Flooding is exposure that takes place in vivio. This means confronting real-life situations.

Aversion Therapy

In aversion therapy, some undesirable response to a particular stimulus is removed by associating the stimulus with another, aversive stimulus. For example, alcohol is paired with an emetic drug (which induces severe nausea and vomiting), so that nausea and vomiting become a conditioned response to alcohol.

Clients would, typically, be given warm saline solution containing the emetic drug. Immediately before the vomiting begins, they are given some glass of whisky, which they are required to smell, taste and swill around in the mouth before swallowing. If vomiting has not occurred, another glass of whisky is given and, to prolong nausea, a glass of beer containing emetic. Subsequent treatments involve larger doses of injected emetic, or increases in the length of treatment time. Between trials, the client may sip soft drinks to prevent

generalization to all drinking behaviour and to promote the use of alcohol substitutes. Meyer and Chesser (1970) found that about half their alcoholic clients abstained for at least one year following treatment, and that aversion therapy is better than no treatment at all. The next focus is on behaviour modification in behaviour therapy.

3.2 Behaviour Modification

Behaviour modification refers to techniques based on operant conditioning, developed by psychologists such as Ayllon and Azrin, to build up appropriate behaviour (where it did not previously exist) or to increase the frequency of certain responses and decrease the frequency of others.

According to Baddeley (1990), most behaviour programmes follow a broadly similar pattern involving a series of steps:

Step 1: Specify the behaviour to be changed. It is important to choose small, measurable, achievable goals

Step 2: The goal should be stated as specifically as possible

Step 3: A baseline rate should be measured over a period of several days, that is, how the person ‘normally’ behaves with respect to the selected behaviour. This may involve detailed observation, which can suggest hypotheses as to what is maintaining that behaviour.

Step 4: Decide on a strategy. For example, selectively reinforce non-yelling behaviour (through attention) and ensure that yelling behaviour is ignored.

Step 5: Plan treatment. It is essential that everyone coming into contact with the patient behaves in accordance with the chosen strategy.

Step 6: Begin treatment

Step 7: Monitor progress

Step 8: Change the programme if necessary (Baddeley, 1990 as cited in Gross, 2011). These steps presented are very important in behaviour modification and it is therefore suggested that we should pay attention to them. The next section deals with operant conditioning

Operant Conditioning

In operant conditioning, behaviours will be learned most quickly if they are paired with the reward or punishment every time the behaviour is emitted. This consistent response is called a continuous reinforcement schedule. Behaviours can be learned and maintained, however, on a partial reinforcement schedule, in which reward or punishment occurs only sometimes in response to the behaviour. Extinction – eliminating a learned behaviour – is more difficult when the learned behaviour was through a continuous reinforcement schedule. This is because the organism will continue to emit the behaviour learned through a partial reinforcement schedule in the absence of the reward, anticipating that the reward will eventually come. A good example is gambling behaviour. People who

frequently gamble are seldom rewarded, but they continue to gamble in anticipation of that occasional, unpredictable win (Nolen-Hoeksema, 2004).

3.4 The Token Economy

The token economy (TE) is based on the principle of secondary reinforcement. Token (secondary or conditioned reinforcers) are given for socially desirable/acceptable behaviours as they occur, and can then be exchanged ('chased in') later on for certain 'primary' reinforcers.

The TE was introduced by Ayllon and Azrin (1968), who set aside an entire ward of a psychiatric hospital for a series of experiments in which reinforcements were provided for activities such as face-washing, teeth-brushing, dressing properly and making beds, and withheld for withdrawn or bizarre behaviour. The participants were 44 female chronic schizophrenic patient, with an average 16 years of hospitalization. Some screamed for long periods, some were mute, many were incontinent, and a few were assaultive. Most no longer ate with cutlery, and some buried their faces in the food.

A baseline measure was made of how often socially desirable behaviours normally occurred. They were then systematically reinforced every time the desired behaviours occurred with plastic tokens that could later be exchanged for special privileges (e.g. listening to records, going to the cinema, renting a private room, extra visits to the canteen). The entire life of each patient was, as far as possible, controlled by this regime. Results showed that the patients significantly

increased the frequency of the desired behaviours when they were reinforced (Gross, 2010).

If the introduction of chlorpromazine and other antipsychotic drugs in the 1950s marked a revolution in psychiatry, the introduction of TE programmes, during the 1960s was, in its way, equally revolutionary (Gross, 2010).

4.0 CONCLUSION

In this unit, you learned about behaviour therapy which is based on classical conditioning and operant conditioning respectively. Both see adaptive and maladaptive behaviour as being acquired in the same way, and both rejected the medical model.

