COURSE GUIDE

EGC815

SEX AND FAMILY COUNSELLING

Course Team

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EGC815 SEX AND FAMILY COUNSELLING

COURSE GUIDE

Introduction

EGC815: Sex and Family Counselling is a one semester, three credit unit course. It is a course for Masters students offering Guidance and Counselling in the Faculty of Education. It is also suitable for any student seeking an understanding of the role of sex in marriage and how counselling could be used to help members of a family both young and old live in harmony with themselves and with one another. It is also useful for those who want to acquire knowledge and skills in handling children and helping them overcome some problematic situations.

The Course

This course is made up of four modules; each module contains four units except module four that has five units making it seventeen units in all. The units are, the concepts of sex and sexuality, human reproductive system, sexual health, sexual dysfunction, introduction to premarital counselling, issues to discuss in premarital counselling, other things to talk about in premarital counselling, counselling strategies, the family and counselling, history and theoretical frameworks of family counselling, effective family counselling, family counselling strategies/therapies, the need for counselling children, preparing for counselling , goals for counselling children, the counselling process, and counselling children with special needs.

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.

What you will learn in this course

This course material on sex and family counselling will help you understand the meaning of sex and sexuality, the human reproductive system, and the role of sex in marriage. It also provides in-depth knowledge on the importance of premarital counselling and the skills required to counsel intending couples. It will take you through a process of acquiring knowledge and skills to help families overcome their difficulties and live in harmony. This course material also provides detailed account and mechanisms and strategies of counselling children with various difficulties and needs. As you go through

the study material, you will learn important skills and acquire knowledge that can be applied in counselling intending couples, families and young people.

Course Aims

The aim of this course is to introduce students to the concept of sex and sexuality, the human reproductive system, sexual health and the role of sex in marriage. The course also aims to provide practical guide to counsellors in training on how to counsel intending couples, families, children and young people.

Course Objectives

In order to achieve the aims of this course, some 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 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 what was required of you by the study unit. Set out below are 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. Differentiate between sex and sexuality.
2. Draw, label and explain the human reproductive system.
3. Discuss the human sexual cycle.
4. Enumerate the indices of sexual health and sexual abnormalities and diseases.
5. Explain what premarital counselling entails.
6. Mention and explain some of the topics discussed during premarital counselling.
7. Master and explain premarital counselling strategies.
8. Explain the importance of family counselling.
9. Mention and discuss some family counselling strategies.
10. Explain the need for counselling children.
11. Explain the goals and strategies of counselling children and young people.
12. Discuss the various needs of children and how counselling can help.
13. Discuss the various strategies for counselling children.
14. Explain the necessary preparations that counsellors need to make before counselling children.

Working through this Course

To complete this course, you are required to read the study units and recommended texts. Each study unit contains a self-assessment exercise and, at some points in the course, you are required to submit assignments for assessment purpose. At the end of this course is a final examination. Stated below are the components of the course and what you are expected to do.

Course Materials
The major components of this course are:
Course Guide
Study Units
Textbooks and other Reference Sources

Presentation Schedule
In addition, you must obtain the text materials. Please, contact your tutor if you have problems in obtaining the required materials.

Study Units
There are seventeen (17) study units in this course as follows:

Module 1

Unit 1 - The Concepts of Sex and Sexuality

Unit 2 - Human Reproductive System

Unit 3 - Sexual Health

Unit 4 - Sexual Dysfunction

Module 2

Unit 1 - Introduction to Premarital Counselling

Unit 2 - Issues to discuss in Premarital Counselling

Unit 3 - Other things to talk about in Premarital Counselling

Unit 4 - Counselling Strategies

Module 3

Unit 1 - The Family and Counselling

Unit 2 - History and Theoretical Frameworks of Family Counselling

Unit 3 - Effective Family Counselling

Unit 4 - Family Counselling Strategies/Therapies

Module 4

Unit 1 - The Need for Counselling Children

Unit 2 - Preparing for Counselling

Unit 3 - Goals for Counselling Children

Unit 4 - The Counselling Process

Unit 5 - Counselling Children with Special Needs

Assessment

An assessment file and a marketing scheme will be made available to do you. In the assessment file, you will find details of the works you must submit to your tutor for marking. There are two aspects of the assessment of this course; the tutor marked and the written examination. The marks you obtain in these two areas will make up your final marks. The assignment must be submitted to your tutor for formal assessment in accordance with the deadline stated in the presentation schedule and the Assignment file. The work you submit to your tutor for assessment will count for 30% of your total score.

Tutor Marked Assignment (TMAs)

There are tutor-marked assignments at the end of each unit of this course. They are for your practice. You do not need to submit them, The Tutor marked assignments that will be graded will be sent to your portals at a stipulated time. The best three of what you have submitted will be recorded. Each assignment counts for 10 marks but on the average when the assignments are put together, the assignments will count 30% towards your course mark. You will be able to complete your assignments from the information and materials contained in the academic calendar. However, it is important for you to demonstrate that you have a very broad and in-depth knowledge of the subject matter.

When each assignment is completed, you must send it online. Ensure that each assignment gets to your tutor on or before the deadline given in the Academic calender. If, for any reason, you cannot complete your work on time, contact your tutor before the assignment date is due to discuss the date unless there are exceptional circumstances warranting such.

Final Examination and Grading

The final examination for EGC815, Sex and Family Counselling will be of three hours' duration and have a 70% of the total course grade. The examination will consist of questions which reflect the practice exercises and tutor-marked assignments you have previously encountered. You may find it useful to review your tutor-marked assignments and the comment(s) on them before the examination. The final examination covers information from all aspects of the course.

Course Marking Structure

The following table lays out how the actual course mark allocation is broken down.

Table 1: Course Marking Structure

Stages of Assessment	**Percentage of Scores**
Assessments	30%
Final Examination	70%
Total	**100%**

Presentation Schedule
The dates for submission of all assignments will be communicated to you. You will also be told the date of completing units and dates for examinations.

Course Overview
Each unit should be studied for one week and the assignments completed. So students should finish the course in 17 weeks.

How to get the most from this Course
You will be required to study the units on your own. But arrangements have been made for you to meet with your tutor for tutorials on regular basis in the study centre. Also, you can organize interactive sessions with your course mates. In distance learning, the study units replace the university lecturer. This is one of the great advantages of distance learning; you can read and work through specially designed study materials at your own pace, and at a time and place that suits you best. Therefore, it is reading the lecture instead of listening to the lecturer. In the same way, lecturer might give you some readings to do, the study units tell you when to read and the text materials or set books to read. You are provided exercises to do at appropriate points, just as a lecturer might give you an in-class exercise. Each of the study units follows common formats. The first item is an introduction to the subject matter of the unit and how a particular unit integrated with the other units and the course as a whole. Next to this, are set of learning objectives. These objectives let you know what you should be able to do by the time you have completed the unit. These learning objectives are meant to guide your study. The moment a unit is finished you must go back and check whether you have achieved the objectives or not. If this is made a habit, then you will significantly improve your chances of passing the course.

The main body of the unit guides you through the required reading from other sources. This will usually be either from your textbooks or books or from a reading section. The following is a practical strategy for working through the course. If you run into any trouble, telephone your tutor or visit the study centre. Remember that your tutor's job is to help you. When you need assistance, do not hesitate to call and ask your tutor to provide it.

1. **Read this Course Guide thoroughly, it is your first assignment.**
2. **Organize a Study Schedule.** Design a 'Course Overview' to guide you through the Course. Note the time you are expected to spend on each unit and how the

assignments relate to the units. Important information, e.g. details of your tutorials and the date of the first day of the Semester is available from the study centre. You need to gather all the information into one place, such as your diary or a wall calendar.

3. **Once you have created your own study schedule, do everything to stay faithful 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 to provide help or assistance before it is too late.
4. **Turn on Unit 1, and read the introduction and the objectives for the unit.**
5. **Assemble the study materials.** You will need textbooks and other learning materials for the units you are studying at any point in time.
6. **Work through the unit.** As you work through the unit, you will know what sources to consult for further information.
7. **Before the relevant due dates (about 4 weeks before the due dates), check the Assignment File for your next required assignment.** Keep in mind that you will learn a lot by doing the assignments carefully. They have been designed to help you meet the objectives of the course and, therefore, will help you score a good grade in the examination. Submit all assignments not later than the due date.
8. **Review the objectives of 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 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 for its return 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-market assignment form and also the written comments on the ordinary assignments.
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 12 hours of tutorials provided in support of this course. Information relating to the tutorials will be provided at the appropriate time. Your tutor will mark and pass comment(s) on your assignments, keep a close watch on your progress and report to the appropriate quarter, any difficulty you may encounter so that assistance can be provided to you during this course. You must take your tutor-marked assignments to the study centre 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 if you need help. Contact your tutor if you are encountering difficulties on any of the following:

- You do not understand any part of the study units or the assigned readings;
- You have difficulties with the exercises;
- You have a question or problem with the assignment,
- You have a question or problem 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 the only chance you have to meet your tutor face-to-face to ask questions which are answered instantly. You can raise any problem encountered in the course of your study with your tutors when you met face-to-face. To gain the maximum benefit from the course tutorials, prepare a question list before meeting your tutors face-to-face. You will learn a lot from participating in discussing actively.

I wish you success with the course and hope that you will find it both interesting and useful.

MODULE 1: Sex and Sexuality

Unit 1: The Concepts of Sex and Sexuality

Unit 2: Human Reproductive System

Unit3: Sexual Health,

Unit 4: Sexual Dysfunction

Unit 1: The Concepts of Sex and Sexuality

Contents

1.0 INTRODUCTION

Have you ever wondered what men and women are like? What psychological characteristics distinguish men and women? Are women strong, caring and wise? Are they less aggressive and independent than men? A great anthropologist, Margaret Mead answered these questions about women and men by saying that the answers depend on their culture. She said that women and men behave the way they have been shaped by their culture. Not everyone shares this view, however, so this unit discusses the two topics that are often referred to by the same name- sex: (a) the gender of a person-male or female and (b) sexual behaviour. Much of who you are and what you do is related to your gender and sexuality. Your experiences as a young boy or girl, the expectations that you learned from society of what it means to be a woman or a man, and how you view the sexual aspects of yourself are central to your total being.

We will also discuss gender identity, gender roles, and sexual orientation. The ways in which we view our gender and our sexual orientation are a product of both biological and psychological factors. These factors result in some differences between men and women in different cultures, but we will find that women and men are more similar in psychological terms than they are different.

2.0 Objectives

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

- Define sex, sexuality and sexual orientation
- State the differences between male and female sexual behaviours
- Explain the biological and psychological aspects of sexuality

3.0 Main Content

3.1Gender and Sex

A person's sex is defined by his or her male or female genitals. Gender, in contrast is the psychological experiences of one's sex (Gentile, 1993). In most cases, a person's sex and

gender are the same, but not always. It is possible for persons with male genitals to feel that their gender is female and vice versa.

It will help advance our discussion to distinguish between two important aspects of gender, gender identity and gender roles. Gender identity is the subjective experience of being a male or a female. As is true for all aspects of personal identity, gender identity is a part of our personalities and central component of our self concepts. Gender role on the other hand, refers to all of the behavior that communicate to others the degree to which we are "masculine" or ferminine" in the terms defined by our culture (Mone 1987, 1988). Thus, your gender role is the outward behavioral expression of your gender identity. Gender roles vary from culture to culture and provide a set of expectations of persons on the basis of their sex.

3.2: **Sexuality**

The term **sexuality** refers to the behaviors in which we engage to obtain sexual pleasure and to all of the feelings and beliefs that are interwoven with sexual behavior. One aspect of our psychological selves that is very much a part of both our sexuality and our gender identity is sexual orientation, our tendency to prefer romantic and sexual partners of the same or different sex. This unit will discuss all of these aspects of gender and sex.

3.3 Gender Differences in Mating and Sexual Behaviour

Many studies conducted in many cultures indicate that women and men differ in ways related to sexual behavior and the selection of a mate (Bjorklund and Shackleford, 1999; Buss, 1995, 1999; Eagly and Wood, 1999). Men tend to prefer a mate who is younger and physically attractive but who has good housekeeping skills. On the average, they are sexually jealous and controlling of their partners but are more likely to feel comfortable with the idea of casual sex for themselves. Women, in contrast, tend to prefer mates who are somewhat older and who have good character.

3.4 Sexual Orientation

Close your eyes and imagine the perfect partner for you for a romantic and sexual relationship. The gender of the person that you imagine reveals a great deal about your sexual orientation. Persons who are sexually attracted to members of the opposite sex are termed heterosexual. In contrast, persons who are attracted to members of the same sex have a homosexual orientation. Most homosexual men use the term gay, whereas most homosexual women use the term lesbian. Other people are attracted to varying extents to both members of their same sex and members of the opposite sex. When this is the case, the sexual orientation is termed bisexual

3.5 Biological and Psychological Aspects of Sexuality

Sexuality is a topic that is full of both interest and emotion for most people. It plays a pivotal role in many intimate relationships, is the subject of intense moral debates, and is plagued by misinformation more than perhaps any other natural aspects of human life. The emotional nature of sexuality may be evident to you now as you read this aspect. Are you approaching the topic of sexuality in the same dispassionate manner that you read about thirst or memory?

In this section, we will briefly discuss sexuality in scientific terms, and will contrast the sexual motive to other motives.

Images and themes of sexuality appear in art and literature reaching as far back as the earliest civilizations, but the scientific study of sexuality has only recently emerged. Two European physicians working at the turn of the twentieth century were at the forefront of early studies of sexuality. Richard Von Krafft Ebing (1840 -1902), a Viennese neurologist, extensively studied variations and derivations in human sexual behavior. However, Krafft-Ebing's view of sexuality was mostly negative and his work filled with misconception. For example, Krafft-Ebing believed that masturbation caused all sexual deviations and was at the root of sexual problems. Today we know that this basic premise of Krafft-Ebing's views of sexuality is false.

A second major figure in the study of human sexuality was Henry Havelock Ellis (1859-1939). An English physician, Ellis was the first to discuss extensively the role of social and cultural influences in shaping human sexual behavior and one of the first scholars to study homosexuality. He also stated for the first time that men and women experience similar sexual desires and that psychological problems such as anxiety and depression can influence physical sexual functioning.

Subsequent to the many published volumes of research by Krafft-Ebing and by Ellies in the early part of the century, there was surprisingly little scientific study of human sexuality for many years. In many ways, the scientific world was not yet prepared to discuss human sexuality objectively. A major turning point in the study of sexuality occurred, however, in the 1940s with the work of Alfred C. Kinsey (1894 - 1956). Kinsey became interested in human sexual behavior when he was made aware of the extremely limited amount of scientific information available on this topic. He conducted large surveys that allowed him to describe many aspects of human sexuality, including the broad range of sexual activities (Kinsey; Pomeroy and Martin, 1948; Kinsey, Pomeroy, Martin and Gebhard, 1953). His methods seem weak today, but he opened the door to better research that would follow.

Other modern pioneers in the study of sexual behavior include John Money of Johns Hopkins University. Money is best known for his studies in sexual development and his classic research of gender roles, a term that he first coined (Money, 1955). Also of great importance was the work of William Masters and Virginia Johnson. They

conducted groundbreaking laboratory studies of volunteers who were observed during the sexual response cycle from the initial excitement to the moment of orgasm, while Masters and Johnson measured the physiological changes that accompany the sexual behavior. Masters and Johnson's two most important books, Human Sexual Response (1966) and Human Sexual Inadequacy (1970), helped form the basis for our understanding of human sexual functioning and sexual problems and stood as the foundation for sex therapy.

4.0 Conclusion

Sex and sexuality have been discussed throughout history in philosophy, literature and the arts, but the scientific study of sex and gender is a relatively new field. The first scientific discussions of sexuality date back only to the early 1900s, and it was only in the 1940s that Kinsey conducted the first objective surveys of sexual behavior.

5.0 Summary

In this unit, we had a detailed look at the psychological aspects of being a male or female. We also looked at the development of the identity and behaviours associated with gender and at the similarities and differences between women and men. We also looked at the related topic of sexual orientation- the gender to whom a person is drawn romantically and sexually.

6.0 Tutor Marked Assignment

1. Explain the following terms: sex, sexuality and sexual orientation

2. Males and females differ in their sexual behaviours. Discuss

3. Differentiate between the biological and psychological aspects of sexuality

7.0 References/Further Reading

UNIT 2: Human Reproductive system

Content

1.0 Introduction

In this unit, we will look at the sexual anatomy of men and women and how they are designed for sexual intercourse and reproduction. We will also describe the sexual response cycles of men and women which is made up of four phases namely the excitement, the plateau, the orgasmic and the resolution phases.

2.0 Objectives

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

- Draw and describe the human sexual anatomy
- Explain the functions of the sex organs
- Explain the sexual response cycle

3.0 Main content

3.1 Sexual Anatomy and Functioning

The major structures of the sexual anatomy of females and males are presented below. The uterus is a pear shaped, muscular structure that carries the fetus during pregnancy. After conception, the fertilized egg implants itself in the wall of the uterus, where it grows and develops during gestation. Except during pregnancy, it is this inner lining of the uterus that is shed during the menstrual cycle approximately every 28 days.

