

The Study Manual is divided into 13 Chapters for ease of study.

The titles of the Chapters AND the Number of Pages is as follows (this number includes chapter outlines):

1. Normal Human Growth & Development — 100 pages
2. Research Methods & Statistical Studies — 33 pages
3. Appraisal or Assessment Techniques — 35 pages
4. Abnormal Human Behavior — 34 pages
5. Counseling Theories, Methods, & Techniques — 98 pages
6. Family Therapy — 56 pages
7. Group Dynamics, Theories, & Techniques — 54 pages
8. Professional Orientation & Ethics — 15 pages
9. Lifestyle & Career Development — 65 pages
10. Social, Cultural, & Family Issues — 46 pages
11. Referral/Triage/Advocacy — 29 pages
12. Consultation — 14 pages
13. Supervision — 18 pages

The following pages provide a sense of the layout of the Study Manual and of the quality of the material.

NORMAL HUMAN GROWTH AND DEVELOPMENT

Chapter 1

Chapter Outline

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NORMAL HUMAN GROWTH AND DEVELOPMENT

Chapter 1

INTRODUCTION

Our English word “develop” etymologically goes back to the Old French “desveloper” meaning to “unwrap” or “unfold.” As man has sought from ancient times to bring understanding to the unfolding or development of a person, numerous hypotheses have been tested, countless theories put forth. Successful, happy living has come to be seen as a process of **growth**, the acquisition of new physical and psychological means.

Yet, as these new resources become available, the next challenge is already apparent. A new developmental task is at hand, which when successfully accomplished, sets the stage for the next level. Conversely, failure to achieve the task sets the stage for difficulty at the next level with the accompanying unhappiness and societal criticism. Thus, there is an ever-present **tension** between the person with his/her newly attained resources and the demands and expectations of society at large.

I. Developmental Research

Researchers have applied various methods in their quest for data that correctly represents the human developmental process. We briefly mention these research methods here simply to remind you that all theories of human development are derived from some method of observing behavior and then designing a way to draw appropriate conclusions from the data gathered.

For observation to be termed “systematic,” the who, what, when, where, how, and the form of recording the behavior must be predetermined.

A. Systematic observations include the following
(Santrock, 1999; Kail & Cavanaugh, 1999):

1. **Laboratory Observations** – Observations take place in a controlled setting. Real world factors are eliminated.
2. **Naturalistic Observations** – Behavior is observed in its natural setting. No manipulation or control of the situation takes place.
3. **Interviews and questionnaires** – Skilled interviewing techniques and questions increase the reliability of the information given in survey methods.
4. **Case studies** – These dramatic, in-depth portrayals of people’s lives provide insight when the unique details of one’s life cannot be easily duplicated.
5. **Standardized tests** – Test scores are compared with the scores of a larger group of similar people.
6. **Life-history records** – A wide array of materials which may include written and oral reports from the subject, public records, etc.
7. **Physiological Research and Research with Animals** – The biological basis of behavior is explored and often explained.
8. **Multimeasure, Multisource, Multicontext** – Using multiple measures, sources, and contexts should provide a more comprehensive and valid assessment of development.

ADDITIONAL MISCELLANEOUS INFORMATION

1. **Ambidextrous** – able to use both hands with equal ease.
2. **Anxiety (or generalized anxiety)** – unexplainable apprehension, fear, or dread; the cause cannot be determined. Note that a phobia has a known source or cause (bugs, heights, elevators, etc.)
3. **Apgar rating or score** – a quantitative rating test used to measure the vital signs of newborns a minute or two after birth; a score of 7 indicates good health; a score of 4 or less indicates that there is high-risk, and medical intervention is required.
4. **Attitude** – refers to how one thinks, acts behaviorally, and feels about a given subject. Research in this area would be conducted by a social psychologist. **Festinger** is associated with the study of attitude changes. **Thurstone** first developed a scale technique to measure attitude. This scale technique was later simplified by **Likert**.
5. **Cannon-Bard or Emergency Theory** – This theory pertains to which comes first, the physical action or the emotional reaction?
 - The **Cannon-Bard** theory states that both occur simultaneously. The brain perceives the emotional stimuli at the same time that the body initiates an action.
 - The **James-Lange** theory asserts that the individual's perception of his physical reaction is the basis of his emotional experience.
 - The cognitive theory proposed by **Schachter and Singer** in 1962 is similar to the James-Lange theory in that emotion follows action. The individual will “feel” the emotion that he or she feels is most appropriate for the arousing situation.
6. **Chaining** – describes the phenomenon (in learning theory) of each response acting as the stimuli for the next response; used by behaviorists to explain complex behaviors.
7. **Cognitive Dissonance** – a non-fitting relationship between two beliefs or ideas that cause psychological discomfort.
8. **Cohort effect** – the effect of a group of people being born at a certain time and being reared in a certain historical setting, i.e. career choices of baby boomers.