5.0 SUMMARY

In this unit, behaviour therapy and modification were learned. You also learn about systematic desensitization developed by Wolpe. He emphasized the exposure of clients to the active ingredients that seems to be the feared object/situation. Furthermore, implosion, flooding, aversive therapy, operant conditioning and token economy were studied.

6.0 TUTOR-MARKED ASSIGNMENT

- Explain the processes in systematic desensitization
- List and explain the processes in behaviour modification

- Differentiate between operant conditioning and token economy

7.0 REFERENCES/FURTHER READINGS

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UNIT 2: COGNITIVE AND COGNITIVE – BEHAVIOURAL THERAPY

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main Content

3.1 Cognitive and cognitive -Behavioural Therapy

3.2 Rational Emotive Behaviour therapy

3.3 Beck's cognitive therapies

4.0 Conclusion

5.0 Summary

6.0 Tutor-Marked Assignment

7.0 References/Further Reading

1.0 INTRODUCTION

In the last unit, you focused on behaviour therapy where you learned about behaviour modification, where techniques like systematic desensitization, implosion, aversion therapies are used. You also learnt about the steps in

behaviour modification, and the issues of operant conditioning and token economy were discussed respectively.

In this unit, you will learn about the concept of cognitive and cognitive – behavioural therapy. The rational emotive behaviour therapy of Albert Ellis and Beck's cognitive therapies will be treated in a way that you will be satisfied, and an evaluation of cognitive – behavioural therapies concludes this unit. So be attentive and remain focus to learn now.

2.0 OBJECTIVES

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

- Explain cognitive and cognitive - behaviour therapy
- Discuss the processes in rational emotive therapy
- Examine Beck's cognitive therapies

3.0 MAIN CONTENT

3.1 Cognitive and Cognitive - Behavioural Therapy

Early behaviour therapists focused on observable behaviour and regarded the inner thoughts of the clients as unimportant. Because of this, these therapists were often viewed as mechanistic technicians who simply manipulated their clients without considering them as people (Carson et al., 2011). Starting in the 1970s, a number of behaviour therapists began to reappraise the importance of "private events" – thoughts, perceptions, evaluations, and self-statements and started to see them as processes that mediate the effects of objective stimulus

conditions and thus help determine behaviour and emotions (Borkovec, 1985; Mahoney & Arnkoff, 1978 as cited in Carson et al., 2011).

Cognitive and cognitive – behavioural therapy (terms used interchangeably) stem from both cognitive psychology (with its emphasis on the effects of thoughts on behaviour) and behaviourism (with its rigorous methodology and performance – oriented focus). At the present time, no single set of techniques defines cognitively oriented treatment approaches. Two main themes are important, however (i) the conviction that cognitive processes influence emotion, motivation, and behaviour, and (ii) the use of cognitive and behaviour change techniques in a pragmatic (hypothesis testing) manner. The next section of this unit will focus on rational emotive behaviour therapy of Albert Ellis and then focus more in detail on cognitive therapy approach of Aaron beck.

3.2 Rational Emotive Behaviour Therapy

One of the earliest developed of the behaviourally oriented cognitive therapies is the rational emotive therapy (now called rational emotive behaviour therapy – REBT) of Albert Ellis. REBT attempts to change a clients maladaptive thought processes, on which maladaptive emotional responses, and thus behaviour, a presumed to depend. Ellis posited that a well functioning individual behaves rationally and time with empirical reality. Unfortunately, however, many of us have learned unrealistic beliefs and perfectionistic values that cause us to expect too much of ourselves, leading us to behave irrationally and then to feel that we are worthless failures. For example, a person may continually think, “I

should be able to win everyone's love and approval" or "I should thoroughly adequate and competent in everything I do". Such unrealistic assumptions and self demands inevitably spell problems (Carson et al., 2011).

The task of REBT is to restructure an individual's belief system and self-evaluation, especially with respect to the irrational "should", "ought", and "musts" that are preventing the individual from having a more positive sense of self-worth and an emotionally satisfying, fulfilling life. Ellis (1962, 1996) says that we usually talk to ourselves when we experience stress; too often the statements are irrational, making them more harmful than helpful. Ellis abbreviated the therapy process into the letters A, B, C, D, E. Now, look at the steps below.