The ovaries are the two structures that produce estrogen and other hormones and produce ova, or egg for reproduction. The fallopian tubes branch off from the top of the uterus, extending near, although not quite touching, the ovaries. The fallopian tubes form a passage in which ova are transported from the ovaries to the uterus. At the bottom of the uterus is the cervix, which is the neck of the uterus that is connected to the vagina. It is through the cervix that menstrual flow is discharged and through which the newborn is passed into the birth canal during delivery.

Figure 1: **Major Structures of the Female Sexual Anatomy.**

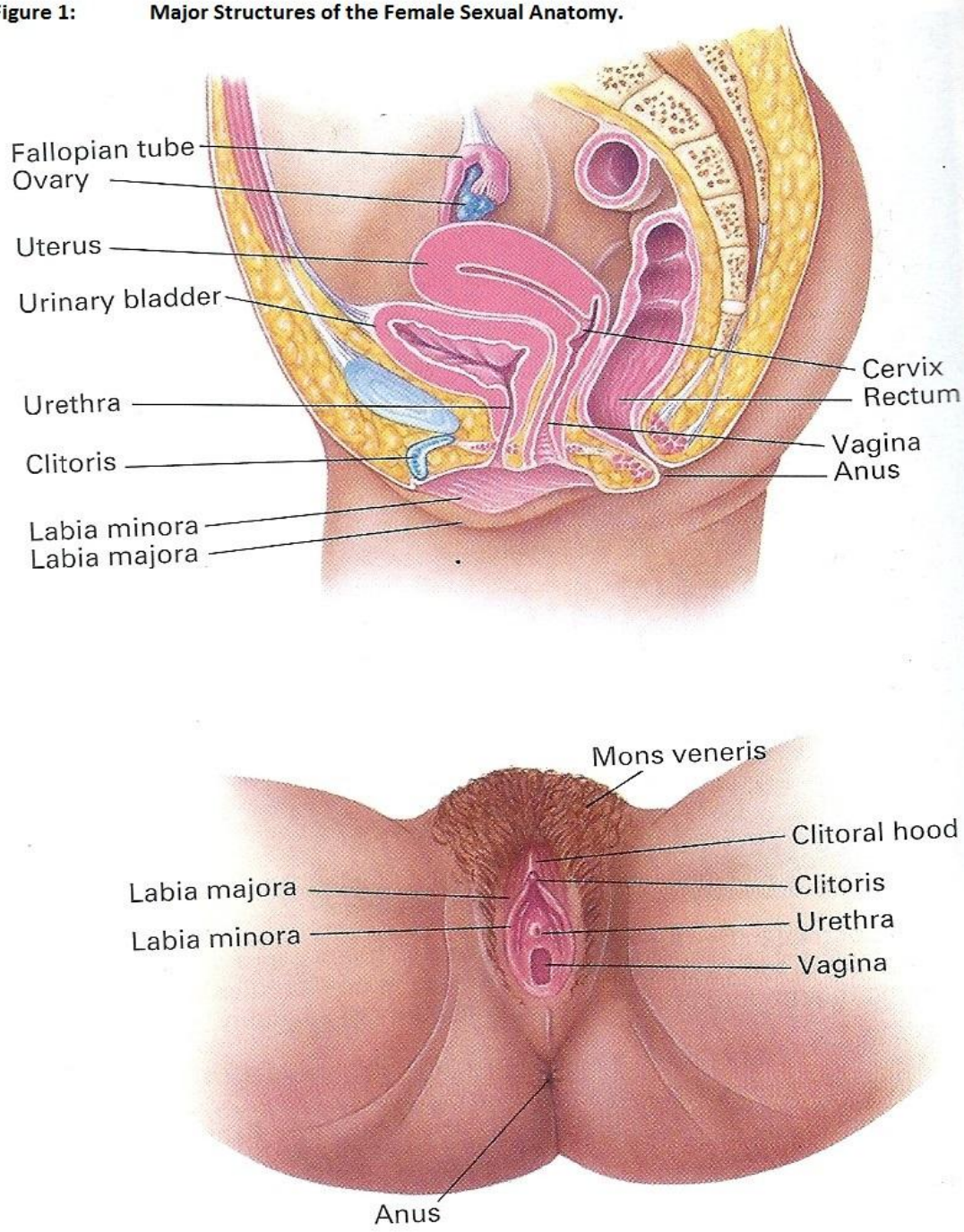
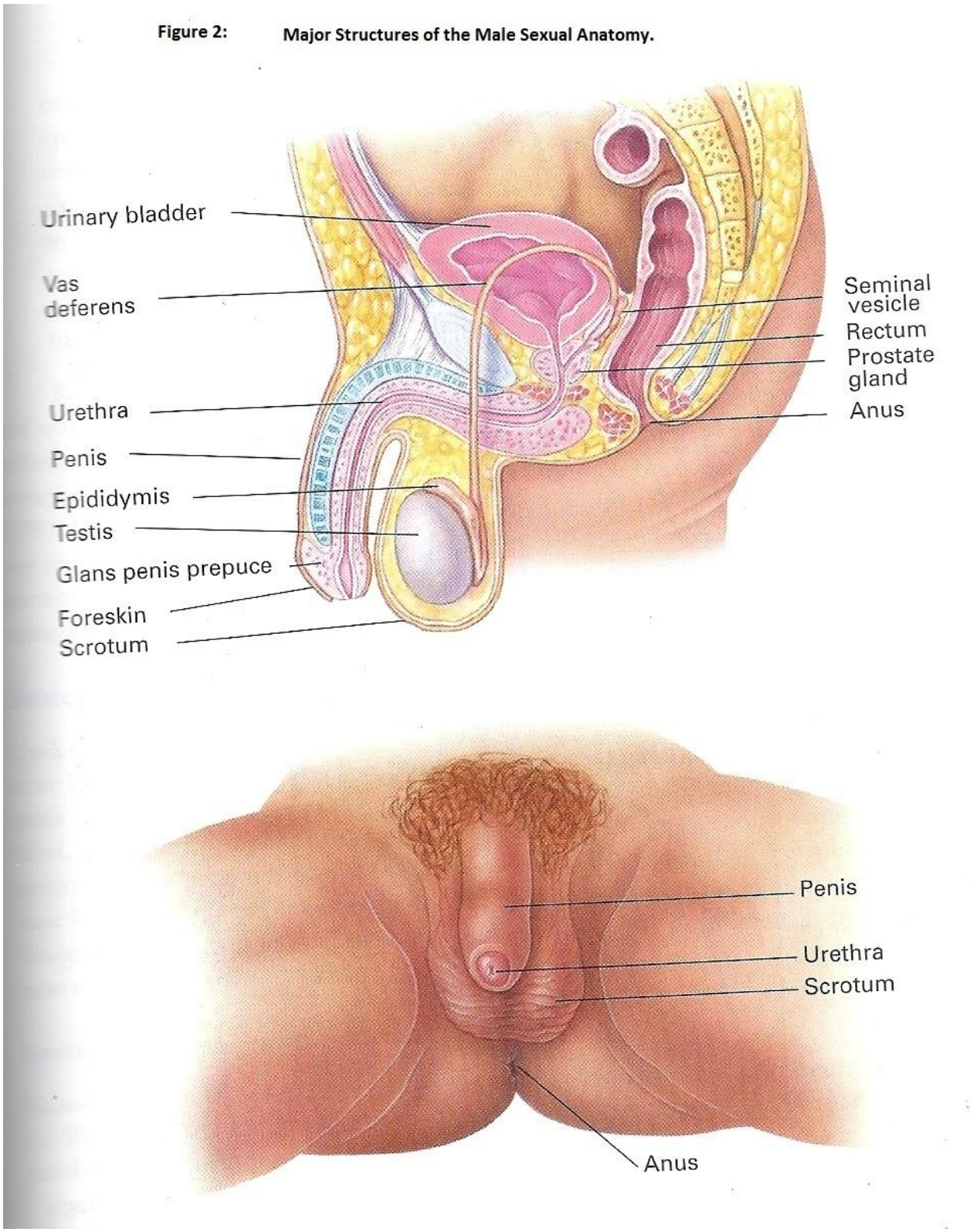


Figure 2: **Major Structures of the Male Sexual Anatomy.**



Culled from the work of Benjamin B. Lahey. Pp 432-433.

The female external genitals consist of a set of structures collectively referred to as the vulva, made up of the mons, labia majora, labia minora, and the clitoris. The mons, a fleshy mound of tissue that sits at the top of the vulva, is the upper area covered with public hair. The labia majora, or large lips of the vulva, are the outer vaginal lips that surround the inner lips, or labia minora. The two labia provide folds that cover the opening of the vagina and are a sensitive source of pleasure during sexual stimulation. The folds of the labia minora converge at the top of the vagina to form a hood for the clitoris, which is the structure at the upper part of the vagina that is most highly responsive to sexual stimulation. The labia and clitoris both play critical roles in female sexual response.

The male reproductive system consists of the testes (testicles) and a related system of tubes and glands. Like the ovaries, the testes produce both hormones and reproductive cells. The male reproductive cells are the sperm, which carry the father's genetic information for conception. The testes are suspended below the abdomen away from the heat of the body because sperm are only produced at a temperature slightly lower than the 98.6^0 temperature of the rest of the body. Extending from each testicle is the epididymis, which holds mature sperm cells after they have been produced in the testes and connects with the vas deferens. The vas deferens is the tube that carries sperm from the epididymis towards the outside of the body. The sperm cells are carried in a fluid called semen, which is produced by the prostate gland and seminal vesicle.

The external genitals of the male and female are structured to allow sexual intercourse. The external male genitals consist of the penis and scrotum. The penis is a tubular structure filled with three spongy tubes that fill with blood during sexual response. It is the filling of the penis with blood that causes it to become stiff and erect during sexual arousal. The scrotum is a loose skin structure that extends behind the penis and supports the testes. The scrotum responds to change in temperature, contracting when cold and relaxing when warm, to ensure that the testes remain at a temperature optimal for sperm production.

3.2 The Sexual Response Cycle

The response of humans to sexual stimuli involves a predictable biological response known as the sexual response cycle. Although there are substantial similarities between the sexual response cycles of women and men, there are some important differences. Masters and Johnson (1966) describe four stages of the sexual response cycle.

3.2 1 Excitement phase. Both women and men show an initial increase in physiological arousal, called the excitement phase. This may begin from visual stimulation, physical contact, odors, fantasies, and the like. Blood flows to the penis and the vagina, erection and lubrication occur, the nipples become erect, the heart beats faster, blood pressure rises, and the body become aroused in other ways.

3.2 2 Plateau phase: If the sexual stimulation is intense enough, sexual arousal builds quickly to the plateau phase, which is characterized by high levels of arousal that are sustained for periods ranging from seconds to many minutes. The degree of sexual pleasure is very high, but not yet at a maximum.

3.2 3 Orgasmic phase. With sufficient stimulation, and under the proper psychological circumstances, the individual usually progresses to the reflexive stage of orgasm. A peak of physical arousal and pleasure is reached. Breathing is rapid, blood pressure and heartbeat reach high levels, the skin flushes, and the individuals partially loses muscular control for a brief time and experiences involuntary spasms of many muscle groups. There is little variability in the orgasmic phase of men, but much more variation in the orgasms of women. Three common patterns of female orgasmic response have been distinguished (Masters and Johnson, 1966). Some women reach a single brief and intense orgasm, like that of men. Other women, depending on the circumstance, experience multiple intense orgasmic peaks. Other women experience a large number of smaller peaks of orgasm.

3.2 4 Resolution phase: Following orgasm, the body's level of physical arousal rapidly declines in the resolution phase. Within a few minutes, body returns to a condition much like its original state prior to the beginning of the response cycle, although heightened relaxation and tiredness are common. In males, the resolution phase is accompanied by a period of time when the male is unresponsive to further sexual stimulation, termed the refractory period. Although women briefly may be too sensitive to enjoy further sexual stimulation during the resolution phase, with individual preferences determining her interest in further stimulation, there is no refractory period in which women are physically incapable of resumed sexual arousal.

4.0 Conclusion

The anatomy of both male and females is constructed to provide the most efficient means of copulation and reproduction. Sexual functioning, referred to as the sexual responds cycle, is similar for male and females, with the primary differences being that men have a refractory period that requires a regeneration of energy between response cycles and women do not have such a refractory period, increasing the potential for repeated orgasms. The differences between men and women in terms of sexual response, however, are far less than once believed.

5.0 Summary

In this unit, we have looked at the sexual anatomy of men and women and how they are designed for sexual intercourse and reproduction. We also described the sexual response cycles of men and women.

6.0 Tutor Marked Assignment

1. Draw the male and female sexual anatomy
2. What are the functions of the male and female sex organs?
3. Describe the sexual response cycles of men and women. How do they differ?

7.0 References/Further Reading

Unit 3: Sexual Health

Contents

1.0 Introduction

This unit will look at sexual motivation, a drive that is very essential to the survival of the species. We will also look at how the sexual drive is similar to other primary motives as well as how it differs from some others.

2.0 Objectives

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

- Explain the term, sexual motivation
- State the similarities between the sexual drive and other primary motives

- Differenciate between the sexual motive and other primary motives.

3.0 Main Contents

3.1 Sexual Motivation

It will come as no surprise to you to learn that human beings have a sexual motive, much as we have motives for hunger or thirst. Without a sexual motive, humans and other animals that depend on sexual reproduction would soon be extinct. Whereas hunger, thirst, and other primary motives are necessary for the survival of the individual, sexual motivation is a primary motive that is essential to the survival of the species. The same basic biological mechanisms are involved in sexual motivation in all mammals, but the biological controls that govern sexual behavior are less significant in humans than in most other animals.

3.2 Similarity to Other Primary Motives

We will understand sexual motivation better if we compare it with other primary motives. The sexual motive resembles hunger, thirst, and other primary motives in a number of important respects.

3.2 1 Hypothalamic control: Like hunger and thirst, the sexual motive is controlled by the hypothalamus. One center in the hypothalamus and related brain structures activates motivation and sexual behavior. This system is the equivalent of the hypothalamic feeding and drinking systems. If the hypothalamus is surgically destroyed, sexual behavior will not be initiated even in the presence of sexually provocative stimuli. A second system of the hypothalamus inhibits sexual behavior. If this inhibitory system is destroyed in laboratory animals, the animals become hypersexual, that is, they engage in unusual and unrestrained amounts of sexual behavior. These two centers act in balance to regulate sexual motivation. The hypothalamus also indirectly influences female sexuality through its control of the menstrual cycle. Women are significantly more likely to initiate sex with a male partner or to masturbate when levels of estrogen peak at the time of ovulation (Adams, Gold, and Burt, 1978). This cycle of increased interest in sex may have evolved to increase the likelihood of fertilization of ova. Understandably, women who take birth control pills, which regulate estrogen levels, do not show this monthly peaking of sexual interest.

3.2 2 Role of external stimuli: Like hunger, which can be stimulated by external stimuli, known as incentives, such as the sights and aromas of dessert stimulating the hunger of a well-fed person, sexual motivation is highly sensitive to external stimuli. The person who initially is not sexually aroused, whether male or female, will often be aroused by a seductive partner or romantic fantasies. Indeed, external stimuli play a very important role in arousing the sexual motive (Wilson, Kuehn and Beach, 1963). One aspect of the role of external stimuli has been termed the Coolidger effect. Following intercourse, males of many animal species will have

intercourse again with the same receptive female sometimes after the refractory period has elapsed. Bermant (1976), for example, found that a ram (male sheep) will have sex an average of five times with the same ewe (female sheep) before seeming to loose interest. However, if a different receptive ewe is introduced after each mating, the ram will mate more than three times as often before losing sexual interest, and it will reach orgasm much more quickly than with the same ewe. Apparently, variety is powerful external factor in sexual motivation for many mammalian species.

3.2 3 Role of learning: We have already seen that learning can play a powerful role in shaping the primary motives. What, when, and how much we eat, for example, is greatly influenced by our learning experiences. Sexual motivation is influenced by learning, at least to the same degree and probably to an even greater extent. The enormous variety in the sexual behavior of the members of any society at any point in history strongly points to the role of learning in sexuality. Differences in sexuality between cultures also portray the influence of learning experiences on sexual motivation.

3.2 4 Role of emotion: Like the other primary motives, especially eating, sexual motivation is influenced to a great extent by our emotions. Because stress, anxiety, and depression are accompanied by increased sympathetic autonomic arousal, and because sexual arousal is mediated by parasympathetic arousal, which is in opposition to sympathetic activity, these emotions generally result in a decrease in sexual motivation. Because the balance between the sympathetic and parasympathetic systems is complicated, however, anxiety and depression sometimes result in an increase in sexual motivation. Just pointing to the obvious influence of strong negative emotions on our sexuality, however, does not begin to do justice to the intricate interplay of emotions and sexuality. Far more than any other motive, sexual passion is powerfully linked to even the delicate nuances of romantic love and other subtle emotions.

