Part I
Introduction

One

Current Psychotherapy and Counselling

Abstract

This chapter presents the current field of psychotherapy and counselling in the context of their historical development. The emphasis is on research-informed developments within or across the distinct theoretical approaches (psychodynamic, cognitive-behavioural, humanistic and integrative). References for helpful resources are provided as well.

Psychotherapy is a healing activity that attempts to alleviate human suffering. It uses psychological means to influence psychopathological symptoms, problematic experiencing, behaviour, and personality characteristics as well as general functioning in life (see Kratochvíl, 2002). To start with, we will have a look at the current research-informed psychotherapy.

Theoretical approaches to psychotherapy and counselling

Counselling and psychotherapy were traditionally developed within several major and distinct paradigms, though most recently there is probably a growing trend towards psychotherapy integration and a more generic understanding of psychotherapy (see Grawe, 2004; Norcross & Goldfried, 2005). Often four main therapy paradigms are recognised: psychodynamic, cognitive-behavioural, humanistic, and integrative and eclectic therapies (see the four volumes of *Comprehensive Handbook of Psychotherapy* edited by F.W. Kaslow, 2004). *Systemic approaches* that developed in the tradition of family and couple therapy and its relatives, such as narrative therapy and constructivist therapies, can probably be considered as another distinct paradigm. Outside those major paradigms there are a significant number of other therapeutic approaches (see Corsini & Wedding, 2007). We will now focus on three broadly defined mainstream paradigms that have received most theoretical and research attention. A more complete overview is provided, for instance, in McLeod (2009).

Psychodynamic approaches represent the first theoretical block. These approaches stem from Freud's psychoanalysis and its long tradition (egopsychology, object relations, etc.). There is growing empirical evidence that supports these approaches (see Shedler, 2010). The developments of empirically studied interpersonal therapy can be loosely assigned to the psychodynamic paradigm as well (see Weissman, Markowitz, & Klerman, 2000).

Cognitive-behavioural approaches represent the second main theoretical paradigm. These approaches currently dominate the field of psychotherapy. This tradition emphasises empirical outcome research, which is well respected in the current era of accountability. Cognitive-behavioural approaches stem originally from two different traditions, cognitive and behavioural. Their combination is probably a pragmatic step as the two paradigms are closely aligned with scientific positivism and 'hard facts'.

Humanistic therapies represent a group of quite distinct approaches, such as person-centred therapy, Gestalt therapy, different existential conceptualisations and, more recently, emotion-focused therapy, all of which are focused on the person more holistically.

Eclectic and integrative therapies represent either a combination of therapies or therapeutic principles from different major paradigms that can be tailored to individual clients' problems (e.g. Beutler & Harwood, 2000), or an attempt to create a more comprehensive theoretical framework (e.g. Prochaska & Norcross, 2003) or a formulation of psychotherapy as a generic activity based on psychological, research-informed principles (Grawe, 2004). The traditional paradigms define the main focus and principles of psychotherapeutic practice. Their development is shaped by clinical experience, theoretical thinking and by research findings.
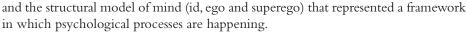
Psychodynamic approaches

Psychodynamic therapies build on Freud's psychoanalysis from the end of the nineteenth and the beginning of the twentieth century. Freud described several theoretical concepts relevant to psychopathology and psychoanalytic therapy. They covered, for instance, a motivation theory, where a central role was played by libido and pleasure-seeking behaviour. Freud also outlined a theory of human development, according to which psychopathology is created on the basis of unmastered developmental tasks of pleasure-seeking (libido-gratifying) behaviour. The psychopathological problems are then fixated in the different developmental stages, such as the oral stage, the anal stage, the phallic stage, the latent stage and the genital stage. Freud also developed a theory of psychological defences that reduce anxiety induced by the conflict between wishes and internal or external obstacles hindering their fulfilment. The defences were linked to individual developmental stages. Freud also described the so-called topographic model of the mind (consciousness, sub-consciousness and unconsciousness)

and the structural model of mind (id, ego and superego) that represented a framework in which psychological processes are happening.