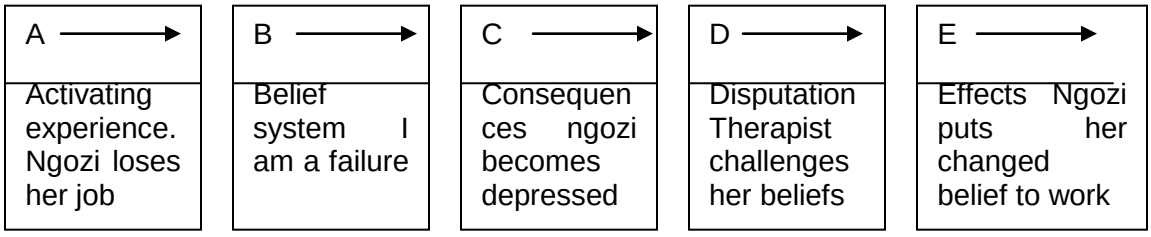

Figure 5.1

A – E Steps in Ellis Rational – Emotive Behaviour Therapy (Adapted from Santrock, 2000)

Therapy usually starts at C, the individual's upsetting emotional consequences; this might involve depression, anxiety or a feeling of worthlessness. The individual often says that C was caused by A, the activating experience, such as the case of Ngozi that lost her job. The therapist works with the individual to

show that an intervening factor B, the individual's Belief system, is usually responsible for why he moved from A to C. Then the therapist goes on to D, which stands for disputation; at this point, the individual's irrational beliefs are disputed or contested by the therapist. Finally, E is reached, which stands for effects or outcomes of the rational – emotive behaviour therapy, as when individuals put their changed beliefs to work. This disputation stage is very important. It helps to dispute a person's false beliefs through rational confrontation. One must not think that he was not promoted in his work place and because of that he feels that he is worthless.

Concluding, rational emotive behaviour therapy aims at increasing an individual's feeling of self-worth and clearing the way for self-actualisation by removing the false beliefs that have been stumbling blocks to personal growth. The philosophy underlying REBT has something in common with that underlying humanistic therapy which you will learn in unit 3 of Module 5, because both take a clear stand on personal worth and human values.

Beck's Cognitive Therapies

Beck's cognitive therapy approach was originally developed for the treatment of depression and was later extended to anxiety disorders, eating disorders and obesity, conduct disorder in children, personality disorders, and substance abuse. Beck (1993) defines cognitive – behavioural therapy (CBT) as:

> *The application of the cognitive model of a particular disorder with the use of a variety of techniques designed to*

modify the dysfunctional beliefs and family information processing characteristics of each disorder.

The cognitive model is basically an information processing model of psychotherapy. A basic assumption of the cognitive model is that problems result from biased processing of external events or internal stimuli. These biases distort the way that a person makes sense of the experiences that he or she has in the world, leading to cognitive errors. Let us now learn about certain cognitive biases that cause people to misperceive reality.

The main cognitive biases in beck's theory. The main cognitive biases in Beck's theory are (i) arbitrary inference, (2) selective abstraction, (3) overgeneralization, and (4) magnification and minimization. Let us take them one by one for explanation.

1. Arbitrary inference: a conclusion drawn in the absence of sufficient evidence – or any evidence at all. For example, a man concludes that he is worthless because it is raining the day he is hosting a club meeting
2. Selective abstraction: a conclusion drawn on the basis of just one of many elements in a situation. For example, a worker feels worthless when a product do not sell well in the market, even though she is not the only one that contributed to its production
3. Overgeneralization: an overall sweeping conclusion drawn on the basis of a single, perhaps trival, event. For example, a student regards his poor

performance in a single class on one particular day as final proof of his worthlessness and stupidity

4. Magnification and minimization: exaggeration in evaluating performance. For example, a man believes he has completely ruined his car (magnification) when he sees a small scratch on the rear bumper. A woman believes herself to be worthless (minimization) despite a succession of praiseworthy achievement (David & Neale as cited in Gross, 2010).

Beck's Therapeutic Processes

In the initial phase of cognitive therapy, clients are made aware of the connection between their patterns of thinking and their emotional responses. They are first taught simply to identify their own automatic thoughts (such as, "This event is a total disaster") and to keep records of their thought content and their emotional reactions. With the therapist's help, they then identify the logical errors in their thinking and learn to challenge the validity of these automatic thoughts. The errors in the logic behind their thinking lead then (i) to perceive the world selectively as harmful while ignoring evidence to the contrary; (2) to overgeneralise (3) to magnify and (4) to engage in absolutistic thinking – for example critical comment and perceiving it as proof of their instance descent from goodness to worthlessness (Carson et al., 2011).

Beck's and Ellis' cognitive therapies have some similarities. However, there are also some differences between them. Rational emotive behaviour therapy is very directive, persuasive, and confrontational. It also focuses on the

therapist's teaching role. In contrast, Beck's cognitive therapy involves more of an open-ended dialogue between the therapist and the individual. The aim of the dialogue in Beck's approach is to get the individuals to reflect on personal issues and discover their own misconceptions. Beck also encourages individuals to gather information about themselves and to try out unbiased experiments that reveal the inaccuracies of their beliefs.

4.0 CONCLUSION

In this unit, you learned that cognitive therapies emphasized that the individual's cognitions or thoughts are the main source of abnormal behaviour. Cognitive therapies attempt to change the person's feelings and behaviours by changing cognitions.