3.3 Differences from Other Primary Motives

Although sexual motivation is similar to the other primary motives in the many ways just mentioned, there are important differences as well (Houston, 1985):

3.3 1. Survival value: We must satisfy the primary motives of hunger, thirst, need for warmth, and so on to survive as individuals and, collectively, to survive as a species. Although satisfaction of the sexual motive is essential to the survival of the species, it is not necessary for individual survival.

3.3 **2. Increases and decreases in arousal**: We are motivated to decrease the physiological arousal created by hunger and other primary motives. However, humans are obviously motivated to both increase and decrease their sexual arousal. The intimate behaviors that we engage in to initiate the arousal phase of sexual response cycle (“foreplay”) obviously increase arousal. Yet the fact that people spend a lot of money each year on erotic videos and erotic telephone

conversations, is strong testimony to our motive to increase sexual arousal and then to decrease it through sexual activity.

3.33 Role of deprivation: Motives such as hunger and thirst rather predictably rise and fall according to the length of time since they were last satisfied. A person who has just eaten a large meal will not be hungry, but a person who has been deprived of food for eight hours will be ravenous. To an extent, the same is true for sex. If you are used to regular sex life, the two weeks that your lover goes home to visit family may lead to a noticeable increase in sexual interest. But sexual motivation is far less linked to deprivation than the other primary motives. Except during the refractory period, humans are susceptible to sexually arousing stimuli and situations almost all the time. On the other hand, individuals without a sexual outlet report going long periods of time without the arousal of sexual longings. Indeed, it has often been observed that we don't really need sex until we have it. The more often we are sexually aroused and satisfied, the more sexual motivation we seem to have.

3.34 **Decreases in energy:** The other primary motives lead to behavior that increases the body's store of energy and other bodily needs. In contrast, sexual behavior results in a marked decrease in energy.

4.0 Conclusion

The sexual motive is similar to other primary motives, such as hunger, in that centers of the hypothalamus play an important role, external stimuli can stimulate the sexual motive, and the sexual motive can be influence from learning experiences and emotions. The sexual motive is different from other primary motives, however, in that it is not necessary to the survival of the individual, it does not always lead to decreases in arousal, it is not influenced by deprivation in the same way, and it leads to a decrease rather than an increase in energy.

5.0 Summary

In this unit, we looked at sexual motivation and its similarities and differences to other primary motives.

6.0 Tutor Marked Assignment

1. What do you understand by sexual motivation?
2. Sexual motivation is similar to other primary motives. Discuss
3. How does the sexual motive differ from other primary motives?

7.0 References/Further Reading

Unit 4: Sexual Dysfunctions

Contents

1.0 Introduction

Human beings differ widely in their sexual preferences and practice. In the sections that follow, we will look at the range of unusual, or atypical, sexual behavior. In the first section, atypical patterns of sexuality are described that are considered abnormal only if the individuals who engage in the sexual practices consider them abnormal for themselves. In the next sections, we will examine patterns of sexuality that are usually and always considered to be abnormal.

2.0 Objectives

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

1. Mention and describe various atypical and abnormal sexual behaviours in human beings.
2. Mention and describe various sexual dysfunctions experienced by both men and women.
3. Explain the various health problems that are related to sexual anatomy.

3.0 Main Contents

3.1 ATYPICAL SEXUAL BEHAVIOURS

3.1 1 Transvestion and Transsexualism

These two superficially similar patterns of sexuality are often confused because they both involve dressing in the clothing of the other sex. But they have little else in common except that they are rarely harmful to anyone. **Transvestism** refers to the practice of dressing in the clothes of the other sex. **Transsexualism**, on the other hand, refers to a condition in which the individual feels trapped in a body of the wrong sex. For example, a person who is anatomically male feels that he is actually a woman who somehow was given the wrong body. In some instances, these individuals undergo hormone injections and plastic surgery to change their sex organs to those of the desired sex.

3.1.2 Fetishism

Fetishism refers to the fact that some individuals are primarily or exclusively aroused by specific physical objects or types of materials (such as leather or lace). In some cases, the fetish is only an exaggeration of normal interest in specific body parts. For example, some individuals are only or primarily aroused by breasts, buttocks, blue eyes and so on. But the term fetish is usually reserved for cases involving inanimate objects, such as panties, shoes, or stockings. A fetish is considered to be abnormal if it interferes with the sexual adjustment of the person or his or her partner. Often, the fetishist (who is usually a male) is aroused only by "used" articles and is sexually aroused by the act of stealing them from an unknowing woman. Because this can be frightening to the victim and is dangerous and illegal, fetishism is considered abnormal when practiced in this manner.

3.1.3 Sexual Sadism and Masochism

Sexual sadism is the practice of receiving sexual pleasure from inflicting pain on others. **Sexual masochism** is the condition in which receiving pain is sexually exciting. Sometimes verbal abuse or "degradation" is substituted for physical pain. Many individuals who practice sadism and masochism, do so with a consenting partner who also enjoys the practice, and they do not inflict pain that is severe or medically dangerous- for example, mild spankings, pinching, and so on. In such cases, Sadism and Masochism may be considered normal if care is taken to avoid accidental harm and one's partner is truly willing.

3.1.4 Voyeurism and Exhibitionism

Voyeurism is the practice of obtaining sexual pleasure by watching others undressing or engaging in sexual activities. Voyeurs generally find this exciting only when the person they are watching is unaware of their presence and when there is an element of danger involved. Because they often frighten the person they are watching, and because the activity is illegal, voyeurism is considered to be abnormal. The voyeur is generally a heterosexual male who has trouble establishing a normal sexual relationship. Some voyeurs commit rape and other serious crimes, but most are not physically dangerous.

Individuals who practice **exhibitionism** obtain sexual pleasure from exposing their gentials to others. Almost all exhibitionists are heterosexual males who typically are married but who are shy and have inhibited sex lives. Exhibitionists generally want to shock their victims but rarely are dangerous in other ways (Tollison and Adams, 1979). Because such behavior is illegal and frightening, however, exhibition is considered abnormal.

3.2 Abnormal Sexual Behaviors

Several other forms of deviant sexual behavior are clearly abnormal because they involve actual, threatened, or implied force to the victim. These acts include rape, sexual abuse of children, incest, and sexual harassment.

3.2.1 Rape

In rape, an individual forces another person to engage in a sexual act. In the vast majority of cases, the rapist is a male and the victim is a female. In almost every instance of rape, women were forced by men or by two or more persons. When women are raped, it is almost always by someone they know well (22 percent). Someone they are in love with (46 percent), or their husband (9 percent). In the much less common instance of men being forced into sex, they are forced by women two thirds of the time.

The aftermath of rape is traumatic. Rape victims almost invariably feel that their entire life has been altered due to their assault (Nadelson, 1990). Many victims of rape experience mental anguish, often referred to as rape trauma syndrome, characterized by intense feelings of anxiety and depression as well as disturbances in sleep, relationship and daily functioning (Calboun and Atkeson, 1989, Thornhill and Thornhill, 1990).

3.2.2 Sexual Abuse of Children

Many children are sexually assaulted and exploited. In a large survey by Kohn, (1987), 27 percent of women and 16 percent of men reported being sexually violated during childhood. There are a variety of types of child sexual abuse. When the sexual contact is perpetrated by a family member, the sexual abuse is termed **incest.** When there is force or threat of force used, the sexual assault is **child rape.** When there is no clear threat of force, the sexual abuse of children is referred to as **child molestation**. Even child molestation is considered to be a form of forced sexual behavior because the child cannot consent in any meaningful way to the sexual behavior.

Many of the effects of child sexual abuse are believed to be long term. Indeed, the aftermath of child sexual abuse may be similar to that of adult sexual assault, in that children tend to be traumatized and suffer traumatic reactions (Finkelhor, 1990). Children are likely to act out sexually in response to sexual victimization, experience a sense of personal betrayal by the person who violated them, feel that they are powerless and lack control, and feel stigmatized because they were assaulted (Finkelhor and Browne, 1985).

Adults who engage in **pedophilia** experience sexual pleasure primarily through sexual contact with children. They usually first gain the trust and acceptance of their victims before engaging in sexual behavior.

3.2.3 Sexual Harassment

Unwanted sexual advances; request for sexual favors, unwanted touching of the legs, breasts or buttocks; sexually suggested comments; and any other forms of coercive sexual behaviours by others constitute **sexual harassment**. Sexual harassment also includes the leering looks and inane remarks that men often foist on women on the street, which have made nearly every woman uncomfortable (angry, frightened, disgusted) at one time or another. Although it is less common, men are also the victims of sexual harassment in colleges and in the workplace.

Every victim of sexual harassment suffers in the sense of becoming less comfortable and relaxed at school or work. In some cases, however, sexual harassment can provoke serious levels of anxiety and depression.

3.3 Sexual Dysfunctions

Several types of problems can interfere with successful and pleasurable sexual intercourse. These problems are quite common and considered abnormal only when they are prolonged. Even when prolonged, however, they do not mean that the individual has psychological problems. Sexual problems can and usually do occur in perfectly normal individuals (Munjack and Staples, 1977).

Sexual dysfunctions are disturbances in any phase of the sexual response cycle. Different dysfunctions may have several different potential causes, both physical and psychological in origin. The most common physical causes of sexual dysfunction are drug or alcohol abuse, side effects of some medication and some forms of illness. It is important, therefore, that all persons with problems with sexual functioning first be evaluated by a physician who specializes in the sexual reproduction system, such as a gynecologist or urologist (Diokno and Hollander, 1991). Fortunately, solutions are available for sexual difficulties caused by medical problems. Many sexual dysfunctions are caused by psychological factors, and they are classified according to the phases of sexual response within which they occur; sexual desire, sexual arousal and orgasm.

3.2 1 Dysfunctions of sexual desire

Among the most common sexual dysfunctions are those involving interest and desire in sexual relations (LoPiccolo and Friedman, 1988). It is important not to confuse sexual desire with sexual frequency, because a person can have frequent sexual encounters to please his or her partner but have very little desire for these sexual interactions. In contrast, a person may have strong sexual desire but not engage in sex for a number of reasons. It is also important to note that everybody has a different natural level of sexual

interest. A person is said to have a disorder of sexual desire only if he or she lacks almost all desire for sexual contact and is troubled by the lack of desire. Two specific types of dysfunctions involve sexual desire. First, **inhibited sexual desire** occurs when a person has sexual desire very infrequently or not at all. The second desire problem is called **sexual aversion disorder** and is characterized by a nearly complete fearful avoidance of sexual contact with others (American Psychiatric Association, 1994).

Both men and women experience disorders of sexual desire. There are numerous possible causes of these problems, including extreme anxiety about sexual intimacy or having had a sexually traumatic experience. In other cases, the person may not have a general lack of desire but may lack interest in his or her sexual partner because of problems in that relationship (Beck, 1995; Kaplan, 1983; LoPiccolo and Friedman, 1988).

Therapists who work with sexual desire problems first examine the person's overall relationship with his or her partner. If there are few relationship problems, therapy for sexual desire problems tends to focus on the anxiety that the person may experience in relation to sexual intimacy. Anxieties may block desires for sexual contact and interfere with sexual interest. Sexual inhibitions may result from experiences and characteristics of the person. These issues are examined in the context of sex therapy, where persons evaluate their anxieties and employ strategies to reduce them. Often therapy will involve both members of a couple to address specific aspects of their sexual interactions (Rosen and Leiblum, 1995).

3.2.2 Dysfunctions of Sexual Arousal

Sexual arousal disorders occur when there is a lack of sufficient sexual arousal including erection of the penis for the male and lubrication of the vagina for the female- during the excitement phase of sexual response. Note, however, that a person is said to have a disorder of sexual arousal only if this failure to respond occurs consistently, occurs even with adequate levels of sexual stimulations, and interferes with sexual pleasure or causes discomfort. Thus, in sexual arousal dysfunction, an interruption of the physical processes occurs in the excitement phase of sexual response namely, blood flow to the genital region and muscle tension. Women may develop **female sexual arousal disorder** (previously referred to as frigidity), which is characterized by a lack of vaginal lubrication and a minimal subjective experience of sexual excitement (American Psychiatric Association, 1994). Disruptions that occur during female sexual arousal disorder are specifically associated with the physical experiences of sexual excitement. Because most women experience transient forms of these difficulties when circumstances do not lend themselves to sexual arousal on occasion, the lack of arousal must be persistent under even favourable circumstances to be considered a sexual dysfunction

Other less common female dysfunction are **vaginismus** and **dyspareunia.** Vaginismus refers to involuntary contractions of the walls of the vagina that make it too narrow to allow the penis to enter for sexual intercourse. In dyspareunia, the woman experiences pain during intercourse. Often, but not always, these conditions are accompanied by

organic dysfunction and anxiety associated with sex. Like the male dysfunctions, the female dysfunction can usually be eliminated with professional help.

Similar to sexual arousal disorder in women, **male sexual disorders** directly reflect the physiological process of sexual excitement in the male sexual response cycle. In men, the most common sexual arousal disorders is **erectile dysfunction** (previously called "Impotence"). Specifically, despite high levels of sexual stimulation, there is insufficient arousal to result in the penis gaining an erection suitable for sexual penetration. As is the case for women, to be considered a sexual dysfunction, these difficulties must be persistent even under ideal circumstances and must be accompanied by a lack of sexual pleasure.

There are many potential causes of dysfunction of sexual arousal, most of which represent a complex interaction between physical and psychological processes (LoPiccolo, 1985). Anxiety, fear, distraction, fatigue, relationship problems, depression, and substance abuse can all cause sexual arousal disorders. Even just worrying about having an erection can sometimes lead to prolonged erectile failure. Sex therapy, therefore, usually addresses these issues in counseling. However, specific sex therapy techniques can be used to reduce sexual anxieties and increase subjective experiences of sexual sensation. For example, a couple may be instructed on how to pay maximum attention to their senses during sexual contact to increase their pleasure experience (Masters and Johnson, 1970).

3.2.3 Orgasm Dysfunctions

Orgasm dysfunctions involve the disruption of the climax phase of the sexual response cycle. Thus, although the person has a sufficient level of desire and arousal, the sexual response cycle does not progress to orgasm. In women, sexual dysfunctions of orgasm are referred to as inhibited female orgasm. This is defined as a persistent absence or prolonged delay of orgasm, despite sufficient sexual stimulation and arousal (American Psychiatric Association, 1994). Notice the important phrase at the end of this definition, "despite sufficient sexual stimulation and arousal". The term inhibited female orgasm should not be used if the sex partners do not fully understand what constitute adequate stimulation for the women or if the partner is not caring enough to provide sufficient stimulation. In addition, because women experience many different normal patterns of sexual response and orgasm, the delay or absence of orgasm must be dissatisfying to the woman before it is thought to be a sexual dysfunction.

Inhibited orgasm has many potential causes, including performance anxiety, relationship difficulties, fear of abandonment and depression. Like other sexual dysfunctions, inhibited orgasm may be the result of sexually traumatic experiences. On the other hand, failure to achieve orgasm is commonly the result of a lack of adequate clitoral stimulation (Goldsmith, 1988). Many of the sex therapy techniques used to reduce fears and anxieties discussed earlier may be used to treat female inhibited orgasm. In addition, inhibited

orgasm may be caused by specific aspects of a relationship or situation that can become the focus of counseling.

In men, the most common orgasm dysfunction involves ejaculating as a result of minimal levels of sexual stimulation, usually just after or even before penetration occurs. When this problem persists over time and becomes distressful, it is considered a sexual dysfunction referred to as **premature ejaculation** (American Psychiatric Association, 1994). There are many causes of premature ejaculation, including inexperience, performance anxiety, fear, and unfortunate learning experiences early in one's sexual history (Annon, 1984). A variety of potential treatments for premature ejaculation can lengthen the period of time before ejaculation occurs. One method, called the squeeze technique, requires either the man or his partner to apply a comfortable but firm squeeze to the penis (either just below its head or at its base) to stop the impending orgasm. The pressure from the squeeze causes a delay of ejaculation when applied several times before ejaculation occurs. With repeated use, it can be an effective treatment for premature ejaculation, as the need for squeezing diminishes over time (Masters and Johnson, 1970).

Some men, in contrast, have an orgasm dysfunction known as **retarded ejaculation**. In this case, the man is rarely able to have an orgasm in spite of adequate sexual stimulation or is able to reach orgasm only after very long periods of stimulation (American Psychiatric Association, 1994).

All sexual dysfunctions share several things in common. First, because they involve sexual behavior, it is often difficult and embarrassing to seek help or discuss the problem. Society sometimes places unrealistic and demanding expectations on the sexual performance of women and men. Second, people with sexual problems may believe that they are psychologically abnormal.

