Counselling and Psychotherapy
What are ‘Counselling’ and ‘Psychotherapy’?

The everyday pressures of life are becoming even greater, meaning that many people are turning to counselling for support. The British Association for Counselling and Psychotherapy (BACP) define counselling as taking place “when a counsellor sees a client in a private and confidential setting to explore a difficulty the client is having, distress they may be experiencing or perhaps dissatisfaction with life, or loss of a sense of direction and purpose. It is always at the request of the client as no one can properly be ‘sent’ for counselling” (BACP, 2010); this is an important point to note as clients who feel reluctant to attend counselling are unlikely to get the best out of their sessions. Burnard (2005:2) continues by stating that the “process of counselling can be clearly defined as the means by which one person helps another to clarify his or her life situation and to decide further lines of action”.

Psychotherapy, similarly, is a talking treatment although those practicing as psychotherapists generally undergo more in-depth training. The UK Council for Psychotherapy (UKCP) explain that professional psychotherapists registered with them “undergo a four-year, postgraduate, in-depth and experiential training in how to work with a variety of people with a wide range of emotional distress, mental health issues and difficulties. Psychotherapists are trained in one or more of the psychotherapy modalities” (UKCP, 2010); these modalities will be looked at further in the course.

Accurately defining the differences between counselling and psychotherapy however, is difficult. Nelson-Jones (2005:4) refers to Tyler (1961) stating that attempts to distinguish the two are “never wholly satisfactory; psychotherapy focuses on personality change of some sort while counselling focuses on helping people use existing resources for coping with life better”. While Feltham and Dyden (1993, in Burnard, 2005:3) offer one of the most encompassing definitions, describing counselling as:
“A principled relationship characterised by the application of one or more psychological theories and a recognised set of communication skills, modified by experience, intuition and other interpersonal factors, to clients’ intimate concerns, problems or aspirations. Its predominant ethos is one of facilitation rather than of advice giving or coercion. It may be of very brief or long duration, take place in an organisational or private practice setting and may or may not overlap with practical, medical, and other matters of personal welfare. It is both a distinctive activity undertaken by people agreeing to occupy the roles of counsellor and client…and it is an emerging profession. It is a service sought by people in distress or some degree of confusion who wish to discuss and resolve these in a relationship which is more disciplined and confidential than friendship, and perhaps less stigmatising than helping relationships offered in traditional medical or psychiatric settings”.

In both counselling and psychotherapy, the aim is for the client to have a supportive, non-judgemental, and confidential environment where they can explore any emotional or psychological problems they may be experiencing. Within counselling sessions, clients can work with the therapist to identify their own personal resources and capabilities which can be difficult to identify in times of anxiety (Buckinghamshire New University, 2010). Many people also find counselling beneficial in this way because it enables them to talk openly about their thoughts and feelings, something which very few people find possible to do with friends and family.

**What are ‘Counsellors’ and ‘Psychotherapists’?**

Both counsellors and psychotherapists are trained listeners who work with clients to help them overcome problems or difficulties they may be experiencing. The Pastoral Foundation (2010) describes a counsellor as:

“Someone who is professionally trained to listen to your problems sensitively and with an open mind, to understand as fully as possible what
is concerning you and how it is affecting your life. Without ‘judging’ or offering ‘advice’, a counsellor can help you to become more aware of your own inner resources and also how you can use these to help you cope and discover new ways of dealing with difficult feelings, people, or situations. A counsellor will work with you within an environment of absolute respect and confidentiality”.

However, despite this, there are numerous professions in which counselling skills are part of everyday practice; this may include for example, those who work as nurses, social workers, doctors, or the police. Currently in the UK, anyone can legally practice as a counsellor and charge fees without undertaking any formal education or training. Whilst attempts to regulate the profession have been made, these have so far been unsuccessful. Professional bodies however, have minimum standards that applicants must meet in order to gain accreditation. It is important for those seeking counselling to look carefully at the qualifications and accreditation of counsellors before working with them.

Psychotherapists, generally, are more experienced. Leeds University (2010) describe how “psychotherapists sometimes have an advanced qualification in one of the mental health professions – psychiatry, psychology, nursing – and additional training in psychotherapy but it is equally common for them to have undertaken a postgraduate training in psychotherapy... Typically psychotherapy training takes a minimum of four years but it is usual for psychotherapists to take longer than this to complete all aspects of their training”.