FROM CHAPTER 5 – Counseling Theories, Methods, and Techniques

PSYCHOANALYTIC THERAPY

I. Major Figure

Sigmund Freud

II. Overview of the Psychoanalytic Model

A. Sigmund Freud learned the “talking cure” (his cathartic method) from Jean-Martin Charcot and Josef Breuer. He went on to theorize the personality structure of the id, ego, and superego as well as the existence of an unconscious mind which resides under or behind the conscious and preconscious minds. Thus, Freud is credited with formulating the first counseling model.

B. The psychoanalytic counselor concentrates on:

1. The client’s past history, especially early childhood events
2. The inter-relationship of the parts of the client’s personality
3. The relationship between the counselor and the client

III. Goals of Psychoanalytic Treatment

- A. Bring the client’s unconscious to the conscious
- B. Help the client work through repressed conflicts
- C. Help the client reach intellectual awareness
- D. Help the client restructure his or her basic personality

IV. Role of the Psychoanalytic Counselor

- A. The counselor is an anonymous expert and makes interpretations of the meaning of current behavior as the behavior relates to the past.
- B. The client is encouraged to develop projections toward the counselor.
- C. The counselor assists with reducing any resistances that develop as the client works with transferences.

V. Normal Development

Successfully resolving and integrating the psychosexual stages of development leads to normal personality development.

VI. Development of Behavioral Disorders

A. Personality flaws result from the failure to successfully resolve conflicts at an earlier stage of ego development.

B. Anxiety occurs when basic conflicts are repressed.

VII. Applications of the Psychoanalytic Model

A. Suitable for: Individuals
Groups
Those in pain
Those who have received intensive therapy and want to progress further
Those who want to become counselors

B. Not suitable for: Self-centered clients
Impulsive clients
Severely impaired psychotics

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VIII. Suitability of the Psychoanalytic Model in Multicultural Counseling

A. Focusing on family relationships and early childhood conflicts is applicable to many minority groups.

B. Clients wanting professional distance appreciate the counselor's formality.

C. The concept of ego defense mechanisms is helpful in explaining personal inner workings as well as relationships to external (environmental) stresses.

D. Clients wanting to learn coping skills for the daily pressures of living will not endure the in-depth, time-consuming, long-term treatment.

E. Some cultures emphasize interpersonal and environmental influences as opposed to the internal focus of psychoanalytic counseling.

IX. Key Psychoanalytic Concepts and Terminology

A. Freud's Structure of Personality

ID – is the original system of personality and the primary source of psychic energy and the seat of instincts. It is the seat of the libido and is ruled by the pleasure principle. The id has no sense of time, never matures, and is chaotic.

EGO – functions to contact the real world. It balances (similar to the fulcrum of a see-saw) between the impulses of the Id and the Superego's controls.

SUPEREGO – is the moral branch of the personality. It represents the ideal rather than the real and strives for perfection. It represents the traditional values and the ideals of society. It rewards through feelings of pride and self-love; it punishes through feelings of guilt and inferiority. Freud believed that successfully resolving the Oedipus complex gives rise to the superego.

B. Psychic energy and early experiences **determine** personality development (a deterministic philosophy).

C. Current behavior is impacted by unconscious motives and conflicts.

D. Sexual and aggressive impulses are foundational to actions and to personality development.

- **Oedipus Complex** – son's attraction for his mother
- **Electra Complex** – daughter's attraction for her father

E. Early experiences are critical; later personality development is successful only if early childhood conflicts are resolved, rather than repressed.

F. Counseling includes **four primary phases** which all pertain to transference:

1. **opening**
2. **developing**
3. **working through**
4. **resolving**

G. **ANXIETY** – is the state of tension that motivates us to do something. Its function is to warn of impending danger and to signal to the ego to take action else the ego will be overthrown. Three kinds of anxiety are the following:

1. **Real**
2. **Neurotic**
3. **Moral**

H. Anxiety is controlled through the development of **ego defense mechanisms**.

I. **Catharsis/Abreaction** – purging of emotions and feelings by giving them expression.

J. **Parapraxis** – an action in which one's conscious intention is not fully carried out, as in the mislaying of objects, slips of the tongue and pen, etc. (Freudian slips).

K. **Countertransference** – The counselor substitutes the client for the original object of the counselor's own repressed impulses (counselor's being extremely angry with or sexually attracted to a client).

X. Techniques Specific to the Psychoanalytic Model

- A. Psychoanalytic techniques are intended to make the client aware of unconscious conflicts. Insight then results allowing the ego to assimilate new material.
- B. Principal techniques include:
1. **Interpretation** – helping client gain **insight** into both past and present events
 2. **Dream Analysis** – interpreting the **manifest** (obvious) and **latent** (hidden) meanings of dreams
 3. **Free Association** – verbalizing whatever comes to mind, even if trivial
 4. **Analysis of Resistance** – helping client understand the basis for hesitation or stopping progress in therapy
 5. **Analysis of Transference** – the client transfers or attributes issues from prior significant authority figures onto the counselor
- C. Case histories are developed from questioning. Testing and diagnosis are often employed.