5.0 SUMMARY

In this unit, you learned that Ellis' approach is based on the assertion that individuals become psychologically disordered because of their beliefs, especially those that are irrational and self-defeating. You also learned that Beck's cognitive therapy was meant for depression which involves getting people to make connections between their patterns of behaviour and emotional responses. With the therapists assistance, they learn about logical errors in their thinking, then how to challenge these mistakes in thinking.

6.0 TUTOR-MARKED ASSIGNMENT

- In what ways are REBT and cognitive therapy similar. In what ways are they different

7.0 REFERENCES/FURTHER READINGS

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UNIT 3: HUMANISTIC – EXPERIENTIAL THERAPIES

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main Content

- 3.1 Humanistic – Experiential Therapies
- 3.2 Client - Centered therapy
- 3.3 Gestalt therapy
- 3.4 Process – experiential therapy

4.0 Conclusion

5.0 Summary

6.0 Tutor-Marked Assignment

7.0 References/Further Reading

1.0 INTRODUCTION

In the last unit, you learned about cognitive and cognitive behavioural therapies. You learned about Albert Ellis-REBT and Beck's cognitive-therapies. You also learned about the similarities and differences in both therapies.

In this unit, you will learn about the humanistic-experiential theory. A prominent psychologist – Carl Rogers will be the major focus in client-centered therapy. Furthermore, you will learn about Gestalt therapy and process-experiential therapy. Stay focused.

2.0 OBJECTIVES

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

- Discuss the essential elements in humanistic therapy
- Explain the central issues in Client-centered therapy
- Explain the role of Gestalt therapy in the treatment of maladaptive behaviour
- Examine the process-experiential therapy

3.0 MAIN CONTENT

3.1 Humanistic - experiential Therapies

Humanistic-experiential therapies emerged as significant treatment approaches after World War II. In a society dominated by self-interest, mechanization, computerization, mass deception, and mindless bureaucracy, proponents of the humanistic – experiential therapies see psychopathology as stemming in many cases from problems of alienation, depersonalization, loneliness, and a failure to find meaning and genuine fulfillment (Carson et al, 2011). Problems of this sort, it is held, are not likely to be solved either by delving into forgotten memories or by correcting specific maladaptive behaviours.

The humanistic-experiential therapies are based on the assumption that we have both the freedom and the responsibility to control our own behaviour – that we can reflect on our problems, make choices; and take positive action. Humanistic experiential therapists feel that a client must take most of the responsibility for the direction and success of therapy, with the therapist serving mainly as counselor, guide, and facilitator. Although humanistic –experiential therapies differ in their details, their central focus is always expanding or clients "awareness". According to Santrock (2000), the humanistic perspective stress the person's capacity for personal growth, freedom to choose one's own destiny; and positive qualities. Humanistic psychologists believe each of us has the ability to cope with stress, control our lives, and achieve what we desire. Each of us has the ability to break through and understand ourselves and our world; we can burst the cocoon and become a butterfly, say the humanists. You can see how important we are in determining our destiny. The next focus is on client-centered therapy.

3.2 Client Centered-Therapy (Person-Centered Therapy)

The client-centered (person-centered) therapy of Carl Rogers (1902 – 1987) focused on the natural power of the organism to heal itself (Rogers, 1951, 1961). Rogers saw therapy as a process of removing the constraints and restrictions that grow out of unrealistic demands that people tend to place on themselves when they believe, as a condition of self-worth, that they should not have certain kinds of feelings such as hostility. By denying that they do in fact have such feelings, they become unaware of their actual "gut" reactions (natural

feelings). As they lose touch with their own genuine experience, the result is lowered integration, impaired personal relationships and various forms of maladjustment.

The primary objective of Rogerian therapy is to resolve this incongruence – to help client become able to accept and be themselves. To this end, client-centered therapists establish a psychological climate in which clients can feel unconditionally accepted, understood, and valued as people. Within this context, the therapist employs non-directive techniques such as empathic reflecting, or restatement of the client's descriptions of life difficulties. If all goes well, clients begin to feel free, for perhaps the first time, to explore their real feelings and thoughts and to accept hates and angers and ugly feelings as part of themselves. As their self-concept becomes more congruent with their actual experience, they become more self-accpeting and more open to new experiences and new perspectives; in short, they become better integrated people.

Roger's therapy was initially called client-centered therapy, but he rechristened it person-centered therapy to underscore his deep belief that every person has the ability to grow. The relationship between the therapist and the person is an important aspect of Rogers' therapy. The therapist must enter into an intensely personal relationship with the client, not as a physician diagnosing a disease, but as one human being to another. Rogers believed each of us grows up in a world filled with conditions of worth, the positive regard we received from others that has strings attached. We usually do not receive love and praise unless we conform to the standards and demands of others. This causes us to

be unhappy and have low self-esteem. Rarely do we feel that we measure up to such standards or that we are as good as others expect us to be.