As previously discussed, it is hard to distinguish the differences between counselling and psychotherapy and the same can be said for counsellors and psychotherapists themselves. Leeds University (2010) continue by describing how:

“In terms of clinical practice, there is often very little difference between these professionals and there are some workers who identify themselves through both terms... in the UK the perceived difference between counselling and psychotherapy largely originated from the different ‘cultures’ of Person-Centred and Psychodynamic therapy which remain
the most dominant traditions. Counselling tended to be more associated with the former and psychotherapy, the latter. However, this distinction no longer holds and it is more typical for professionals who describe themselves by either term to integrate their learning from a variety of therapeutic traditions over the course of their careers…There is very little difference between a counsellor and psychotherapist and what is more important is their practice, registration and accountability”.

Who Needs Counselling?

Morton (1997:1) describes how the popularity of counselling and psychotherapy has greatly increased over recent years; the demand for such services “continues to grow with more and more people turning to counsellors or psychotherapists to help them cope better with psychological problems and to live a more fulfilling life”.

There are many reasons a person may seek counselling or psychotherapy; the diagram opposite identifies some of these:

Can you think of any other reasons why a person may seek help from a counsellor or psychotherapist?
What are the Symptoms of Schizophrenia?

The general symptoms of schizophrenia include:

- Paranoia
- Social isolation
- Unusual emotional reactions
- Unusual sensitivity
- Hostility
- Hyperactivity or inactivity
- Deterioration in personal hygiene
- Inability to concentrate

The symptoms of schizophrenia however, can vary from person to person. They are also divided into three sections:

- **Positive symptoms** – the presence of symptoms which are not normally noted in the general population
  
  - Delusions
  - Disrupted thoughts and behaviour
  - Hallucinations
  - Grossly disorganised behaviour

- **Negative symptoms** – the absence of what is generally noted in the general population
  
  - Catatonic behaviour
  - Flattened or blunted affect
  - Alogia (difficulties with speech, lessening fluency, inability to hold conversation)
Avolition (difficulty in creating goal-directed behaviour, social withdrawal, lack of interest or enthusiasm in previously enjoyed activities)

- Cognitive symptoms – problems with attention, certain types of memory and executive functions, which allow planning and organisation
  - Inability to sustain attention
  - Difficulties with “working memory”
  - Poor executive functioning

What Causes Schizophrenia?

The NHS (2010) explains that it is difficult to determine the causes of schizophrenia, but that research suggests it could be the result of several “physical, genetic, psychological, and environmental factors”.

These factors include:

1. Brain Abnormalities
   - Imbalances of specific amino acids, certain proteins, specific neurotransmitters
   - Brain structure – loss of brain tissue and abnormal activity in parts of the brain which are responsible for emotion, reasoning, and memory can lead to the onset of schizophrenia.

2. Genetic Factors
   - It is believed that schizophrenia is more common in those with a family history of the condition. However, 60% of those with the condition do not have a family history of schizophrenia
3. Developmental Factors

- Exposure to a virus during infancy
- Prenatal exposure to a viral infection
- Early parental loss / separation
- Low oxygen level due to prolonged labour, premature birth or low birth weight.

4. Additional Factors

- Environmental stresses
- Hormonal changes
- Side effects from some drugs

How is Schizophrenia Diagnosed?

Under the DSM-IV, a diagnosis of schizophrenia can be made under the following criteria:

**A. Characteristic Symptoms: Two (or more) of the following, each present for a significant portion of time during a one-month period (or less if successfully treated):**

- Delusions
- Hallucinations
- Disorganised speech (e.g. frequent derailment or incoherence)
- Grossly disorganised or catatonic behaviour
- Negative symptoms, i.e. affective flattening, alogia, or avolition

*Note: only one Criterion A symptom is required, if delusions are bizarre or hallucinations consist of a voice keeping a running commentary on the person’s behaviour or thoughts, or two or more voices conversing with each other.*

**B. Social / Occupational Dysfunction: For a significant portion of time since the**
onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. Duration: Continuous signs of the disturbance persist for at least six months. This six-month period must include at least one month of symptoms (or less if successfully treated) that meet Criterion A (i.e. active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g. odd beliefs, unusual perceptual experiences).

D. Schizoaffective and Mood Disorder Exclusion: Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive Episode, Manic Episode, or Mixed Episode have occurred concurrently with the active-phase symptoms. Or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. Substance / General Medical Condition Exclusion: The disturbance is not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition.