Often, the first place to seek help for a sex problem is a medical doctor who can evaluate the person for possible physical problems related to the sexual difficulty. A physician can also refer persons with sexual dysfunctions to a psychologist who specializes in sex therapy if needed.

3.4 Health Problems Related to Sexual Anatomy

Several health problems related to female and male sexual anatomy requires our attention. These include forms of cancer and sexually transmitted diseases, including AIDS. Although these are medical problems, they have a psychological component- namely the behavior that we engage in that increase or decrease our risks and opportunity for early detection.

3.4.1 Cancers of Sexual Anatomy

It is important for women to have regular gynecological examinations to check for possible cancers of the cervix, uterus, and ovaries. Any unusual changes in the menstrual cycle or atypical discharges should be reported to a physician. In addition, it is important for women to perform breast self examinations each month. Breast self examination should be performed at the end of each menstrual period, when the breast are least likely to be swollen or tender (in older women who have experienced menopause, self – examinations should be done on a monthly basis). Women should carefully feel and look for any changes in sizes, shape, or color of the breast and nipples. Signs of breast cancer include puckerings of the skin, dimples, lumps, bumps, soreness, or any unusual nipple discharge or bleeding. Any such indications should be reported immediately to a physician. Although many such bumps and chargers are not dangerous, it requires a medical professional to determine this. Early detection of breast cancer offers the best hope for fighting this serious health threat. In addition to performing monthly breast self examinations, it is also important for women to have their breasts examined by a physician after the age of 20. Further, women should also ask their doctors when they should receive a mammogram, a low dose X ray that is particularly accurate at detecting cancers before they can be felt in a self examination.

There are also health problems related to male sexual anatomy. Men, particularly over 40, should have regular examinations by a physician that include checks for abnormalities of the prostate that may indicate prostate cancer. It is important for men to learn how to perform a self examination of their testicle to detect early signs of testicular cancer. This is particularly crucial between the ages of 16 and 35, when testicular cancers are most common. The examination should be performed once a month. After showering, when the scrotum is likely to be relaxed and the testicles are loosely suspended, men should roll each testicle gently between their thumb and forefinger, feeling carefully for any lumps, bumps, or unusual tenderness. Testicles are smooth when they are healthy, so bumps or indentations are possible signs of cancerous growth. It is, however, normal to feel the epididymis, which may seem like a bump, along the back of each testicle. Not all bumps are caners, but it requires a medical professional to distinguish dangerous bumps from harmless ones. If detected early, testicular cancer has a very high rate of cure. However, when undetected, testicular cancer is among the most deadly forms of cancer.

3.4.2 Sexually Transmitted Diseases

Diseases that are caused by microorganisms spread through sexual contact were once called veneral diseases but today are referred to as **sexually transmitted diseases (STDs)**. Throughout the ages, countless occurrences of STD epidemics have ravaged people across continents. Some are easily treated and cured if detected early in their course; others are incurable and may eventually lead to death. When untreated and unattended, all STDs can cause chronic illness and infertility, and they pose serious threats to pregnant women and their offsprings. All STDs are serious health problems that require

immediate medical attention. The likelihood of contracting any sexually transmitted diseases increases sharply with the number of different sex partners a person has and with the frequency of unsafe sex (Michael and other, 1994). In this section, we will discuss the most common types of STDs.

Syphilis. This is caused by a spiral, corkscrew -shaped bacterium called a spirochete. Syphilis progresses through a series of stages of infection. The first stage is referred to as primary syphilis, which may last two weeks to a month after infection. Early symptoms of syphilis infection usually include the appearance of a painless sore in the area where the spirochete entered the body, most often the penis or vaginal area. This sore is called a chancre and may at first appear to be a pimple, but usually it will become open and appear infected. The chancre goes away, but the person still has syphilis, which then enters its secondary stage. Secondary syphilis is characterized by bumpy skin rashes that develop over various areas of the body (including the palms and soles) and that are accompanied by several common symptoms of illness, including fever, headache, nausea, swollen glands, sore throat, loss of hair, and loss of appetite. During the primary and secondary stages, syphilis can be cured in most cases with antibiotics. But if untreated, syphilis eventually develops into its tertiary stage, which includes numerous serious health complications. The spirochetes may infect the tissues of the heart, brain, spinal cord, joints, and a number of other organ systems and eventually can cause death.

Gonorrhea. Like syphilis, gonorrhea is a bacterial infection. However, the course of gonorrhea infection is quite different from syphilis. In men, gonorrhea's earliest symptoms involve the discharge of pus from the penis and painful burning and itching during urination. These symptoms usually occur within the first weeks of infection. In women, the early symptoms of gonorrhea infection usually involve a yellow- green vaginal discharge. Women may also experience vaginal itching when infected with gonorrhea, but many infected women do not detect the infection early in its course. In men and women, untreated gonorrhea can result in numerous serious health threats, including progression of the infection to the bladder, kidneys, hearts, and brain. Fortunately, when detected, gonorrhea is usually cured easily with antibiotics. However, in recent years, strains of gonorrhea and syphilis that are very difficult to treat with antibiotics have become common. (Aral and Holmes, 1991).

Chlamydia. Chlamydia is caused by a small organism that invades several different types of cells in the body and uses them to multiply itself. The symptoms of Chlamydia are usually vague and difficult to define. Often, there are no immediate signs of infection, with infection becoming apparent after a long period of time. Men may experience burning sensations during urinations and may have a pus discharge from the penis. Chlamydia may also move into the testes and cause infertility. In women, the symptoms may include burning and itching of the vagina and burning sensations during urination. Untreated infections in women may progress to the fallopian tubes, causing infertility, and may develop into pelvic inflammatory disease, resulting in fever and serious illness.

If detected, chlamydia is treated with antibiotics and is usually curable. However, Chlamydia may be recurrent.

Pubic lice. This STD, commonly called "crabs", is caused by very small parasitic organisms that can barely be seen that bite into the skin and feed on blood, causing skin itching. Pubic lice are treated with a variety of medicated shampoos and other applications.

Genital Herpes. Caused by the herpes simplex virus (type 2), genital herpes is treatable, but not curable. Similar to herpes simplex type 1, which causes cold sores, the symptoms of genital herpes are principally small, painful lesions that appear in the genital area. These lesions appear to be like small blisters that open and become wet. When present, herpes lesions are highly contagious and allow for the transmission of the virus to others who come in contact with them. It is also important for the infected person to avoid touching the herpes lesions or to wash thoroughly after doing so. Exposure of the herpes virus to the eyes can be particularly dangerous, potentially causing damage to the cornea. After the initial outbreak, the lesions will eventually go away. However, in most cases, the lesions reoccur over a period of time because the virus lays dormant in the body. Although herpes cannot be cured, it can be treated with antiviral medication that slows its development and can help reduce the occurrence of further outbreaks. Herpes as is true for all STDs, requires the attention of health care professional for proper treatment.

Genital warts. Caused by the human papilloma virus, genital warts usually appear months after infection. The warts vary in color, size and texture and may appear on the penis, vulva, or anal area or inside the urethra. Gential warts are not usually painful and are not considered dangerous themselves, although they are related to the development of other serious conditions, such as cervical cancer. The treatment of genital warts involves their removal through freezing, surgical removal, or other methods.

Acquired Immunodeficiency Syndrome (AIDS). Caused by the human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS) is a fatal STD. HIV is transmitted through blood, semen, and vaginal fluids. Sexually, HIV is primarily transmitted from person to person through vaginal or anal intercourse and oral sex. HIV destroys specific blood cells, called T-Helper cells, which are responsible for the body's immune response to infectious agents. When infected with HIV, a person does not become ill for a long period of time, usually years. However, the person can infect others during the years prior to becoming ill. In time, the number of T-Helper cells diminishes, leaving the body vulnerable to a wide range of potential infections. Usually 7 to 10 years after infection, a person may become ill with one of many infections, such as pneumonia, cancer, or other ailment, and may not be able to recover from it. After the person experiences one of several specific infectious diseases or when a specific number of T-Helper cells have been depleted, the person is diagnosed with AIDS. It is not possible to tell if someone is infected with HIV by looking at him or her. The only definitive test for HIV is a blood test.

The most recently available statistics show that there is a staggering, worldwide pandemic of HIV infection. A total of 40 million people have contracted HIV around the world. The highest rates of infection are in African nations south of the Sahara deserts, Asia, and South America and the Caribbean. To date, more than 15 million people have died of AIDS worldwide, with most deaths being in sub Saharan Africa, where the pandemic first began.(Lahey, 2003).

AIDS Facts and AIDS Prevention. Sadly, we have known how to prevent AIDS for many years, but far too many people have ignored the realities of AIDS for themselves and have not taken preventive steps. AIDS can be prevented when people understand how HIV is transmitted and take sensible steps to avoid acquiring it.

What is your own level of risk for contracting AIDS? Overall, men are more likely than women to become infected with HIV. The most common routes of infection are different for women and men. Women are most likely to be infected with AIDS by having heterosexual sex (vaginal, oral, or anal) with an infected man or by sharing a needle with an infected person when injecting drugs. There have been very few cases of HIV infection from homosexual sex among women, but it can happen. In contrast, men are most frequently infected with HIV through sex (oral or anal) with another man or by sharing needles. Both women and men have been infected from blood transfusions and tissue transplants, but better screening methods have reduced this risk.

It is possible to lower your risk of infection to essentially zero by abstaining from sex or by having an exclusive sexual relationship with someone who is also free of HIV. All other types of sexual activity carry some level of risk of HIV infection but the consistent use of condoms substantially lowers risk of HIV infection.

3.0 Conclusion

Atypical patterns of sexual behavior that involve no harm to the individual or others are considered to be normal, even though they are unusual and perceived as immoral by some members of society. Other forms of deviant sexual behavior are considered abnormal if they result in harm to anyone.

A number of sexual dysfunctions interfere with pleasurable and successful sexual intercourse. Problems in sexual desire, sexual arousal, and orgasm occur in both men and women. When the cause of sexual dysfunction is not physical, the problem commonly stems from lack of information, anxiety, or relationship difficulties. For this reason, sex therapists specialize in addressing psychological issues that can lead to sexual difficulties. For both females and males, there are important health issues related to sexual anatomy, including breast, cervical, and testicular cancer, all of which can be effectively treated if detected early.

5.0 Summary

Here is a recap of all we discussed in this unit. The transvestite obtains sexual pleasure from dressing in clothing of the other sex. Transsexualism is the condition in which individuals consider themselves to be trapped within bodies of the other sex. Unless the individual is troubled by the condition, transvestism and transsexualism are generally not harmful to anyone. Fetishism-obtaining sexual pleasure from specific objects- need not be harmful but can be if the objects are stolen or the preference causes trouble in some other way. Sadism- sexual arousal from inflicting pain may be harmless if practiced in a mild way with a completely willing partner but is generally considered abnormal because of the pain and medical risk involved. Masochism- sexual arousal from receiving pain is generally considered abnormal for the same reason. Voyeurism is the practice of obtaining sexual pleasure by peeping at nude or sexually involved individuals. Exhibitionism is the practice of obtaining sexual excitement by exposing one's genitals to an unwilling person. Because of the frightening nature and illegality of these activities, both exhibitionism and voyeurism are considered abnormal. Forced sexual behavior - including rape, sexual abuse of children, incest, ad sexual harassment-are always considered abnormal because of the inherent psychological and physical harm that may occur.

Sexual behavior also increases the risk of a variety of diseases. These include diseases caused by bacteria such as syphilis and gonorrhea, pubic lice, or viruses such as genital herpes and genital warts, which may be treated for symptoms but are not curable. The most deadly sexually transmitted disease is HIV infection, the virus that causes AIDS.

6.0 Tutor Marked Assignment

To be sure that you have learned the key points from the proceeding sections, cover your book and try to answer each question. If you give an incorrect answer to any question, return to the book to see why your answer was not correct.

1. Sexual behavior is considered to be abnormal if it is ……
a. Atypical b. Strange or bizarre
c. Harmful d. Infrequent
2. A person who obtains sexual pleasure from dressing in clothing of the other sex is said to be ……....
a. A transvestite b. A transsexual
C. A Transylvanian d. All of the above
3. A person who obtain sexual pleasure by watching others undressing or engaging in sexual activities is said to be ……
a. An exhibitionist b. A pedophile
b. A masochist d. A voyeur
4. Most persons who commit child molestation are ……..

a. Homosexual females b. Heterosexual females

c.Homosexual males d. Heterosexual males

1. Have you ever experienced, engaged in, or witnessed sexual harassment? What do you think can be done to reduce the frequency of this problem?
2. Some people believe that those who practice transvestism are not psychologically healthy. What do you think?

7.0 References/Further Reading

MODULE 2: PREMARITAL COUNSELLING

Unit 1 Introduction to Premarital Counselling

Unit 2 Issues to discuss in Premarital Counselling

Unit 3 Other things to Talk About

Unit 4 Counselling Strategies

UNIT 1: INTRODUCTION TO PREMARITAL COUNSELLING.

Content

1.0 Introduction

Premarital counseling is a type of therapy that helps couples prepare for marriage. It can help ensure that intending couples have a strong and healthy relationship- giving them a better chance for a stable and satisfying marriage. Premarital counseling can also help couples identify weaknesses that could become bigger problems during marriage. It is often provided by licensed therapists known as marriage and family therapists or counsellors. It might also be offered through religious institutions as well. In fact, some spiritual leaders require premarital counselling before conducting a marriage ceremony.

2.0 Objectives

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

- Explain the importance of premarital counselling
- Explain the necessary preparations needed before counseling
- Discuss what goes on during counselling

3.0 Main contents

3.1 Importance of Premarital Counselling

Premarital counselling helps couples improve their relationships before marriage. Through premarital counselling, couples are encouraged to discuss a wide range of important and intimate topics related to marriage such as:

- Finances, communication, beliefs and values;
- Roles in marriage, affection and sex, children and parenting, family relationships, decision making,
- Dealing with anger, time spent together, among others.

Premarital counseling helps partners improve their ability to communicate, set realistic expectations for marriage and develop conflict- resolution skills. In addition, premarital counseling can help couples establish a positive attitude about seeking help with their marriages down the road.

Keep in mind that you bring your values, opinions and personal history into a relationship and they might not always match your partner's. In addition, many people go into marriage believing it will fulfill their social, financial, sexual and emotional needs and that is not always the case. By discussing differences and expectations before marriage, you and your partner can better understand and support each other during marriage. Early intervention is important because the risk of divorce is highest early in marriage.

3.2 How To Prepare For Premarital Counselling

The only preparation needed for premarital counseling is to find a therapist. Before scheduling sessions with a specific therapist, consider whether the therapist would be a good fit for you and your partner. You might ask questions like:

- Education and experience: What is the educational and training background of the therapist/counsellor.
- Logistics: Where is his office? And what are his office hours.
- Treatment plan: How long is each session? How often are sessions scheduled? How many sessions should I expect to have? What is the therapist's policy on canceled sessions?
- Fees and insurance: How much is charged for each session? Will I need to pay the full fee upfront.

3.3 What To Expect During Counselling

Premarital counseling typically includes five to seven meetings with a counselor. Often in premarital counseling, each partner is asked to separately answer a written questionnaire. These questionnaire encourage partners to assess their perspectives of one another and their relationship. They can also help identify a couples strengths, weaknesses and

potential problem areas. The aim is to foster awareness and discussion and encourage couples to address concerns proactively. Your counselor can help you interpret your results together, encourage you and your partner to discuss areas of common unhappiness or disagreement, and set goals to help you overcome challenges.

Your counselor might also have you and your partner use a tool called a Couples Resources Map- a picture and scale of your perceived support from individual resources, relationship resources, and cultural and community resources. You and your partner will create separate maps at first. Following a discussion with your counselor about differences between the two maps, you will create one map as a couple. The purpose is to help you and your partner remember to use these resources to help manage your problems.

In addition, your counselor might ask you and your partner questions to find out your unique visions for your marriage and clarify what you can do to make small, positive changes in your relationship.

4.0 Conclusion

Preparing for marriage involves more than choosing a wedding dress and throwing a party. Couples should take the time to build a solid foundation for their relationship.

Premarital counseling has one distinct advantage: Learning how to communicate and work through problems is a lot easier before rather than after the wedding. Once married, couples already have unspoken expectations for each other. Before marriage, they are still in a building stage-the expectations are there, but it is easier to be open about the issues that threaten difficulty. And by learning how to talk through differences, you will form good habits that will carry you through the years.

4.0 Summary

In this unit, we looked at the importance and preparations for premarital counseling.

5.0 Tutor Marked Assignment

1. Is premarital counselling important? Explain.
2. How should would be couples prepare for counseling?
3. What should be expected from premarital counseling?

7.0 References/Further Reading

Unit 2: ISSUES TO DISCUSS DURING PREMARITAL COUNSELLING

Contents

1.0 Introduction

Counseling is not just for people with problems. Intending couples have nothing to lose, but everything to gain through premarital counselling. They will strengthen their chances of staying together if they learn the skills needed. This is especially relevant in today's climate, with divorce so prevalent and many couples not having role models to follow. Counsellors can step in and become their relationship expert to prepare them for marriage. Some of the issues to tackle during premarital counseling are discussed below.