To free the person from worry about the society's demands, the therapist engages in unconditional positive regard in which the therapist creates a warm and caring environment, never disapproving of the client. Rogers believed this unconditional positive regard improves the person's self-esteem. The therapists role is "nondirective". The therapist is there to listen sympathetically to the client's problems and to encourage positive self-regard, independent self-appraisal and decision making. Though person-centered therapist give approval to the person, they do not always approve of the person's behaviour.

In addition to unconditional positive regard, Rogers also advocated the use of these techniques in person-centered therapy:

- Genuineness, which involves letting a client known the therapist's feelings and not hiding being a façade.
- Accurate empathy, which focuses on the therapist's identification with the client. Rogers believed that therapists must sense what it is like to be the client at any moment in the client-therapist relationship
- Active listening, which consist of giving total attention to what the person says and means. One way therapists improve active listening is to restate and support what the client has said and done (Santrock, 2000). The next focus is on Gestalt therapy.

3.3 Gestalt Therapy

In German, the term gestalt means “whole” and gestalt therapy emphasizes the unit of mind and body-placing strong emphasis on the need to integrate thought, feeling and action. Gestalt therapy was developed by Frederick (Fritz) Perls (1969) as a means of teaching clients to recognize the bodily processes and emotions they had been blocking off from awareness.

Perls was trained in Europe as a Freudian psychoanalyst, but as his career developed, his ideas became different from Freud’s. Perls (1969) agreed with Freud that psychological problems originate in unresolved past conflicts and that these conflicts need to be acknowledged and worked through. Also like Freud, Perls stressed that interpretation of dreams is an important aspect of therapy.

But in other ways, Perls and Freud were miles apart. Perls believe that unresolved conflicts should be brought to bear on the here and now of the individual’s life. The therapist pushes clients into deciding whether they will continue to allow the past to control their future or whether they will choose right now what they want to be in the future. To this end, Perls confronted individuals and encouraged them to actively control their lives and be open about their feelings.

Gestalt therapists use a number of techniques to encourage individuals to be open about their feelings, to develop self-awareness, and to actively control their lives. The therapist sets examples, encourages between verbal and

nonverbal behaviour, and uses role playing. To demonstrate an important point to a client, the Gestalt therapist might exaggerate a client's characteristic. To stimulate change, the therapist often will openly confront the client.

Another technique used in Gestalt therapy is role playing, either by the client, the therapist, or both. For example, if an individual is bothered wither by conflict with her mother, the therapist might play the role of the mother and reopen the quarrel. The therapist might encourage the individual to act out her hostile feelings toward her mother by yelling, swearing, or kicking the couch, for example. In this way, Gestalt therapists hope to help individuals better manage their feelings instead of letting their feelings control them.

As you can see, the Gestalt therapist is much more directive than the non directive, person-centered therapist. By being more directive, the Gestalt therapist provides more interpretation and feedback. Nonetheless, both of these humanistic therapies encourage individuals to take responsibility for their feelings and actions, to truly be themselves, to understand themselves, to develop a sense of freedom, and to look at what they are doing with their lives. This is purely taking responsibility on how you want your life to be as a human being. You will now learn about the last therapy under humanists which is called process-experiential therapy.

3.4 Process – Experiential Therapy

Process-experiential (PE) therapy is a relatively new treatment approach that combines client-centered therapy and gestalt therapy. Developed by Greenberg and his colleagues (Greenberg, 2004 as cited in Carson et al., 2011), this treatment emphasizes the experiencing of emotions during therapy. Clients are also asked to reflect on their emotions and encouraged to create meaning from them. The therapist plays a more active role than in pure client centered therapy and may work to guide the client to experience emotions more vividly through a variety of different techniques. Like other humanistic-experiential therapies, the relationship with the therapist is regarded as extremely important and the vehicle through which progress in treatment is made. The major impact of this therapy and other humanistic therapies is that they have effects on our human nature and they are viewed as good psychotherapeutic processes.

4.0 CONCLUSION

Many of the humanistic-experiential concepts used in this unit, such as the uniqueness of each individual, the importance of therapist genuineness and not hiding behind a façade, the satisfaction that comes from realizing one's potential, the importance of the search for meaning and fulfillment, and the human capacity for choice and self-direction shows that this approach is a good psychotherapy.

5.0 SUMMARY

In this unit, you studied about humanistic-experiential therapies. The humanistic – experiential therapies are based on the assumption that we have both the freedom and capacity to control our behaviour. You also learned about person-centered therapy of Carl Rogers that emphasized that therapists should show genuineness, empathy and accurate listening. Moreover, you learned about gestalt therapy of Fritz Perls and the process-experiential therapy of Greenberg that is regarded as a very new approach in the humanistic perspectives.