F. Relationship to a Pervasive Developmental Disorder: If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

Subtypes
Paranoid Type
A type of Schizophrenia in which the following criteria are met:
- Preoccupation with one or more delusions or frequent auditory hallucinations
- None of the following is prominent: disorganised speech, disorganised or catatonic behaviour, or flat or inappropriate affect

Catatonic Type
A type of Schizophrenia in which the clinical picture is dominated by at least two of the following:
- Motoric immobility as evidenced by catalepsy (including waxy flexibility) or stupor
- Excessive motor activity (that is apparently purposeless and not influenced by external stimuli)
- Extreme negativism (an apparently motiveless resistance to all instructions or maintenance of a rigid posture against attempts to be moved) or mutism
- Peculiarities of voluntary movement as evidenced by posturing (voluntary assumption of inappropriate or bizarre postures)
- Stereotyped movements, prominent mannerisms, or prominent grimacing
- Echolalia or echopraxia

Disorganised Type
A type of schizophrenia in which the following criteria are met:
- All of the following are prominent:
  - Disorganised speech
  - Disorganised behaviour
  - Flat or inappropriate affect
- The criteria are not met for Catatonic Type.

Undifferentiated Type
A type of schizophrenia in which symptoms that meet Criterion A are present, but the criteria are not met for the Paranoid, Disorganised, or
Catatonic Type.

- Residual Type
  A type of schizophrenia in which the following criteria are met:
  - Absence of prominent delusions, hallucinations, disorganised speech, and grossly disorganised or catatonic behaviour.
  - There is continuing evidence of the disturbance, as indicated by the presence of negative symptoms or two or more symptoms listed in Criterion A for schizophrenia, present in an attenuated form (e.g. odd beliefs, unusual perceptual experiences).
Grief and Bereavement Counselling Tools and Strategies

One of the first tools for grief and bereavement counselling is knowing how to interact with the person that is experiencing the grief. During periods of grief and bereavement, people may be sensitive to the words and actions of others. Additionally, as we have learned before, they may already be easily angered, frustrated, confused, and anxious. Taking actions to ensure that the grief and bereavement counsellor does not contribute to those stressors is important.

To avoid contributing to the stress of grief and bereavement, counsellors should:

- Keep eye contact and facial expressions that are caring and open
- Avoid any gestures that hide the face
- Pay attention to the person experiencing grief and bereavement
- Keep a straight posture when having a conversation to show that they are attentive and interested
- Face the person so that they know they have the counsellor’s attention
- Sit level with the person so that they can relate to the counsellor and feel they are equally involved
- Do not cross the arms; crossing the arms is a sign of rejection or frustration
- Use a naturally toned voice level
- Speak in a relaxed manner
- Avoid speaking to the person that is grieving as if they are a child (unless they are a child)
- Stay on topic
- Spend a great deal of time listening, unless the person asks specific questions or for feedback
- Do not rush the conversation or the subject
- Allow moments of silence so that the person can gather their ideas, thoughts, or control of their emotions
- Use open-ended questions to support new decisions in different emotions and experiences

Examples of open-ended questions include:
○ How did that make you feel?
○ Tell me about that
○ What happened next?
○ What did you expect?

- Use reflective listening; paraphrase what the person has said to ensure correct understanding of what has been mentioned, this will also reassure them that the counsellor is listening.

Another strategy to cope with grief and bereavement is the use of rituals. Dr. Kenneth Doka created four categories of rituals that can be used as a coping mechanism tool when helping people cope with grief and bereavement.

Those rituals are:

1. **Community Rituals**

   Community rituals include continuing to do the things in life that were traditional or ritual, between the person grieving and the person that has been lost. Continuing with these rituals or traditions helps the person feel as if what they have lost is still a part of their life.

2. **Transition Rituals**

   Transition rituals are those rituals that indicate that another stage of the grieving process has been reached. For the acceptance stage, for example, the person grieving may pack up the belongings of the person that is deceased, accepting that the person lost is not going to return.

3. **Affirmation Rituals**

   Affirmation rituals are those rituals and traditions that include writing or creating an artistic piece that serves as a letter or message to the person that
has been lost. This ritual is a way to immortalise the things that the grieving person feels they need to say, but never had the chance to say.

4. **Intensification Rituals**

Intensification rituals are those actions that share the connection and the relationship with the person lost within the community. These types of rituals are things like
Assignment 4

1. Discuss the effects of abuse and trauma on mental health for both adults and children.

2. Discuss the steps you would need to take if a client disclosed abusing their child. How could you ensure this did not break down the therapeutic relationship?

3. Write a reflective log of what you have learned so far in this course. You should make reference to both the knowledge and the skills you have gained since your first log, and to what you still need to learn.
Antidepressants

Although the name ‘antidepressants’ suggests that these medications are specifically for treating depression, they are also commonly used to treat other illnesses and symptoms, such as severe anxiety, panic attacks, PTSD (Post-traumatic stress disorder), eating disorders, obsessive compulsive disorders and chronic pain; they are not however, used to treat mild depression. Some antidepressants also have a sedative effect.