2.0 Objectives

By the end of this unit, you should be able to explain the major issues to be discussed during premarital counselling.

3.0 Main contents

3.1 Issues to be discussed during premarital counselling

Issues to be discussed during premarital counselling include the following: Individual Differences, Leaving and cleaving, Expect surprises, Make a commitment to the marriage no matter what, Model after the right couples, Evaluate often, Good communication, Finances, among others.

1. **Individual Differences**: Opposites do tend to attract. Each spouse is not only different physically, but there are differences in backgrounds, outlook on life and the way to approach a situation. This is not intended as a curse against marriage. The more a couple learns to celebrate those differences, the stronger a marriage will become.
2. **Leaving and cleaving**: Either set of in-laws should not be allowed to dictate how you lead your new family. Decide in advance that no one, related or otherwise, is going to be a wedge between you two. Every couple has lots of other relationships, including perhaps children someday, but none of them should be allowed to interfere with the oneness intended to be achieved with the marriage.
3. **Expect surprises**: Life will not always be blissful in marriage. There will be hard days, whether self-induced or life- induced. Life brings changes and those times have

the ability to catch even the best marriages off guard if not prepared for them. We can never be fully prepared for what might happen, but we can prepare ourselves that when something comes, whatever it is and no matter how hard it is, that we will handle it. Couples should use these times to improve the strength of their marriage rather than allow them to pull the marriage apart.

4. **Make a commitment to the marriage no matter what:** Couples usually assume they are doing this by performing the marriage rites together, but statistics show otherwise. Many times these days a person is saying "I am committed until it becomes difficult or until the love we have today fades". That is not proper. Marriage is more than simply a feeling of love, it is a commitment to love… for better or worse… from this day forward. Verbalizing and agreeing to that, and continuing to remind yourself of that through the difficult days, will help the marriage last. Couples should ask for help as soon as possible, not letting problems in the marriage linger too long without asking for help. Remove the fear of asking for professional counselling if necessary. It would be better to get help early than to see the marriage disintegrate beyond repair.
5. **Model after the right couples:** Counsellors should encourage couples to find a couple whose marriage they admire and follow them closely. Most likely they have some stories to share. Things may not have been as wonderful throughout their marriage as they are today. No doubt they have learned some practices to having a strong marriage. Counsellors should challenge couples to learn all they can from the couple they want to be like.
6. **Evaluate often**: Couples should ask themselves often, are we growing together as a couple or further apart? Is the marriage growing stronger or are there holes that need addressing? Don't assume your spouse feels as you do. (This is especially true for men who often don't know there is a problem.). Establish the understanding early in the relationship that you have the right to periodically check on the state of your marriage.

7. **Good communication**-The key issues for proper communication include the basic communication skills. If couples have trouble talking through the issues in their lives, it is better to learn how to do it when they are engaged. Even if they generally communicate well, there may be specific issues they would need some help working through . They should seek wisdom to know what to and not to say, how to say it and when. Couples should be taught to talk to each other in the right way, without criticism and arguing. They should learn how to talk lovingly about problems .

Some counselors say that arguing is good. It is not. Arguments truly get the issues out in the open, but it does not do it in a proper way. And besides, there are other deeper issues that are hidden behind the now anger-covered scenes.

8. **Wise Decision-making**- Engaged couples should learn how to make bigger decisions ahead of time as well as how to resolve misunderstandings. Discussing family planning is an example of a topic that needs to be resolved earlier on and decisions taken. Couples might differ but each opinion is to be respected. They should be taught

not to be caught off guard. They should look ahead and see when stressful times or hard decisions are coming, and discuss how to handle them ahead of time.

9. **Finances and marriage**- Couples should discuss their attitudes about money with each other. Talk about budgeting and debt.

Review financial guidelines and answer targeted financial questions. Couples often argue over how to handle their finances. The husband can still make decisions and expect the wife to understand and appreciate that, but he is not wise to do it without his wife's input. The reason to marry is to gain extra wisdom. Get into the touchy areas like credit cards, debts in general, giving, having a common purse. Remember this topic builds on the former ones that discuss good communication and decision making.Finances is a very important area for them to discuss. It is better that they go into marriage knowing these things rather than resenting them later. Let them discuss budgets, honeymoon planning and wedding budget. They should think and plan about their first year's expenses. Couples should not go into debts for the wedding for that would only put more pressure on the marriage and it is not proper either. They are to be content with what they have and live within their means. Buying more than they can afford is a sign of greed.

4.0 Conclusion

Counsellors should encourage couples to put God first in their marriage. It is not just the preacher's answer, it is the best secret to a lasting marriage. "A chord of three strands is not easily broken. A couple's individual or collective relationship with God will ensure they can endure the hardest days of marriage. When the relationship with God suffers, the marriage will often suffer. Satan looks for any excuse to destroy the marriage. Pour your heart and life into Christ and let Him strengthen and sustain your marriage

5.0 Summary

In this unit, we have looked at some of the issues that the counselor should discuss with his or her counselees during premarital counseling sessions. Such topics as Individual differences, leaving and cleaving, surprises, modeling after the right couples, communication, finances and the fear of God.

6.0 Tutor Marked Assignment

1. Mention and discuss five important topics that should be handled during premarital counseling.
2. Explain the basic communication process in marriage.

7.0References/FurtherReading

http://foundationsforfreedom.net/Topics/ADT/Counsel/Premarital_Counselling

www.ronedmondson.com/2011/10/7-issues-to-address-in-pre-marital_counselling

Unit 3 OTHER THING S TO TALK ABOUT

Contents

1.0 Introduction

Premarital counseling is for every intending couple. Every marriage presents difficulties and obstacles, and premarital counselling will help couples overcome them. Other things to talk about in premarital counseling sessions include: religion, children, habits and family issues among other things.

2.0 Objectives

By the end of this unit, you should be able to discuss other relevant topics treated during premarital counseling like Children, Wills, Divorce and others.

3.0 Main contents

3.1 Wills: Couples should be encouraged to make "wills" if they have not done so and to discuss how each would want to be treated while dying.

3.2 Children: Couples are to discuss about children, do you want them. Agree on the number to have and discuss time line. What would you do if you discovered you were infertile? How do you feel about adoption?

3.3 Values: What does your relationship mean to each of you. Ask them to write a statement privately about their relationship and to read them out loud to each other. What values do you want to make central to your lives together and to instill in your children (make lists). They are to Make lists of life goals and then compare them. Discuss how the couple should and will handle disagreements. What to do when one offends the other and what to do when you offend another. They also need to discuss how they feel about monogamy and what their attitudes and approaches would be if one of them slipped up.

3.4 Crisis Management: What they would do if they felt their marriage was in crisis. Would you agree up front that you would both attend marriage counselling if the other partner requested it even if your marriage was not in crisis.

3.5 Divorce. Talk about divorce. You do not have any business getting married unless you have sat down and have had a long frank talk with your partner about divorce. How do you feel about it? Has it happened to anyone in your family? How do you feel about that? Do you feel like it is an option in your life? If so why, when and how. The counsellor should challenge them to think even harder, because divorce is a huge and difficult subject.

4.0 Conclusion

Counselling can help you recognize where your partner stands on a variety of topics, and where his or her priorities lie, which will confirm your sense of your selves as a couple, or in some cases, open your eyes to the fact that you might be making a mistake.

5.0 Summary

In this unit, we looked at some other topics that should be discussed during premarital counseling, such as writing of wills, children, values, crises management and views about divorce.

6.0 Tutor Marked Assignment

1. Enumerate and explain five other important issues to be discussed during premarital counselling.

7.0 References/further reading

apracticalwedding.com/2009/12/pre-marital-counselling-and-why-i-think/

http://foundationsforfreedom.net/Topics/ADT/Counsel/Premarital_Counselling

www.wedding.theknot.com/wedding-planning/planning-a-wedding/article

www.wisegeek.com/what-is-pre-marital-counselling.htm

Unit 4 The Counselling Process

Contents

1.0 Introduction

It is important to direct a couple in premarital counselling to think seriously about what they want for their marriage and to make some commitment to pursue that goal. This unit suggests possible guidelines to follow during counselling sessions.

2.0 Objectives

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

1. Design practical guidelines to premarital counselling sessions
2. Describe what to do in each session of premarital conselling

3.0 Main Contents

3.1 Session one

This first session helps establish a rapport between the couple and the counsellor. The counsellor has to make the couple comfortable, and then direct them to think seriously about what they want for their marriage and to make some commitment to purse that goal for a successful marriage.

This session could be started with a dinner or an outing. Appointments are fixed and 2-3 weeks intervals are ideal or closer schedule if the wedding is drawing close. Appointments should not be scheduled for more than a month's interval because continuity is very important.

Go over the overview and introduce the sessions. Reassure them that you are ready to help them build a solid foundation for their marriage. Let them understand the importance of premarital counselling.

Assign home work.

3.2 Session Two

Forms for the sessions are to be gotten ready by now. They could be down loaded online or the counselor could construct them.

Understanding our differences- Emphasize the way one gains appreciation of the other. Make them feel that they cannot do without each other. Their commitment to their mate will work together with the realization of how their to-be spouse so wonderfully meets their need and helps spurt them forward into better knowing each other.

Use testing devices to find out what each of them are like temperamentally and to see the opposites. Seeing how different the two are helps point out potential problems. Check if one appreciates the other, and if they will take advantage of the other person's gift. Differences will bother us if we do not rightly appreciate our mate. We will after all, spend our lives with our partner. The commitment needed to bind the couple together is the most important aspect of marriage. Both should be taught to love no matter what.

3.3 **Session Three** This session should be used to discuss the topics enumerated above.

3.4 **Session Four** This session should be used to discuss the topics enumerated above.

3.5 Session five Exploring Sexual Intimacy

Exploring sexual intimacy for engaged couples summarizes and focuses on the special needs brought out through the past lessons and prepares couples for sexual intimacies after marriage. This last session aims to pull all the main session points together. By now, the counselor has seen the strengths and weaknesses of the couple. They should encourage them to rightly face those problems so that they might have a strong marriage.

Our culture conveys so many wrong things about sex. Religious houses at times do too. In this session try to paint a beautiful picture of what is good and lovely in its proper context.

The main questionnaire should be reviewed to see if there are any significant problems. For example, the couple might have shared some physical intimacies with each other or others in past, and someone might have STD. These issues must be dealt with before marriage. Because marriage is built on intimacy, there is no way one can have a strong marriage and keep such significant matters hidden from one's partner. If there were suspicious activities from the past, the spouse should know and choose whether to continue with the marriage or not. If such matters are stated before marriage, it provides

the partner an option to know what he or she is really like. In these cases, resentment will be minimized.

This session is a follow up on the differences mentioned in the earlier session. Differences show up in how the man and woman's sexual needs, responses and expressions differ. Emphasize the need for men to go slow (be romantic).

This last session should be shorter and let them understand that the counsellor is there for them all the time in case they run into difficulties in the future.

- Make sure their honey moon is planned
- Discuss wedding plans.
- Explain the beauty of marriage and sex as an expression of that oneness.
- Warn of emphasis on sex in our culture. Do not use pornography or sensual movies to stimulate.
- Through a chart show the differences of the couple in the area of romance. It might be hard to speak about some of these items but you need to say what needs to be said.
- As time allows, go over raising children. (parenthood).

4.0 Conclusion

- Plan any further meetings as needed. Mention that you will have one more meeting in about 10 months time.
- See if there are any special wedding or honeymoon concerns.
- Give any other assignments that might be helpful such as "raising children".

End the session here.

5.0 Summary

In this unit we looked at the process of premarital counselling and how to terminate the counselling session.

6.0 Tutor Marked Assignment

1. Describe how you will organize premarital counselling sessions for a would be couple.
2. List and explain seven points you must discuss with them

7.0 References/Further Reading

http://foundationsforfreedom.net/Topics/ADT/Counsel/Premarital_Counselling

MODULE 3: FAMILY COUNSELLING

Unit 1 The Family and Counselling

Unit 2 History and Theoretical Frameworks

Unit 3 Effective Family Counselling

Unit 4 Counselling Strategies/Therapies

Unit 1 The Family and Counselling

Contents

1.0 Introduction

The word family comes from the Latin word "familia" which means a group of people affiliated by consanguinity (by recognized birth), affinity (by marriage), or co-residence or shared consumption. Members of the immediate family include a spouse, parent, brother and sister, and son and daughter. Members of the extended family may include grandparents, aunt, uncle, cousin, nephew and niece or sibling-in-law. In most societies, the family is the principal institution for the socialization of children. As the basic unit for raising children, anthropologists most generally classify family organization as matrifocal (a mother and her children); conjugal (a husband, his wife, and children; also called nuclear family); avuncular (for example, a brother, his sister and her children); or extended family in which parents and children co-reside with other members of one parent's family. As a unit of socialization, the family is the object of analysis for anthropologists and sociologists of the family. Sexual relations among members of a family are regulated by rules concerning incest such as the incest taboo. Family is also an important economic unit studied in family economics.

2.1 Objectives

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

1. Define the concept of family
2. Mention the various types of family
3. Explain the importance and functions of the family

4. Explain the importance of family counseling.

3.0 Main Contents

3.1 Functions of the family

One of the primary functions of the family is to produce and reproduce persons, biologically and /or socially. This can occur through the sharing of material substances (such as food); the giving and receiving of care and nurture; jural rights and obligations; and moral and sentimental ties. Thus one's experience of one's family shifts over time. From the perspective of children, the family is a "family of orientation". The family serves to locate children socially and plays a major role in their enculturation and socialization. From the point of view of the parent(s), the family is a "family of procreation", the goal of which is to produce and enculturate and socialize children. However, producing children is not the only function of the family; in societies with a sexual division of labour, marriage, and the resulting relationship between two people, is necessary for the formation of an economically productive household.

3.2 The Nuclear Family in Industrial Society

Contemporarily society generally views the family as a haven from the world, supplying absolute fulfillment. Zinn and Eitzen describe the family as haven… a place of intimacy, love and trust where individuals may escape the competition of dehumanizing forces in modern society. During industrialization, the family as a repository of warmth and tenderness (embodied by the mother) stands in opposition to the competitive and aggressive world of commerce (embodied by the father) .The family's task was to protect against the outside world. However, Zinn and Eitzen note that the protective image of the family has waned in recent years as the ideals of family fulfillment have taken a new shape. Today, the family is more compensatory than protective. It supplies what is vitally needed but missing in other social arrangements. They also have a lot of problems to contend with, such as desertion by spouse, illegitimate children, abuse and divorce among others. These call for family counselling to forestall further decline and instability in the society.

3.4 What is Family Counselling

Family counseling is a type of psychotherapy that may have one or more objectives. It may help to promote better relationships and understanding within a family. It may be incident specific, as for example during a divorce, or the approaching death of a family member. Alternatively, it may address the needs of the family when one family member suffers from a mental or physical illness that alters his or her behaviour or habits in negative ways.

Counseling for families often occurs with all members of the family unit present. But sometimes, this may not always be the case. A family member who suffers from

alcoholism or drug addiction might not attend sessions, and might actually be the reason why other family members are seeking counselling.

How can Family Counselling help?

Family Counselling can help the whole family to communicate better, and to understand and resolve differences. When families go through change, it can be difficult to learn to adapt. Counselling can help family members to support one another through these difficult times, to reduce conflict and arguments and grow stronger as a result. Couples considering separation or divorce, or are already separated, can find guidance and practical support on what to do next during family counseling.

You can also get dedicated support if you are parenting troubled teenagers, which can help you and your family through some of the challenges of this difficult period. It also helps parents realize the extent to which their child has bottled up their feelings – once the child feels safe, they can speak openly for the first time…. Children really appreciate being listened to. They pick up on conflict and if they don't have another outlet it can badly affect them.

What to expect in Family Counselling

You will meet with a counsellor, who will provide confidential and non-judgmental support, and who will encourage everyone who comes to have their say and to share their feelings, if they wish. At the first appointment, the counsellor will ask you to talk through what's happening, and what you'd like to change. You will then work with the counsellor to decide what happens next.

Counselling is a different experience for everyone, and what happens in your sessions will depend very much on what you hope to get out of it, and on the unique needs of your family. You can expect family counselling to help you to build stronger relationships between every member of the family and help you to work together as a team.

4.0 Conclusion

In the field's early years, many clinicians defined the family in a narrow, traditional manner usually including parents and children. As the field has evolved, the concept of the family is more commonly defined in terms of strongly supportive, long-term roles and relationships between people who may or may not be related by blood or marriage.

As the family evolves so are the myriads of issues and challenges that accompany it, hence the need for family counseling.

5.0 Summary

In this unit, we looked at the concept of family, the various types of families and the functions of the family. We also discussed the meaning of and need for family counseling as well as what to expect during family counseling.