XI. Criticisms of the Psychoanalytic Model

- The functions of the id, ego, and superego cannot be empirically tested.
- ~~Not suitable in the common counseling setting.~~
- ~~Not suitable for many minority, ethnic, or cultural groups.~~
- ~~Not suitable for solving specific problems of lower socioeconomic individuals.~~
- ~~Social, cultural, and interpersonal influences are largely ignored.~~
- ~~Regressive and reconstructive therapy requires ego strength that is not always present.~~
- The training time for counselors is lengthy, often considered impractical.
- Classic psychoanalysis positions the client on a couch performing free association with an unseen analyst. This expensive process requires several sessions a week for several years.

XII. Additional Information Related to the Psychoanalytic Model

- Freud's psychoanalytical model was the first counseling model. The terms and concepts of his personality theory are foundational to this counseling model and can be found in the chapter on Normal Human Growth and Development in this Study Manual.
- Freud authored *The Interpretation of Dreams*, often called "the Bible of Psychoanalysis," in 1900.
- Freud studied with Josef Breuer, who taught him the benefits of the talking cure or catharsis. **Anna O.**, thought to be the first psychoanalytic patient, was diagnosed with hysteria (symptomology with no organic basis). During hypnosis she could recall painful events she could not talk about otherwise. Talking about these events later brought her relief. While Freud later moved away from hypnosis, these experiences led him to his foundational premise that techniques producing catharsis are therapeutic.
- Freud's reason for moving away from hypnosis was apparently at least two-fold:
 1. He was quoted as saying that he was not very good at it
 2. He believed that symptom substitution (dealing with only the symptom and not the underlying cause could result in the emergence of an additional symptom) could occur
- ~~Freud used his constructs of the Oedipal complex and castration anxiety to explain the fear of a five year-old boy named **Little Hans**. Little Hans was afraid to go into the streets where he thought a horse might bite him.~~
- Freud analyzed the diary of Daniel **Schreber**, a mental patient for 9 years, and came to the conclusion that Schreber's paranoia grew out of unconscious homosexual feelings.
- **EGO-DEFENSE MECHANISMS** – assist in coping with anxiety and defend the ego by either denying or distorting reality. They operate on an unconscious level. (See next page)

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FROM CHAPTER 6

Family Therapy

INTEGRATIVE MODELS

I. Important Figures

William Pinsof	Joseph Eron	Thomas Lund
Richard Schwartz	Neil Jacobson	Andrew Christensen

II. Overview – Integrative Models

A. Integrative family therapy refers to a formal decision-making process by which techniques are borrowed from a variety of models. There is no single integrative model, rather there are numerous efforts to construct new models.

B. The term “integration” refers to three approaches:

1. **Eclecticism** draws from a variety of approaches.
2. **Selective borrowing** in which techniques or concepts are taken from models to compliment one primary model.
3. **Specially designed integrative models** are theoretical models that draw on several approaches.

III. Goals of Treatment – Integrative Models

A. When therapists combine aspects from a number of models, they achieve **increased comprehensiveness**. The previously outlined models typically have a narrow focus on a certain area. Integrative models usually draw understanding into a wider range of phenomena thus increasing the requisite variety of the therapist.

B. Another goal is to expand the horizons of understanding without losing focus. Rather than create an entirely new model, theorists can utilize the previously organized concepts and enhance their usefulness.

IV. Role of the Counselor – Integrative Models

- A. The role of the counselor will vary based on chosen models of integration.
- B. The stance of the counselor is typically more collaborative in nature.

V. Role of the Symptom – Integrative Models

The role of the symptom is assessed through the lens of the models integrated into the new approach.

VI. Normal Family Development

- A. The conceptualization of family development is based on the chosen models. For example, with Integrative Problem-Centered Therapy, Pinsof first views a family from a strategic lens then through the experiential model of Satir. The family is then analyzed from a psychopharmacological perspective and finally from a transgenerational point of view.
- B. Other integrative models will utilize the concepts from two models and stay within the premises of those models (such as the Narrative Solutions Model by Eron and Lund).

VII. Development of Behavioral Disorders

- A. Behavioral disorders are assessed through the lens of the models integrated into the new approach.
- B. An understanding of the initial models aids in understanding of behavioral disorders. For example, from the perspective of Internal Family Systems by Richard Schwartz, disorders occur as the individual family members lose sight of their core selves. From a multiplicity perspective, the various parts of the personality take over leadership and hide the core self. From a systems perspective, the various parts have begun to interact in a dysfunctional manner.

VIII. Key Concepts and Terminology

- A. Cross model boundaries
- B. Combine theoretical or technique elements from various models
- C. Focused on client and presenting problem
- D. Identify generic elements of treatment
- E. Reflect a broad view of the change process
- F. Appreciate diversity of thought in the field
- G. Pragmatic in nature
- H. Focus on one or more systems' elements (individual, couple, family)
- I. Emphasize the self-of-the-therapist

IX. Techniques – Integrative Models

- A. There are no specific techniques that are applied to all integrative models.
- B. A larger repertoire of techniques allows the therapist to have a great requisite variety from which to choose.
- C. However, technique selection is deliberate and should follow the formal integration which has already occurred within the various models.

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