Common antidepressants include:

- Amitriptyline hydrochloride (Elavil, and also in the compounds Triptafen and Triptafen-M)
- Amoxapine (Ascendis)
- Citalopram (Cipramil)
- Clomipramine (Anafranil)
- Dosulepin/dothiepin (Prothiaden)
- Doxepin (Sinequan, Xepin)
- Escitalopram (Cipralex)
- Fluoxetine (Oxactin, Prozac)
- Fluvoxamine (Faverin)
- Imipramine (Tofranil)
- Isocarboxazid
- Lofepramine (Gamanil, Lomont)
- Maprotiline hydrochloride (Ludiomil)
- Mianserin hydrochloride
- Mirtazapine (Zispin)
- Moclobemide (Manerix)
- Motival
- Nortriptyline (Allegron; also in the compound Motival)
- Paroxetine (Seroxat)
- Phenelzine (Nardil)
- Reboxetine (Edronax)
- Sertraline (Lustral)
- Tranylcypromine
- Trazodone hydrochloride (Molipaxin)
Antipsychotics (major tranquillisers)

Antipsychotics are mainly used to treat psychosis and are common treatments for schizophrenia and bipolar disorder; they can also be used to treat severe depression and some physical illnesses. As stated in the NICE guidelines for the management of schizophrenia, antipsychotics are not a cure, but they can help to control symptoms, to enable the person to engage fully with other treatments, such as therapy.

Some common antipsychotics include:

- Amisulpiride (Solian)
- Aripiprazole (Abilify)
- Chlorpromazine (Largactil)
- Clozapine (Clozaril)
- Flupenthixol (Depixol, Flupenthixol, Fluanxol)
- Fluphenazine (Moditen)
- Haloperidol (Serenace, Haldol)
- Loxapine (Loxapac)
- Olanzapine (Zyprexa)
- Pericyazine (Neulactil)
- Perphenazine (Fentazine)
- Pimozide (Orap)
- Prochlorperazine (Stemetil)
- Promazine
- Quetiapine (Seroquel)
- Risperidone (Risperdal)
- Sulpiride (Sulpilil, Sulpor)
- Thoridazine (Melleril)
- Trifluoperazine (Stelazine)
- Zotepine (Zoleptil)
Crisis Work

Suicide

Why do people commit suicide?

A person may commit suicide for a number of reasons; the underlying reasons can include:

- **To bring about change:** suicide is a way for a client to change how they feel or what is happening in their present life.
- **To make a choice:** when a client feels that they do not have choices or that important choices are being taken away from them, suicide may seem to be the only choice left to them.
- **To exert control:** an act of suicide is meant to stop the person’s behaviour, to control events or to effect change in others.
- **As a way to punish oneself:** suicidal behaviour is a means of relieving guilt or punishing oneself for his or her actions.
- **As a way to punish others:** the act of suicide may be intended to inflict harm or punishment on others.

Talking to a client who is suicidal

When talking to a client who is suicidal, it is important as a therapist to remember:

- Not to appear shocked, as this will put distance between you and your client
- Not to be sworn to secrecy – seek support from your supervisor or other colleagues if necessary, including any agencies who deal in crisis intervention and suicide prevention
- Offer your client hope that there are alternatives to suicide
- Ensure you take action which removes a means of suicide, such as stockpiled medications
- Seek help if necessary
- Be direct with your client and speak openly and matter-of-factly about suicide
- Be willing to listen to your client
- Do not debate with your client the ‘rights’ and ‘wrongs’ of suicide
- Show interest in and support for your client
- Do not dare your client to commit suicide
- Use active listening skills and constructive questions.
- Be resourceful
- Be practical
- Get support / help for yourself
- Avoid being judgemental or shocked, minimise your client’s fears, patronising them or using guilt, or agreeing confidentiality

Suicide Management Plan

As a therapist, you should:

- Avoid labelling your client’s suicidal feelings as the result of behaviour or of being manipulative
- Ask the client questions about their future plans
- Assess / judge the hopelessness of your client
- Keep documentation of your decisions and rationale
- Identify where your client is on the continuum of suicidality (low – high risk)
- Establish the client’s present situation
- Determine the client’s accompanying psychopathology
- Ask yourself how realistic your client’s plans of suicide are
- Identify deterrents and protection

Questions to ask:

- Have you thought about harming yourself?
- What have you thought about it?
- When did you start thinking this way?
- Do you want to die?
- Have you told anyone you feel this way?
- Have you made a suicide plan?
- Have you made any preparations to commit suicide? (firearms etc.)
- Do you have the means to commit suicide? (firearms etc.)
- What has stopped you from committing suicide so far?
- What gives you hope?