6.0 Tutor Marked Assignment

1. Define the concept “Family” and explain the functions of the various types of families.

2. What is family counseling?

3. What can a family expect during counseling?

7.0 References/Further Reading

en.wikipedia.org/wiki/family#fathers.27_rights

Unit 2 History and theoretical frameworks of family therapy

1.0 Introduction

Different theoretical models exist in family counseling. The therapist may work from a behavioral stance, from Gestalt principles, or from a combination of therapeutic approaches. Whatever the approach, the main goal continues to be to improve the relationship of each family member to the others, so that the family progresses as a harmonious unit. In this unit, we are going to look at the development of family counseling over the years as well as the theoretical basis of the practice.

2.0 Objectives

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

1. Enumerate the stages of development of family counseling.
2. Mention and explain some theories of family counseling.

3.0 Main Contents

3.1 Development of Family Counselling

Formal interventions with families to help individuals and families experiencing various kinds of problems have been part of many cultures, probably throughout history. These interventions have sometimes involved formal procedures of rituals, and often included the extended family as well as non-kin members of the community. Following the emergence of specialization in various societies, these interventions were often conducted by particular members of a community, for example, a chief priest, physician, and so on-usually as an ancillary function[1].

Family therapy as a distinct professional practice within Western cultures can be argued to have had its origins in the social work movements of the 19th century in the United Kingdom and the United States.[1] As a branch of psychotherapy, its roots can be traced somewhat later to the early 20th century with the emergence of the *child guidance* movement and *marriage counseling*.[2] The formal development of family therapy dates to the 1940s and early 1950s with the founding in 1942 of the *American Association of marriage counselors*), and through the work of various independent clinicians and

groups- in the United Kingdom (John Bowlby at the Tavistock Clinic), the United States (john Elderki9n Bell, Na than Acker man, Christian Midelfort, Theodore Lidz, Lyman Wynne, Murray Bowen, Carl Whitaker, Virginia Satir),and Hungary (D.L.P. Liebermann)-who began seeing family members together for observation or therapy sessions.[1][3] There was initially a strong influence from psychoanalysis (most of the early founders of the field had psychoanalytic backgrounds) and social psychiatry, and later from learning theory and behavior therapy-and significantly, these clinicians began to articulate various theories about the nature and functioning of the family as an entity that was more than a mere aggregation of individuals. [2]

The movement received an important boost in the mid-1950s through the work of anthropologist Gregory Bateson and colleagues-Jay Haley, Donald Jackson, John Weakland, William Fry, and later, Virgina Satir, Paul Watzlawick and others-at Palo Alto in the United States, who introduced ideas from cybernetics and general systems theory into social psychology and psychotherapy, focusing in particular on the role of communication (see Bateson project).

By the mid-1960s, a number of distinct schools of family therapy had emerged. From those groups that were most strongly influenced by cybernetics and system theory, there came MRI Brief Therapy, and slightly later, strategic therapy, Salvador Minuchin's *structural family therapy* and the Malian systems model. Partly in reaction to some aspects of these *systemic* models, came the *experiential* approaches of Virginia Satir and Carl Whitaker, which downplayed theoretical constructs, and emphasized subjective experience and unexpressed feelings (including the subconscious), authentic communication, spontaneity, creativity, total therapist engagement, and often included the extended family.

By the late-1970s, the weight of clinical experience-especially in relation to the treatment of serious mental disorders-had led to some revision of a number of the original models and a moderation of some of the earlier stridency and theoretical purism. There were the beginnings of a general softening of the strict demarcation between schools with moves toward rapprochement, integration, and eclecticism-although there was, nevertheless, some hardening of positions within some schools.

From the mid-1980s to the present, the field has been marked by a diversity of approaches that partly reflect the original schools, but which also draw on other theories and methods from individual psychotherapy and elsewhere- these approaches and sources include: brief therapy, a structural therapy, constructivist approaches (e.g., Milan systems, *post-Milan collaborative conversational, reflective*), solution-focused therapy, narrative therapy, a range of cognitive and behavioral approaches, psychodynamic and object relations approaches, attachment and Emotionally Focused Therapy, *intergenerational* approaches, network therapy, and multisystemic therapy (MST).[8][9][10][11][12][13][15][16] Multicultural, intercultural, and integrative approaches are being developed.[16][17][18][19][20][21]Many practitioners claim to be " eclectic", using

techniques from several areas, depending upon their own inclinations and /or the needs of the client(s), and there is a growing movement toward a single "generic" family therapy that seeks to incorporate the best of accumulated knowledge in the field and which can be adapted to many different contexts;[22] however, there are still a significant number of therapist who adhere more or less strictly to a particular, or limited number of, approach(es).[23]

In Nigeia, family counseling is still in its infancy stage as there are no licensed family therapists yet. Little of what is being done in that are done by general practitioners and by religious houses and concerned relatives.

3.2 Summary of Theories and Techniques of Family Counselling

Theoretical Model	Theorists	Summary	Techniques
Adlerian Family Therapy	Alfred Adler	Also known as " Individual Psychology". Sees the person as a whole. Ideas include compensation for feelings of inferiority leading to striving for significance toward a fictional final goal with a private logic. Birth order and mistaken goals are explored to examine mistaken motivations of children and adults in the family constellation.	Psychoanalysis, Typical Day, Reorienting, Re-educating.
Attachment Theory	John Bowlby, Mary Ainsworth	Individuals are shaped by their experiences with caregivers in the first three years of life. Used as a foundation for object Relations Theory. The strange situation experiment with infants involves a systematic process of leaving a child alone in a room in order to assess the quality of their parental bond.	Psychoanalysis, Play therapy

Bowenian Family Systems	Murray Bowen, Betty Carter, Philip Guerin, Michael Kerr, Thomas Fogarty, Monica McGoldrick, Edwin Friedman, Daniel Papero	Also known as "Intergenerational Family Therapy" (although there are also other schools of intergenerational family therapy). Family members are driven to achieve a balance o f internal and external differentiation, causing anxiety, triangulation, and emotional cutoff. Families are affected by nuclear family emotional processes, sibling positions and multigenerational transmission patterns resulting in an undifferential family ego mass.	Detriangulation, Nonanxious Presence, Genograms, Coaching
Cognitive Behavioral Family Therapy	John Gottman, Albert Ellis, Albert Bandura	Problems are the result of operant conditioning that reinforces negative behaviours within the family's interpersonal social exchanges that extinguish desired behavior and promote incentives toward unwanted behavours. This can lead to irrational beliefs and a faulty family schema.	Therapeutic Contracts, Modeling, Systematic Desensitization, Shaping, Charting, Examining Irrational Beliefs.
Collaborative Language Systems	Harry Goolishian, Harlene Anderson, Tom Andersen, Lynn Hoffman, Peggy Penn	Individuals form meanings about their experiences within the context of social relationship on a personal and organizational level. Collaborative therapists	Dialogical Conversation, Not knowing, Curiosity, Being Public, Reflecting Teams.

		help families reorganize and dissolve their perceived problems through a transparent dialogue about inner thoughts with a "not knowing" stance intended to illicit new meaning through conversation. Collaborative therapy is an approach that avoids a particular theoretical perspective in favor of a client – centered philosophical process.	
Communication Approaches	Virginia Satir, John Banmen, Jane Gerber, Maria Gomori	All people are born into a primary survival triad between themselves and their parents where they adopt survival stances to protect their self-worth from threats communicated by words and behaviors of their family members. Experiential therapists are interested in altering the overt and covert messages between family members that affect their body, mind and feelings in order to promote congruence and to validate each person's inherent self-worth.	Equality, Modeling Communication, Family Life Chronology, Family Sculpting, Metaphors, Family Reconstruction.
Contextual Therapy	Ivan Boszormenyi-Nagy	Families are built upon an unconscious network of implicit loyalties between parents and children that can be damaged when these "relational ethics" of	Rebalancing, Family Negotiations, Validation, Filial Debt Repayment.

		fairness, trust, entitlement, mutuality and merit are breached.	
Emotion-Focused Therapy	Sue Johnson, Les Greenberg	Couples and families can develop rigid patterns of interaction based on powerful emotional experiences that hinder emotional engagement and trust. Treatment aims to enhance empathic capabilities of family members by exploring deep-seated habits and modifying emotional cues.	Reflecting, Validation, Heightening, Refraining, Restructuring.
Experimental Family Therapy	Carl Whitaker, David Kieth, Laura Reberto, Walter Kempler, John Warkentin, Thomas Malone, August Napier	Stemming from Gestalt foundations, change and growth occurs through an existential encounter with a therapist who is intentionally "real' and authentic with clients without pretense, often in a playful and sometimes absurd way as a means to foster flexibility in the family and promote individuation.	Battling, Constructive Anxiety, Redefining Symptoms, Affective Confrontation, Co-Therapy, Humor
Family Mode Deactivation Therapy (FMDI)	Jack .A. Apsche	Target population adolescents with conduct and behavioral problems. Based on Schema theory, Integrate mindfulness to focus family on the present. Validate core beliefs based on past experiences. Offer viable alternative responses. Treatment is based on case conceptualization process, validate and	Cognitive behavioral therapy, Mindfulness, Acceptance and commitment therapy, Dialectical behavior therapy, Defusion, Validate-Clarify-Redirect.

			clarify core beliefs, fears, tiggers, and behaviours. Redirect behaviour by anticipating tiggers and realigning beliefs and fears.	
Feminist Therapy	Family	Sandra Bem	Complications from social and political disparity between genders are identified as underlying causes of conflict within a family system. Therapists are encouraged to be aware of these in fluencies in order to avoid perpetuating hidden oppression, biases and cultural stereotypes and model an egalitarian perspective of healthy family relationships.	Demystifying, Modeling, Equality, Personal Accountability
Milan Systemic Therapy	Family	Luigi Boscolo, Gianfranco Cecchin, Mara Selvini Palazzoli, Giuliana Prata	A practical attempt by the "Milan group" to establish therapeutic techniques based on Gregory Bateson's cybernetics that disrupts useen systemic patterns of control and games between family members by challenging erroneous family beliefs and reworking the family 's linguistic assumptions.	Hypothesizing, Circular Questioning, Neutrality, Counterparadox
Medical Therapy[45]	Family	George Engel, Susan McDaniel, Jeri Hepworth & William Doherty	Families facing the challenges of major illness experience a unique set of biological, psychological and social difficulties that require a specialized skills of a therapist who	Grief work, Family Meetings, Consultations, Collaborative Approaches

		understands the complexities of the medical system, as well as the full spectrum of mental health theories and techniques.	
MRI Brief Therapy	Gregory Bateson, Milton Erickson, Heinz von Foerster	Established by the Mental Research Institute (MRI) as a synthesis of ideas from multiple theories in order to interrupt misguided attempts by families to create first and second order change by persisting with " more of the same", mixed signals from unclear metacommunication and paradoxical double- bind messages.	Reframing, Prescribing the Symptom, Relabeling, Restraining (Going Slow), Bellac Ploy.
Narrative Therapy	Michael White, David Epston	People use stories to make sense of their experience and to establish their identity as a social and political constructs based on local knowledge. Narrative therapists avoid marginalizing their clients by positioning themselves as a co-editor of their reality with the idea that " the person is not the problem, but the problem is the problem".	Deconstruction, Externalizing Problems, Mapping, Asking Permission.
Object Relations Therapy	Hazan & Shaver, David Scharff & Jill Scharff, James Frano.	Individuals choose relationships that attempt to heal insecure attachments from childhood. Negative patterns established by their parents (object) are	Detriangulation, Co-therapy, Phychoanalysis, Holding Environment.

		projected onto their partners.	
Psychoanalytic Family Therapy	Nathan Ackerman	By applying the strategies of Freudian psychoanalysis to the family system therapists can gain insight into the interlocking psychopathologies of the family members and seek to improve complementarity	Psychoanalysis, Authenticity, Joining, Confrontation
Solution Focused Therapy	Kim Insoo, Berg, Steve de Shazer, William O'Hanlon, Michelle Weiner-Davis, Paul Watzlawick	The inevitable onset of constant change leads to negative interpretations of the past and language that shapes the meaning of an individual's situation, diminishing their hope and causing them to overlook their own strengths and resources.	Future Focus, Beginner's Mind, Miracle Question, Goal Setting, Scaling
Strategic Therapy	Jay Haley, Cloe Madanes	Symptoms of dysfunction are purposeful in maintaining homeostasis in the family hierarchy as it transitions through various stages in the family life cycle.	Directives, Paradoxical Injunctions, Positioning, Metaphoric Tasks, Restraining (Going Slow).
Structural family Therapy	Salvador Minuchin, Harry Aponte, Charles Fishman, Braulio Montalvo	Family problems arises from maladaptive boundaries and subsystems that are created within the overall system of rules and rituals that governs their interactions.	Joining, Family Mapping, Hypothesizing, Reenactments, Reframing, Unbalancing

Culled from Wikipedia file://F:/Familly_Counseling%2022.html

4.0 Conclusion

The conceptual frame works developed by family therapists, especially those of family systems theorists, have been applied to a wide range of human behaviour, including organizational dynamics and the study of greatness and have been found to be very effective. Counsellors should master them and use the techniques under them to help hurting families in Nigeria.

5.0 Summary

In this unit, we have looked at the development of family counseling over the years and the activities of the various vanguards of the therapies. We also discussed the various theories of family counseling as well as the techniques under each theory.

6.0 Tutor Marked Assignment

1. Enumerate the stages of development of family conselling from its origins to the 21st century.

2. List ten theories of family counseling, mentioning the propounder(s) of each theory .

3. Discuss in detail any five theories of family counselling and list the techniques under each theory.

7.0 References/Further Reading

Unit 3 Effective family counseling

Contents

1.0 Introduction

Family therapy, also referred to as **couple and family therapy, marriage and family therapy, family systems therapy**, and **family counseling**, is a branch of psychotherapy that works with families and couples in intimate relationships to nurture change and development. It tends to view change in terms of the systems of interaction between family members. It emphasizes family relationship as an important factor in psychological health.

The different schools of family therapy have in common a belief that, regardless of the origin of the problem, and regardless of whether the clients consider it an "individual" or "family" issue, involving families in solution often benefits clients. This involvement of families is commonly accomplished by their direct participation in the therapy sessions. The skills of the family therapist thus include the ability to influence conversations in a way that catalyses the strengths, wisdom, and support of the wider family system.

2.0 Objectives

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

1. Enumerate the goals of family counseling.
2. Explain the processes involved in family counseling.
3. Explain some techniques of family counseling.

3.0 Main contents

3.1 Goals of Family Counselling

Part of the goal of the therapist is to observe interactions between family members. Another part is to observe the perception of non-interesting family members. Thus, if two family members get into an argument in a session, the therapist might want to know how

the other family member are dealing with the disagreement or the way in which the two fighting member s comport themselves.

In addition, to observation, the therapist often helps the family reflect on better ways of communicating with each other. So family counseling may in part be instruction and encouragement. In fact, it often teaches family members new and more positive ways to communicate to replace old, negative communication patterns.

Observations may also be used to point out how poor communication, especially when particularly filled with strife, affects the behaviour and happiness of children. Children benefit from the safe forum of a session. They may get to discuss the things they don't like about behaviour of care givers and /or siblings. Such discussions might not be permitted in the home setting.

As in a group counseling, the therapist also acts as moderator in family counseling. He or she attempts to ensure that each family member gets fair time for expressing concerns and contributing to the conservation as to how the family can do better. Sometimes the therapist may identify one or more family members may need more than the counseling model, and might benefit from individual therapy. The personal issues of one member of a family may affect other family members.

The therapist may identify that the family cannot progress to a better relationship format without some individuals receiving more help, and possibly medication. A family member with a bipolar chemistry may want to be a better parent, but may be physically unable to change radical mood swings without a combination of individual therapy and medication.

Family counselling may not take a long time to complete. Often families benefit from four to five sessions. Sometimes families require more help and might need 20-30 sessions to resolve significant or ongoing family issues. For families, therapy often helps because it involves a disinterested third party who does not favour any one member of the family. This is generally why a therapist for one family member should not be a counsellor for the client's family. Display of partiality can render the counseling ineffective

3.2 The Counselling Process

A family therapist usually meets several members of the family at the same time. This has the advantage of making differences between the ways family members perceive mutual relations as well as interaction patterns in the session apparent both for the therapist and the family. These patterns frequently mirror habitual interaction patterns at home, even though the therapist is now incorporated into the family system. Therapy interventions usually focus on relationship patterns rather than on analyzing impulses of

the unconscious mind or early childhood trauma of individuals as a Freudian therapist would do- although some schools of family therapy, for example *psychodynamic* and *intergenerational*, do consider such individual and historical factors (thus embracing both *linear* and *circular* causation) and they may use instrument s such as the genogram to help to elucidate the patterns of relationship across generations.