6.0 TUTOR-MARKED ASSIGNMENT

- Explain the techniques used in Rogerian therapy
- What are the differences between the gestalt therapy and the Carl Rogers' therapy
- Explain the techniques used in gestalt therapy

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UNIT 4: PSYCHODYNAMIC THERAPIES

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main Content

- 3.1 Psychodynamic Therapies
- 3.2 Freudian Psychoanalysis
- 3.3 Interpersonal therapy

4.0 Conclusion

5.0 Summary

6.0 Tutor-Marked Assignment

7.0 References/Further Reading

1.0 INTRODUCTION

In the last unit, you learned about humanistic-experiential therapies. Rogerian therapy that uses the technique of genuineness, empathy and accurate listening was discussed. Frederisk (Fritz) Perls Gestalt therapy was clearly

explained and the process-experiential therapy of Greenberg that combined the person-centered and Gestalt therapy was studied.

In this unit, Freudian psychodynamic therapy will be examined with emphasis on his monumental psychoanalytic method of treatment. The other form of psychodynamic therapy known as interpersonal therapy by Harrystack Sullivan will be treated. You need to pay good attention to have good comprehension of this interesting discourse.

2.0 OBJECTIVES

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

- Discuss psychodynamic theory of Sigmund Freud
- Explain Freudian psychoanalysis
- Examine the interpersonal theory of Sullivan

3.0 MAIN CONTENT

3.1 Psychodynamic Therapy

Psychodynamic therapy is a treatment approach that focuses on individual personality dynamics, usually from a psycho-analytic or some psychoanalytically derived perspective. Psychoanalytic therapy is the oldest form of psychological therapy and began with Sigmund Freud. The therapy is mainly practiced in oriented psychotherapy. As developed by Freud and his immediate followers, classical psychoanalysis is an intensive (at least three sections per week), long-term procedure for uncovering repressed memories, thoughts, fears, and

conflicts presumably stemming from problems in early psychosexual development, and helping individuals come to terms with them in light of the realities of adult life (Carson et al., 2011).

In psychoanalytically oriented psychotherapy, the treatment and the ideas guiding it may depart substantially from the principles and procedures laid out by orthodox Freudian theory, yet the therapy is still loosely based on psychoanalytic concepts. For example, many psychoanalytically oriented therapists schedule less frequent sessions (e.g. once per week) and sit face to face with the client whereas Freud had them recline on the couch while he sat in the chair on the left, out of their view (Santrock, 2000). From this point, we now focus on classical psychoanalysis of Freud. What therapeutic approach did he use in his therapy? This takes us to Freudian Psychoanalysis.

3.2 Freudian Psychoanalysis

Psychoanalysis is Freud's therapeutic technique for analyzing an individual's unconscious thought. Freud believed that clients problem could be traced to childhood experiences, many of which involved conflicts about sexuality. He also recognized that the early experiences were not readily available to the individual's conscious mind. Only through extensive questioning, probing, and analyzing was Freud able to put the pieces of the person's personality together and help the individual become aware of how these early experiences were affecting present adult behaviour.

Psychoanalysis is historical reconstruction. It aims to unearth the part in hope of unmasking the present (Myers, 2004). To reach the shadowy world of the unconscious, psychoanalytic therapists often use the following therapeutic techniques: free association, catharsis, interpretation, dream analysis, analysis of resistance and analysis of interference. You will learn about these terms now. Be attentive.

Free Association: This technique used by psychoanalysts consists of encouraging individuals to say aloud whatever comes to mind no matter how trivial or embarrassing. Usually a client lies in a relaxed position on a couch and gives running account of all the thoughts, feelings, and desires that come to mind as one idea leads to another. The therapist normally takes a position behind the client so as not to disrupt the free flow of associations in any way.

Although such a running account of whatever comes into one's mind seems random, Freud did not view it as such; rather, he believed that associations are determined just like other events. The purpose of free association is to explore thoroughly the contents of the preconscious that part of the mind considered subject to conscious attention but largely ignored. Analytic interpretation involves a therapist's tying together a client's often disconnected ideas, beliefs, and actions into a meaningful explanation to help the client gain insight into the relationship between his or her maladaptive behaviour and the repressed (unconscious) events and fantasies that drive it (Carson et al., 2011).

Catharsis: Catharsis is the psychoanalytic term for people's release of emotional tension when they relive an emotional charged and conflicted experience. Catharsis was a word used by the Greek philosopher Aristotle (384 – 322 BC) to denote the purging of emotions that results from watching a tagged performance of a tragedy. In psychoanalysis, Catharsis is the bringing to consciousness of repressed ideas, accompanied by the expression of emotions, thereby relieving tension. Many therapists believe that catharsis, or the expression of emotions connected to memories and conflicts, is also central to the healing processes in psychodynamic therapy (Nolen-Hoeksema, 2004). Catharsis unleashes the energy bound in unconscious memories and conflicts, allowing this material to be incorporated into more adaptive self-view (Nolen-Hoeksema, 2004).

Dream Analysis

Psychoanalysts believe that dreams express impulses, fantasies and wishes that the client's defenses keep in the unconscious during waking hours. Even in dreams, which Freud termed "the royal road to the unconscious", defensive processes usually disguise the threatening material to protect the dreamer from the anxiety that the material might evoke (Passer & Smith, 2001).

Freud distinguished between the dream's manifest and latent content. Manifest content is the psychoanalytic term for the conscious, remembered aspect of a dream. Latent content is the psychoanalytic term for the unconscious, unremembered, symbolic aspects of a dream. The psychoanalyst interprets the

dream by analyzing the manifest content for disguished unconscious wishes and needs, especially those that are sexual and aggressive in nature.

Interpretation: Interpretation plays an important role in psychoanalysis. As the therapists interprets free association and dreams, the person's statement and behaviour are not taken at face value. To understand what is truly causing a person's conflicts, the therapist constantly searches for symbolic, hidden meanings in what the individual says and does. From time to time the therapist suggests possible meanings of the person's statements and behaviour.

Resistance: This is the psychoanalytic term for the person's unconscious defense strategies that prevent the analyst from understanding the person's problems. Resistance occurs because it is painful to bring conflict into conscious awareness. By resisting therapy, individual do not have to face their problems. Showing up late or missing sessions, arguing with the psychoanalyst, or faking free associations are examples of resistance. Some people go on endlessly about a trivial matter to avoid facing their conflicts. A major goal of the analyst is to break through this resistance (Stream, 1996 as cited in Santrock, 2000). The last point here to be examined is analysis of transference.

Transference: This is the psychoanalytic term for the person's relating to the analyst in ways that reproduce or relive important relationships in the individual's life. As client and therapist interact, the relationship between them may become complex and emotionally involved. Often people carry over, and unconsciously apply to their therapist, attitudes and feelings that they had in their relations with

a parent or other person close to them in the past, a process known as transference. This client may react to their analyst as they did to that earlier person and feel the same love, hostility or rejection that they felt long ago. If the analyst is operating according to the prescribed role of maintaining an impersonal stance of detached attention, the often affect laden reactions of the client can be interpreted, it is held, as a type of projection – inappropriate to the present situation, yet highly revealing to of central issues in the client's life. For example, should the client vehemently (but inaccurately) condemn the therapist for lack of caring and attention to the client's needs, this would be seen as a "transference" to the therapist of attitudes acquired in childhood interactions with parents or other key individuals.

In addition, the problems of transference are not confined to the client, for the therapist may also have a mixture of feelings toward the client. This counter transference, wherein the therapist reacts in accord with the client's transferred attributions rather than objectively, must be recognized and handled properly by the therapist. For this reason, it is considered important that therapists have a thorough understanding of their motives, conflicts, and "weak spots" (Carson, et al., 2011). According to Gross (2010) counter-transference refers to the therapist's feelings of irritation, dislike or sexual attraction towards the client. It is suggested that all psychoanalyst should undergo psychoanalysis themselves before they begin independent practice. The next focus is on interpersonal therapy.

3.3 Interpersonal Therapy (IPT)

Interpersonal therapy was first articulated by Harry Stack Sullivan. Its central idea is that all of us, at all times, involuntarily invoke schemas acquired from our earliest interactions with others, such as our parents, in interpreting what is going on in our current relationships. Where these earlier relationship have had problematic features such as rejection or abuse, the “introjected” characteristics of those earlier interaction partners may distort in various ways the individual’s ability to process accurately and objectively the information contained in current interpersonal transactions. Thus the formerly abused or rejected person may come to operate under the assumption that the world is generally rejecting and/or abusive. This mistrust stemming from this belief is bound to affect current relationship negatively.

Interpersonal therapy seeks to expose, bring to awareness, and modify the effects of the remote developmental sources of the difficulties the clients is currently experiencing.

4.0 CONCLUSION

In this unit, you have learned about psychodynamic therapies with emphasis on Freudian psychoanalysis and interpersonal therapy. The original version of psychoanalysis is not common in practice today. Psychologists see it as difficult, costly in time, money and emotional commitment. It may take several years before all major issues in the client’s life is successfully resolved.

5.0 SUMMARY

In this unit, you have studied important things about psychodynamic therapies. You learned about the concept of therapy, you also learned about Freudian psychoanalysis and under psychoanalysis the techniques used by Freud in his therapeutic treatment were analysed. These include free association, catharsis, interpretation, dream analysis, analysis of resistance and analysis of transference. Harry Stack Sullivan interpersonal therapy was briefly highlighted as a therapy that creates awareness about past internalized knowledge that affects our present behaviour and hence client misinterpret the world as unsafe.