The distinctive feature of family therapy is its perspective and analytical frame work rather than the number of people present at a session. Specifically, family therapists are relational therapists: they are generally more interested in what goes on *between* individuals rather than *within* one or more individuals, although some family therapists- in particular those who identify as psychodynamic, object relations, *intergenerational,* or *experiential* family therapists (EFTs)- tend to be as interested in individuals as in the *systems* those individuals and their relationships constitute. Depending on the conflicts at issue and the progress of therapy, a therapist may focus on analyzing specific previous instances of conflict, as by reviewing a past incident and suggesting alternative ways family members might have responded to one another during it, or instead proceed directly to addressing the sources of conflict at a more abstract level, as by pointing out patterns of interaction that the family might not have noticed.

Family therapists tend to be more interested in the maintenance and /or solving of problems rather than in trying to identify a single cause. Some families may perceive cause- effect analyses as attempts to allocate blame to one or more individuals, with the effect that for many families a focus on causation is of little or no clinical utility. It is important to note that a circular way of problem evaluation is used as opposed to a linear route. Using this method, families can be finding patterns of behavior, what the cause are, and what can be done to better their situation (Gale,2007). The number of sessions depends on the situation, but the average is 5-20 sessions.

3.3 Techniques of family counselling

Family therapy uses a range of counseling and other techniques including: **Structural therapy** which looks at, identifies and re-orders the organization of the family system. **Strategic therapy** which looks at patterns of interactions between family members. **Systemic/ Milan therapy**- This focuses on belief systems. **Narrative therapy**-This has to do with Restorying of dominant problem-saturated narrative, with emphasis on context and separation of the problem from the person. **Transgenerational therapy** which relies on transgenerational transmission of unhelpful patterns of belief and behaviour. Other techniques include:

- Communication theory
- Media and communication psychology
- Psychoeducation
- Psychotherapy
- Relationship education
- Systemic coaching

- Systems theory
- Reality therapy
- Attachment-focused family therapy
- The genogram

4.0 Conclusion

The perspective and analytical frame work of family therapy distinguishes it from other forms of therapies. Family therapists are more interested in the maintenance and /or solving of problems rather than in trying to identify a single cause. The therapy uses a range of counselling and other techniques including structural, strategic, narrative, reality and many other therapies, to achieve its goals

5.0 Summary

In this unit, we have discussed how family counseling can be effective by looking at the goals, processes and techniques of family counseling.

6.0 Tutor Marked Assignment

1. What are the goals of family counseling?

2. Discuss the process of family counseling.

3.0 Explain five techniques of family counseling.

7.0 References/Further Reading

Unit 4 Approaches to Family Counselling

1.0 Introduction

In family counseling, the counselor should evaluate the couple's personal and relationship story as it is narrated, interrupt wisely and facilitate both de-escalation of unhelpful conflict and the development of realistic, practical solutions.[17][18] The practitioner may meet each person individually at first but only if this is beneficial to both, is consensual and is unlikely to cause harm. Individualistic approaches to couple problems can cause harm. The counselor or therapist encourages the participants to give their best efforts to reorienting their relationship with each other. One of the challenges here is for each person to change their own responses to their partner's behaviour. Other challenges to the process are disclosing controversial or shameful events and revealing closely guarded secrets. Not all couples put all of their cards on the table at first. This can take time. In the sessions that follow, we will review practical steps in family counselling.

2.0 Objectives

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

1. Mention and discuss the basic and core principles of family counseling.
2. Discuss some strategies of counseling couples and families
3. Use any of the strategies to counsel couples that have problems and report your finding to the class.

3.0 Main contents

3.1 Practical Guide to family counselling.

Couple therapist may refer to a psychiatrist, clinical social workers, psychologists, pastoral counsellors, marriage and family therapists, and psychiatric nurses. The duty and

function of a relationship counselor or couples therapist is to listen, respect, understand and facilitate better functioning between those involved.

3.1.1 The basic principles for a counselor include:

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

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

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

3.1.3 Common core principles of relationship counseling and couples therapy are:

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

3.2 Counselling Strategies for Handling Families

3.2.1 Strategy 1

Two methods of couples therapy focus primarily on the process of communicating. The most commonly used method is active listening, used by the late Carl Rogers and Virginia Satir. More recently, a method called **"Cinematic Immersion"** has been developed by Warren Farrell. He observed that active listening did a better job creating a safe environment for the criticizer to criticize than for the listener to hear the criticism. The listener, often feeling overwhelmed by the criticism, tended to avoid future encounters. He hypothesized that we were biologically programmed to respond defensively to criticism, and therefore the listener needed to be trained in-depth with mental exercises and methods to interpret as love what might otherwise feel abusive. His method is Cinematic Immersion. Each helps couples learn a method of communicating designed to create a safe environment for each partner to express and hear feelings.

3.2.2 Strategy 2

Emotionally focused therapy for couples (EFT-C) is based on attachment theory and uses emotion as the target and agent of change. Emotions bring the past alive in rigid interaction patterns, which create and reflect absorbing emotional states. As one of its founders Sue Johnson says: Forget about learning how to argue better, analysing your early childhood, making grand romantic gestures, or experimenting with new sexual positions. Instead, recognize and admit that you are emotionally attached to and dependent on your partner in much the same way that a child is on a parent for nurturing, soothing, and protection.

3.2.3 Strategy 3

Behavioral couples therapy. This is the most researched approach to couples therapy. It is a well established treatment for marital discord. This form of therapy has evolved to what is now called integrative behavioral couples therapy. Integrative behavioral couples therapy appears to be effective for 69% of couples in treatment, while the traditional model was effective for 50-60% of couples. At five-year follow-up, the marital happiness of the 134 couples who had participated in either integrative behavioral couples therapy or traditional couples therapy showed that 14% of relationships remained unchanged, 38% deteriorated, and 48% improved or recovered completely.

4.0 Conclusion

Ideas and methods from family therapy have been influential in psychotherapy generally. A survey of over 2,500 US therapists in 2006 revealed that of the 10 most influential therapists of the previous quarter-century, three were prominent family therapists and that the marital and family systems model was the second most utilized model after cognitive behavioral therapy. These proved strategies should be utilized to help families in trouble.

5.0 Summary

In this unit, we looked at family counseling in practice. We examined the basic and core principles guiding the practice as well as some practical examples of using the strategies. I hope you have been well equipped to handle family issues as you encounter them in your daily practice.

7.0 Tutor Marked Assignment

1. Mention five basic principles a family counselor should observe.
2. What are some of the goals family counseling is set to achieve?
3. Mention some strategies that have been used in family counseling. How effective are they?
4. Use any of the family counselling strategies and treat a couple who are having problems and report your findings to the class.

7.0 References/Further Reading

MODULE 4

COUNSELLING SERVICES FOR CHILDREN

Unit 1 The Need For Counselling children

Contents

1.0 Introduction

The need for counselling services for children in schools is acute and growing every day. We want our children to be good learners, but they cannot achieve when they are burdened with unhappiness. The therapeutic approach enables our pupils to achieve well and the school to maintain and/or raise standards. Counsellors provide emotional and

therapeutic services in primary and secondary schools, building children's resilience through talking, creative work and play. Counselling helps children to cope with wide-ranging and often complex social issues including bullying, bereavement, domestic violence, anger or anxiety, family breakdown, neglect, friendship issues and trauma. In this unit, we are going to look at the need and importance of counseling children. Our focus would be children in primary and secondary schools.

2.0 Objectives

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

1. Define Counselling and Psychotherapy
2. Explain the need for early intervention and how counseling can benefit young people.
3. Enumerate the indices of children that need counselling

3.0 Main contents

3.1 What is Counselling?

Counseling is a way of helping people with personal problems. Counselors work with a wide range of concerns including anxiety, depression, bereavement, loneliness, self-esteem, difficulties in relationships, self-injury and eating problems, among others.

Counseling is based on building a trusting relationship between counselor and client. It can help people talk about their experiences and make sense of them. Counseling can allow people to express difficult feelings and to learn how to manage them in a helpful way. Counselors are trained to listen helpfully and carefully to people's problems without judging or criticizing. They do not give advice but support their clients to make positive decisions for themselves.

3.1.1 Counselling and Psychotherapy

There is considerable overlap between the two and many similar skills are used in both approaches. A great deal depends on the training of different counselors and psychotherapist, on their experience and what they hope to achieve. Psychotherapy may take longer and involve greater exploration of someone's past experiences, in order to make sense of their present life

3.2 Counselling Young People

Counseling for children and young people may differ from counseling for adults, and depend on the child's age, specific difficulties and their development. Different methods may be used to encourage young children to be able to express their difficulties, such as play and art. For example, reading stories and talking about feelings of a character in that

story may help the child to discuss their own feelings, or drawing or painting or drama may help children to express themselves. These methods all give the counsellor a great insight into the unconscious mind of the child.

Older children may prefer talking therapy, or a mixture of both, and the counselling approach will depend on a particular individual. Although different methods may be used for counseling children, the aim of counseling for both children and adults is ultimately the same: to help the individual cope better with their emotions and feelings and to be able to relate well with others.

3.3 The need for early intervention.

The number of evidence points to a significant need for early counseling support:

- One in ten children aged between 5 and 16 years (three in every classroom) has a mental health problem, and many continue to have these problems into adulthood. Half of those with life time mental health problems first experience symptoms by the age of 14.
- Among teenagers, rates of depression and anxiety have increased by 70% in the past 25 years.
- One in five children have symptoms of depression and almost a third of the 16-25 year- olds surveyed had thought about or attempted suicide.
- Children are less likely to suffer from serious psychological/ mental health difficulties in later life if they receive support at an early age, providing a cost saving to adult mental health / psychological services.
- Growing evidence indicates that promoting positive mental /psychological health also improves a wide range of positive school outcomes, including enhanced academic progress, better attendance and lower truancy rates.
- Research, monitoring and evaluation indicates that children receiving counseling services show improvements in a range of measures, enabling children and schools to become happier and healthier.

3.4 Indices of children that need counselling

Some common behaviour concerns in children and young people include but are not limited to the following:

Abuse, Anger, aggression and violence, anxiety, attention deficit hyperactivity disorder (ADHD),Autism and Asperger's syndrome, behaviour problems, Bipolar disorder, Bullying, Depression, Disabilities, Divorce and separation, Domestic violence, dyslexia and dyspraxia, eating problems, family relationships, friendship problems, Hearing voices, internet and mobile phone use, obsessions and compulsions, parents mental health and drug/ alcohol problems, physical illness, post traumatic stress disorder (PTSD), Psychosis, Schizophrenia, school problems,

school work and exam stress, self esteem, self harm, sleep problems, special education needs, stealing and lying, suicidial feelings, young carers.

Other child related issues that require counselling may include:

- Family and step-family relationships
- Bereavements/loss
- Emotional problems
- Literacy and numeracy problems

4.0 Conclusion

The cost of not providing early counseling support are considerable: children suffer, costs to tax payers rise and society loses the potential of another individual. Provision of counselling services in schools can be transformational. It ensures that these children can thrive and take the best possible path in life.

5.0 Summary

In this unit, we looked at what counselling is and tried to differentiate counselling from psychotherapy. We also explained how counselling children differs from counselling adults, the need for counselling children and the indicators that show when a child needs counseling.

6.0 Tutor Marked Assignment

1. What is counseling?

2. Differentiate between counseling and psychotherapy

3. How can counselling benefit children?

4. List five indices of early counseling.

7.0 References/Further Reading

www.counselling-directory.org.uk/childrelatedissues.html

www.place2be.org.uk/what-we-do

www.youngminds.org.uk/for-parent/services-children-young-people/co

Unit 2 Preparing For Counselling

Contents

1.0 Introduction

Sometimes children and young people (and their families) may need extra support if they are finding it difficult to deal with or understand their emotions and or behavior. Schools often provide professional counsellors to help young people and their families and families might also decide to seek for help on their own. In all the cases, counselors need to be prepared and also be ready to alley some of the fears that parents may have about their children taking part in counselling.

2.0 Objectives

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

1. Explain the necessary preparations counselors need to make before counselling children.
2. Explain how to prepare parents before their children take part in counselling.

3.0 Main contents

3.1 Counsellor Preparations

- Model – Offer a flexible menu of services, tailored to meet schools' needs. The typical model is based on a team of five or more personnel (both clinical staff and highly skilled volunteers) delivering a range of services in a school.
- Primary schools: Children in primary schools are at a vital stage of their development. Offer them support to cope with emotional and behavioural difficulties which has a positive impact on the whole class, and helps teacher focus on teaching. Also offer support for school staff and parents.
- Secondary schools: The aim should be to help students to achieve their full potentials and to deal positively with the challenges they face. Provide both universal and targeted services for young people in schools, alongside support for school staff and parents.

Be committed to thorough research and evaluation so as to be able to fine-tune your model to meet the needs of the children. Children with the most pronounced needs should have one-to-one support. Parents who need extra support should be able to meet with the counselor. Teachers should get advice about challenging children.

3.2 Client/Parental Preparations

Some issues that parents and clients bother about are discussed here. They include the following:

3.2.1 Is my Child Seeing Someone who is Properly Trained?

It is a good idea for parents to ask their child's counselor or psychotherapist about their training, qualifications and experience.

3.2.2 What if my Child says some private things about my Family?

It is important that your child feels free to talk about experiences in the family that may be troubling or confusing them. It is important that parents give approval to their children to talk to the counselor. It is understandable to feel worried about what your child may wish to talk about in counseling. However, parents should bear in mind that the strict code of ethics counselors follow includes clauses about confidentiality. The counselor is not there to judge you or anyone else in your family, their sole purpose is to help your child manage their problems and try to resolve them in a positive way.

3.2.3 Can I ask my Child about Counseling Sessions?

The counseling relationship is very private and personal, and each child will respond differently. Some children may wish to talk to their parents about sessions, while others, especially teenagers, many wish to keep the content of the sessions to themselves. It is important to be guided by your child and to respect these individual differences. There may be times when your child seems more upset following a counseling session, and this may be because they have been talking about painful feelings. Showing sensitivity to their distress, while also respecting their right to privacy, is a difficult but important balance for parents to achieve.

3.2.4 Can I ask my Child's Counselor how Sessions are Going?

It is natural that you will want to know how your child is getting on in their counseling. Some counselors may arrange to meet with parents to review progress. They will only do this with your child's consent and knowledge of what is to be discussed. It is important to remember that the counselor will have agreed to a confidential relationship with your child and has a duty to stick to this. The only very rare exception to this would be if the counselor thought your child was at serious risk of harming themselves or others.

3.2.5 For how long will my child need to see a counsellor?

The time period is usually decided on at the end of the first meeting between counselor and client. Many counselors work for short fixed term periods such `as six or twelve weeks, although some work in a more open ended way, continuing to provide sessions until the client feels ready to leave.

4.0 Conclusion

Counselors offer a menu of services for primary and secondary schools, providing support for children, parents, teachers, and other school staff. But for counselling to be effective, necessary preparations have to be made by the counsellor and clients and their parents have to be prepared too.

5.0 Summary

In this unit, we looked at the preparations to be made by both the counsellor and the parents of the children before embarking on counselling.

6.0 Tutor Marked Assignment

1. What preparations do you need to make as a counsellor before counselling children?

2. How do you prepare parents before you counsel their children?

7.0 References/Further Reading

Unit 3 Goals For Counselling Children

Contents

1.0 Introduction

As counselors there are four different types of goals to keep in mind while counseling children: fundamental goals, parental goals, counselor formulated goals and the child's goals. Fundamental goals are usually achieved by giving precedence to the child's goals while attending to parent and counsellor goals.

2.0 Objectives

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

1. Mention and explain the four types of goals to keep in mind while counselling children.

3.0 Main contents

3.1 Goals for Counselling Children

Before counseling children, it is important to understand the nature and purpose of counseling children. This includes being clear about our goals and to have clear ideas about how these goals can be achieved. The achievement of goals is not only dependent on the media used and on the style of working, but is critically dependent on the child –counsellor relationship.

3.2 Levels of Goal Setting

Four levels of goal – setting have been identified in counselling children:

Level 1 goals- fundamental goals

Level 2 goals- the parents goals

Level 3 goals - goals formulated by the counselor

Level 4 goals- the child's goals

All of these goals are important and have to be kept in focus during the counseling process. However, at various times during the process, some goals need to have preference over others. How this is achieved is the responsibility of the counselor. We will now discuss each of the four levels of goals.

3.2.1 Level 1 Goals- Fundamental Goals.

These goals are globally applicable to all children in therapy. They include the following:

- To enable the child to deal with painful emotional issues.
- To enable the child to achieve some level of congruence with regard to thoughts, emotions and behavoiurs.
- To enable the child to feel good about themselves
- To enable the child to accept their limitations and strengths and to feel good about them.
- To enable the child to change behaviours which have negative consequences.
- To enable the child to function comfortably and adaptively within the external environment (for example, at home and at school).
- To maximize the opportunity for the child to pursue developmental milestones.

3.2.2 Level 2 Goals- The Parents' Goals

These are set by the parents when they bring their child for counseling. They are related to the parent's own agenda and are usually based on the child's current behaviours. For example, if a child is always fighting, the parents' goal is likely to be to extinguish this behavior.

3.2.3 Level 3 Goals- Goals Formulated By The Counsellor

These goals are formulated by the counselor as a consequence of hypotheses which the counselor may have about why the child is behaving in a particular way. An example is the child who is always fighting. The counsellor may see the fighting as a consequence of the child's emotional issues. So the counsellor's goal might to be to address and resolve the child's emotional issues which will in turn extinguish the fighting behaviour.

When formulating hypotheses about the possible cause of child behaviour, counselor should draw on information from their own case work experience, their theoretical

understanding of child psychology and behaviour, and from their knowledge of current research and the relevant literature.

3.2.4 Level 4 Goals – The Child's Goals

These goals emerge during the counselling sessions and are the child's own goals, although the child will usually be unable to verbalize them as such. They are based on materials which the child brings to the session. For example, a counselor may enter a session having a level 3 goal that the child needs to be empowered. It may emerge during the session that the child wants to talk about a painful loss and is not ready to be empowered. In this situation, the counselor can respond to the child's needs by attending to the level 4 goal and allowing the child to talk about his loss.

There is always a danger when the counselor holds rigidly to a predetermined agenda because the child's own needs might be overlooked rather than addressed. For the child's real needs to emerge and be adequately dealt with, the counselor must stay with the child's own process. Generally, level 4 goals must take precedence over other goals. Unless the issues which are uppermost for the child are addressed first, then the likelihood of counseling having a successful outcome will be diminished.

4.0 Conclusion

It is important to view each child's experience as unique, so counselors need to be careful in setting level3 goals. Our assumptions about what a child needs in therapy might be wrong. The counselor should always review their goals during the course of counseling and be open to amending them wherever necessary. Developing the skills required to discover the child's real needs takes practice and experience.

5.0 Summary

In this unit, we have looked at the four levels of goal-setting in counseling children. They are: fundamental, parental, counsellor and the child's goals.

6.0 Tutor Marked Assignment

1. What do you think the most important goals should be when counseling children?
2. Should the goals be set by the counsellor or by the child's parents or guardians or by the child? Give reasons for your answers.

7.0 References/Further Reading

www.sagepub.com/upm-data/55174_Geldard.pdf

Unit 4: The Counselling Process

Contents

1.0 Introduction

It is obvious that we cannot counsel children in the same way that we counsel adults. Adults are counselled by sitting down with them and inviting them to talk with us. But if we try to use the same strategy with children, many of them will not talk except to answer direct questions. They would also become bored with the conversation after a short while.

To get the child to talk freely about painful issues, we need to involve the child on play, or in the use of media such as miniature animals, clay or various forms of art. Alternatively, we might involve the child in storytelling or take them on an imaginary journey. By combining the use of verbal counseling skills with the use of media or some other strategy, we are able to create an opportunity for the child to join us in a therapeutically useful counselling process. The cousellor should provide the child with the environment in which to undergo therapeutic change.

2.0 Objectives

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

1. Explain the steps to take to engage children and young people in the counselling process.

3.0 Main Contents

3.1 How to engage the child/young person in the counseling process.

3.1.1 Set an appropriate physical environment to engage children and young people in counselling

An appropriate physical environment may include:

- Means by which an emotionally safe and empathic environment is created.
- Appropriate space which is child friendly.
- Toys, puppets, experiential activities (crayons, textas, paints),sand tray and symbols e.g dolls house, books and resources appropriate to various ages and which are culturally appropriate.
- Resources for care-giver and other family members where relevant.

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3.1.2 Use age appropriate engagement techniques to gain child and /or young persons trust.

Age appropriate engagement techniques may include:

- Age and developmentally appropriate communication techniques especially the use of play therapy.
- Storytelling.
- Using strategies that empower the child /young person.
- Demonstrating empathy.
- Maintaining confidentiality.
- Asking open-ended questions.
- The ability to ask direct questions about violence in a sensitive appropriate way.
- Active listening.

3.1.3 Use communication strategies that are appropriate for the children /young people's development stage, culture and emotional needs.

These may include the following:

- Methods of communicating with different age, religious, gender and sexual identity groups.
- Non-judgmental communication techniques.
- Cultural and sub-cultural awareness/ sensitivity.
- Validating child or young person's emotions.

- Using appropriate body language.
- Asking open-ended questions.

3.1.4 Maintain an ethical relationship with children/young people in accordance with standards and legislative requirements.

Ethical relationship must include:

- Counseling practice that reflect the obligations of the practitioner under codes of ethics, and standards of professional membership and /or legislation, to ensure the safety and well being of the child and /or young person in the counseling relationship.
- Counseling knowledge and application of:

i. International conventions relating to the rights of children and young people.
ii. Relevant international conventions on civil and human rights.

3.1.5 Enable children to identify problems areas and effectively participate in the counseling process.

3.1.6 Assess parental / family influences and engage with parents appropriately.

3.2 Respond appropriately to allegations and disclosures of abuse.

3.2.1 Respond to disclosure and allegations include:

- respond to disclosures and allegations in accordance with legislative requirements and organization procedures.

Legislative and statutory requirements may include

i. Relevant state / territory/ commonwealth legislation (e.g. domestic violence, guardianship, disability service, immigration, anti-discrimination, child protection, legal practice legislation, other legislation specific to children and young people).
ii. International conventions relating to the rights of children and young people
iii. Relevant international conventions on civil and human rights
iv. Freedom of information legislation

3.2.2 Document factual information and observations as required by the organization and any statutory child protection legislation.

3.2.3 Identify and assess risk for clients in relation to family domestic violence and other child protection concerns.

Assess risk for clients include:

- Self-identification o f risk, threat or attempts to self-harm.
- Evidence of physical injuries.
- Threat to safety
- Current or previous criminal charges for assault of client by partner /ex-partner, parents.

- Current or previous police involvement
- Objective assessment of care-givers current ability to protect child /young person from further assault or harm.
- Feelings of depression, anger, low self-esteem, suicidal, thoughts, emotional distress or sleep disturbances.
- Medical problems such as overuse of tranquilizers, or alcohol, drug or substance abuse.
- Intimidation and harassment
- Child /young person being denied access to required medications / resources.
- Existing or previous orders relating to domestic violence (e.g apprehended violence order), or breach of orders.
- Avoidance of discussion regarding possible abuse.
- Implausible explanation for injuries.
- Frequent hospital visits / admissions.
- Current or previous parental separation.
- Family court and /or relationship history.
- Children who have been in care.

3.3 Formulate conceptualization of the presenting problem.

3.3.1 Identify factors relevant to the context of children/ young persons in counseling.

Factors relevant to the context of children /young persons in counseling may include:

i. Current or previous parental separation.
ii. Family court and /or relationship history.
iii. Children's behavior and developmental level.
iv. Other factors that may indicate a history of violence.
v. Feelings of depression, anger, low self-esteem, suicidal thoughts, emotional distress or sleep disturbances.
vi. Presenting issues including assessment with parents/care givers.

3.3.2 Develop hypothesis to explain child / young person's presenting problems.

3.3.3 Monitor and review progress of sessions towards child / young person's goals.

3.4 Implement case work process when counseling children and young people.

3.4.1 Develop a clear plan of how sessions will be conducted in collaboration with children and young people.

3.4.2 Develop measurable outcomes, treatment goals, treatment plans and after session plans with children and young people's input utilizing perspectives relevant to working with children and young people.

Perspectives relevant to working with children and young people may include but is not limited to:

- Systemic
- Experiential
- Play therapy.

3.4.3 Work collaboratively with other stake holders, including family members, other significant persons and professionals.

3.4.4 Record plans and complete other case documentation in accordance with practice setting policies, professional standards and legislative obligations.

3.4.5 Use a range of therapeutic interventions to engage and work with children and young people.

Case work processes may include:

- Interviews with child /young person, their family, significant others and care givers.
- Completing applications and other forms such as questionnaire.
- Case documentation file notes, case plans.
- Using specialist communicators, interpreters.
- Classification tools
- Obtaining and processing information from professionals including medical reports and psychological and developmental assessment.
- Obtaining. Processing and /or providing information to/from service providers including child protection authorities.
- Liaison with schools.

3.5 Terminate Counseling Session

3.5.1 Recognize when the couselling is no longer serving the interests or need of the client and family.

3.5.2 Discuss with the client(s) when counseling no longer appears to serve the clients interest or needs and either renegotiate the professional relationship or terminate the service.

Terminate counselling sessions may include:

- Planned termination of counseling
- Client or parents decision to terminate the sessions
- Counselor assesses and identifies issues of concern in a client case which determine whether to continue counseling would be unethical and /or place client and /or others at risk.

3.5.3 Engage client(s) in determining any further external interventions as identified and arrange appropriate referrals.

3.5.4 Discuss with the client any interruptions to counseling planned or otherwise, and implement alternative interim counseling.

Interruptions to counseling may include:

- Counselor illness
- Consellor planned leave
- Consellor changes employment
- Interruptions due to organization change
- Consellor ceases practice
- Other external factors e.g. client illness, expert recommendations that counseling cease.

3.6 Seek feedback from the client(s) about the counseling service provided.

3.6.1 Review counseling progress and provision regularly with the client in a developmentally appropriate way.

3.6.2 Obtain feedback from the client at the conclusion of the counseling service.

3.6.3 Use a range of developmentally appropriate feedback strategies to encourage client contribution to improved counseling practice.

Client feedback strategies may include but not limited to:

- Interviews with colleagues
- Developmentally appropriate evaluation forms
- Complaints
- Recommendations
- Suggestion
- Focus group work
- Feedback on client from parent

3.6.4 Review and reflect on client feedback and incorporate this information as part of supervision for the purpose of practice improvement.

4.0 Conclusion

Using media or activity in conjunction with counseling skills supports children to talk about sensitive issues and results in effective counselling.

5.0 Summary

In this unit, we have looked at the steps to be taken to engage children and young people in the counselling process. They include: engaging the child I the counselling process, responding to allegations and disclosures of abuse, formulating conceptualization of the presenting problem, implementing case work process, terminating the conselling session and seeking feedback from clients about the counsellig session.

6.0 Tutor Marked Assignment

1 Discuss the steps and activities the counselor needs to engage in for an effective counselling process.
2 At what point do you terminate a counselling session?

7.0 References/Further Reading

www.training.gov.au/TrainingComponentFiles/CHC08/CHCFCS804B_RI.pdf

Unit 5 Counselling children with special needs

Contents

1.0 Introduction

Counseling children and young people with special needs involves helping them to develop a positive attitude to life, recognize their strength and express themselves. It does not involve making decisions for the child, imposing benefits on them or preaching. This unit contains information that will practically prepare counselors to handle this group of children. Counseling may be provided to children and young people on their own, or it may be provided to a child as part of a family (family counseling).

2.0 Objectives

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

1. Describe steps to be taken in counselling abused children
2. Mention other categories of children with special needs and explain how to counsel some of them.

3.0 Main Contents

3.1 Counselling Abused Children

Here are some practical guides on how to counsel abused children.

1. Externalize the problem. Help the child see the problem as temporary and from outside, rather than permanent and from within. Focus on solutions, competencies and abilities.

2. Learned helplessness. This comes when a child feels that both good and bad events are uncontrollable. Teach the child mastery and competence. Don't over protect them. Let the rewards you give them be proportional to their accomplishments.

3. Help the child deal with disappointments, not to avoid them.

4. Constantly teach the child to delay gratification. “Yes, but first do this.” “When you calm down, we will talk about it.” This is the model for cooperation. Children have needs alright but so do others.

5. Reduce Anxiety. Set clear limits and boundaries, especially with out-of-control children.

6. Help children not to “be their own grandparent”. Children like parenting their parent. Appreciate the child for their efforts and let them “retire” and be children again.

7. Teaching a child to be a tyrant is abusive too. They feel worse, not better in the long run. Help parents understand that a fussy, demanding, crying child who is throwing a temper tantrum is not being abused. Many fear that they are being abusive toward their own child if the child is crying. You will have a happier child in the long run if you do not meet their demands in such a fashion. Let them earn through cooperation, and let them discover limits to their world.

8. Teach the child to self-soothe. Help parents not to feel so needed rather they should allow the child to have mastery over the situation. Use phrases like “that was scary, and at first you weren’t sure you could handle it, but then you got your confidence back”.

9. Help the child to learn self calming techniques other than chemicals. Such techniques as baths, walks, music, exercise and relaxation. When the child feels out of control, help the child get back in control, not to have the parent get out of control too.

10. Never letting your child be unhappy will make them very unhappy. They need to learn to manage disappointment and learn that life is not being 100% at their beck and call. Parents who shield their children from disappointment, grief, death and pain will have an extremely incompetent child. The goal of parenting is helping them become capable children, not protected children.

11. Telling your child that “there is nothing to fear” will make them more fearful. If your child expresses fear that you might die in a car accident, and you tell them that there is nothing to worry about…, they know that you are lying. Any child who watches the television knows that the world is dangerous. Help them learn to master their fears.

3.2 Counselling Orphans and other Vulnerable Children

Here are some practical guidelines to follow when counselling orphans and other vulnerable children.

3.2.1 Getting the environment right

If you feel that it is safe to do so, create a space to talk which is private and quiet and where you know you will be free from interruptions (always seek the advice of a

colleague about the safety and appropriateness of this action). Where possible, make sure the seating is comfortable and make sure that there is appropriate heating and ventilation.

Get the message across that you have time to attend to the issue that you want to address. Get the message across that the conversation is private and that you will not be passing on what the child/young person says to any third party*.

* You have to also make it clear that if the child/young person gives you information that suggests that they or others are in danger (for example a disclosure of abuse or threat of self-harm) you cannot keep this confidential. *Make sure that you are fully aware of your organisation's child protection policies.*

3.2.2 Getting the listening right

One way of encouraging a child or young person to talk is to make sure that they know you are listening. You can do this by just being attentive and by showing with your body language that you are listening. Sometimes this will be by facing the child and making good eye contact. Sometimes sitting side by side (for example during a journey) will be less threatening. Try not to interrupt when the child/young person is talking. By occasionally nodding or quietly saying "yes" or "aha" the child/young person should be encouraged to open up. Reporting back to the child a short summary of what they have just said and asking them if you have got it right is another way of doing this. Make sure you look and sound calm, unhurried and caring.

3.2.3 Asking the right questions

Try to ask more open questions than closed questions.

An open question is one which cannot be answered with yes or no and which encourages a more detailed answer, for example:

- *"What are your feelings about this?"*
- *"What are the advantages of doing things the way you have suggested?"*
- *"What are the disadvantages?"*

Avoid closed questions such as:

- *"Are you sad?"*
- *"Are you looking forward to the school holidays?"*

Another disadvantage of closed questioning is that the desired answer might be implied within the question and you might inadvertently steer the child/young person to give an answer that they wouldn't otherwise have given. An example of this would be:

"*Are you going to stop speaking to that boy who has been upsetting you?"*

The implied expected answer here is quite clearly "*yes"*.

3.2.4 Being affirming

To encourage the flow of conversation it is important that you show respect by taking an accepting attitude. The message you should try to get across is "I have respect for your opinions and your view of the world at this present time". This is not the same as saying that you agree with the child's opinions or actions and it is okay for you to make it clear that your opinions and moral views are different, as long as this is done in a respectful way.

3.2.5 Limiting the advice

Try to limit the direct advice that you give during your conversation. This is more important for older than for younger children who clearly need more guidance. This is especially the case at the beginning of a piece of problem-solving conversation. For example, it is usually better to start with "What do you think is the best thing for you to do next?" than to say, "What you should do next is..."

3.2.6 How to make it work

- Do not turn your conversation into an interrogation. However good you are at counselling some children/young people will not be ready to talk to you or want to talk to you. This does not mean that you have failed. It might be that they will talk later or that they will talk to a colleague of yours who they know better or a colleague of the opposite sex.

- Make sure that you recognize when you are getting out of your depth. If your conversation with a child/young person uncovers clear evidence of abuse or serious mental distress/ill health, seek immediate advice from your local mental health specialist team.

- After your conversation with a child/young person make sure that you take time out to reflect with a colleague or supervisor about the interaction that you have had. Try to be aware of yourself and your own response.

4.0 Conclusion

You need many years of practice and usually a qualification to become an accomplished counsellor. However, anyone, regardless of qualifications and training can become a more effective helper by learning to apply the basic techniques of counselling. These we have taken time to present and explain in this Course Material.

5.0 Summary

In this unit we have looked at practical guides on how to counsel children with special needs including the abused, orphans and other vulnerable children. Mastering the skills outlined in this unit and in the entire study material means that you are on your way to becoming a great counsellor.

6.0 Tutor Marked Assignments

1. List ten points you must observe when counselling abused children. Explain five of them.
2. Discuss five points to note when counselling orphans and other vulnerable children.

7.0 References/ Further Reading

www.johnswank.com/11%20Strategies%20that%20Really%20Work%20for...

GOOD LUCK.

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