6.0 TUTOR-MARKED ASSIGNMENT

- Explain psychoanalysis of Freud as a therapeutic technique in treating maladaptive behaviour
- What is catharsis in Freudian therapy?
- Explain the concept of transference and counter transference.

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UNIT 5: MARITAL AND FAMILY THERAPY

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2.0 Objectives

3.0 Main Content

3.1 Marital Therapy

3.2 Family Therapy

4.0 Conclusion

5.0 Summary

6.0 Tutor-Marked Assignment

7.0 References/Further Reading

1.0 INTRODUCTION

In the last unit, you learned about psychodynamic therapies. The Freudian psychoanalysis was well discussed. The processes involved in psychoanalysis such as free association, catharsis, interpretation, dream analysis, analysis of resistance and analysis of transference were clearly explained.

In this last unit, you will learn about marital and family therapy. This is an important issue to be discussed because most problems brought to therapists are clearly relationship problems.

2.0 OBJECTIVES

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

- Explain marital therapy
- Explain family therapy

3.0 MAIN CONTENT

3.1 Marital Therapy

The large numbers of couples seeking help with relationship problems have made coupled counselling a growing field of therapy. Typically the couple is seen together, and improving communication skills and developing more adaptive problem-solving methods are both a major focus of clinical concern. Although it is quite routine at the start of couples therapy for each partner secretly to harbour the idea that only the other will have changing (Cordova & Jacobson, 1003 as cited in Carson et al., 2011), it is nearly always necessary for both partners to alter their reactions to the other.

For many years the gold standard for marital therapy has been traditional behavioural couple therapy (TBCT). TBCT is based on a social learning model and views marital satisfaction and marital distress in terms of reinforcement. The treatment is usually short-term (10 to 26 sessions) and is guided by a manual.

The goal of TBCT is to increase caring behaviours in the relationship and to teach partners to resolve their conflicts in a more constructive way through training in communication skills and adaptive problem solving (Carson et al., 2011)

However, this form of treatment (TBCT) does not work for all couples. Moreover, even among couples who show an improvement in relationship satisfaction, the improvement may not be maintained over time. The limitations of TBCT have led researchers to conclude that a change focused treatment approach is not appropriate for all couples. This in turn, has led to the development of integrative behavioural couple therapy (IBCT). Instead of emphasizing change, TBCT focuses on acceptance and includes strategies that help each member of the couple come to terms with and accept some of the limitations of his or her partner. It does not mean that change is forbidden. Rather, within IBCT, acceptance strategies are integrated with change strategies to provide a form of therapy that is more geared to individual characteristics and the needs of the couple. Now, let us look at family therapy has some similarities with marital therapy.

3.2 Family Therapy

Therapy for a family obviously overlaps with couples and marital therapy but has somewhat different roots. Whereas marital therapy developed in response to the large number of clients who come for assistance with couples problems, family therapy began with the finding that many people who has

shown marked improvement in individual therapy, often in institutional settings had a relapse when they returned home.

One approach to resolving family disturbance is called structural family therapy. This approach, which is based on systems theory, holds that if the family context can be changed, then the individual members will have altered experiences in the family and will behave differently in accordance with the changed requirements of the new family context. Thus an important goal of structural family therapy is changing the organization of the family in such a way that the family members will have to behave more supportively.

Structural family therapy is focused on present interactions and requires an active but not directive approach on the part of the therapist. Initially, the therapist gathers information about the family – a structural map of the typical family interactions patterns, by acting like one of the family members and participating in the family interactions as an insider. In this way the therapist discover whether the family system has rigid or flexible boundaries, who dominate the power structure, who gets blamed when things go wrong, and so on. Structural family therapy has quite a good record of success in the treatment of anorexia nervosa.

4.0 CONCLUSION

In this unit, you have learned about marital and family therapy. Large numbers of couples seeking help with relationships problem gave rise to both marital and family therapy.

5.0 SUMMARY

In this unit, you learned something concerning marital and family therapy. Marital therapy helps in improving communication skills and developing more adaptive problem solving styles. Both TBCT and IBTC are useful therapeutic approaches. The structural family therapy is a good approach in family therapy.

6.0 TUTOR-MARKED ASSIGNMENT

- What is marital therapy? Explain the two different forms of marital therapy.
- What is family therapy? How does therapist use the structural family therapy?

7.0 REFERENCES/FURTHER READINGS

Carson, R.C., Butcher, J. N., Mineka, S & Hooley, J. M. (2011). Abnormal Psychology (13th edition). Pearson Education Inc.