The basic element of psychopathology was, according to Freud, conflict of opposing motives, which he assumed to be in the unconsciousness. Neurotic symptoms were, according to him, a compromise between opposing unconscious motivational forces (the psychodynamics of latent wishes), which due to the fact that psychological energy stays the same, show in conversion symptoms (see Milton, Polmear, & Fabricius, 2004). The basic motives were then typically of a sexual or aggressive nature.

With regard to principles of treatment, Freud was emphasising that psychoanalytic work focuses on the uncovering of unconscious functioning. The tool of the therapist was the interpretation of unconscious conflicts which became visible through free associations, dreams and the transference of unconscious conflicts to the relationship with the therapist.

Freud's concepts were, over the generations, well received by a number of mental health professionals, and have subsequently been built on, developed and revised by other psychoanalysts. The most comprehensive concepts were:

- *ego-psychology* (dating from the 1950s onwards and associated with authors such as Hartman and Mahler), which stressed the cognitive functions of the ego and their use in treatment;
- *object relations theory* (associated with British authors Klein and Winnicott, and with Kernberg in America, originating in the 1940s and 1950s), which supposes that the object of wishes is the other person and that early interpersonal functioning in intimate relationships, and the cognitive and affective processes mediating this functioning, creates stable patterns of interpersonal relating (see Westen & Gabbard, 1999);
- *self-psychology* (originating in the 1970s and 1980s and particularly associated with Kohut), which emphasises motives connected to self-esteem and the experience of self-esteem, including identification with significant others in early childhood and empathy in treatment;
- in recent years, especially in North America, one can find *relational psychoanalysis*, which focuses on the reflection of interpersonal functioning between the analyst and the patient (cf. Mitchell, 1997).

Current empirical knowledge and psychoanalytic concepts

The richness of psychoanalytic theoretical conceptions was not always recognised in the mainstream of psychology. Despite this fact, many of the psychoanalytic conceptions, based on the analysts' clinical experience, correspond nicely with current psychological knowledge. This is illustrated by the American analysts Drew Westen and Glen Gabbard (1999; see also Westen, 1998) in their overview comparing psychoanalytic personality theories with current empirical psychological knowledge. For

instance, Westen and Gabbard point to the proved importance of emotions as primary motivational mechanisms that have a potential to be adaptive. They cite evidence showing that people are motivated by parallel motivational systems which potentially lead to conflict. The presence of conflict is, according to them, also suggested by the existence of ambivalence in human experiencing, visible in the fact that positive and negative emotions correlate only moderately.

Westen and Gabbard (1999; cf. Westen, 1998) further emphasise the existence of an empirically-based agreement that a lot of mental life is unconscious; that stable structures of personality are formed in childhood; that needs and motives are influenced through the internalisation of the needs and motives of significant others. In addition, Westen and Gabbard document evidence that mental representations of self and others influence interpersonal functioning and psychological symptoms (for instance, differentiated, benign and interacting perceptions in projective tests correlate with psychological health). Similarly, people who do not report problems in self-rating scales, but whose childhood descriptions are incoherent or are describing a distressed childhood, have higher blood pressure and heart activity, both visible symptoms of anxiety that would suggest the presence of defences in self-reflection or self-presentation.

Westen and Gabbard's (1999; Westen, 1998) review also points to research studies showing the relationship between personality features in childhood and psychopathology in adulthood. They also refer to research studies that show how often cognitions are in the service of emotions and motivational processes. They stress the associative nature of human psychological functioning and parallel information processing, the awareness of which may be hindered by human wishes, fears and values.

Current psychodynamic scene

Psychodynamic approaches to psychotherapy are diverse and may differ according to traditions in different countries. They represent variations of the main paradigm, which assumes that psychopathology stems from unconscious motivational conflicts that are part of personality structures and of interpersonal functioning. These unconscious conflicts have their roots in personal history, especially in early experiences with significant others. The therapeutic work attempts to provide, with the help of the therapist and in the therapeutic relationship, insight and experiential working-through of the beliefs that are part of the conflicting motivation.

Traditional psychoanalytic training, with an emphasis on long-term personal analysis, still exists. Psychoanalytic associations (e.g. the International Psychoanalytic Association and the American Psychoanalytic Association) play a central role. Psychoanalytic and psychodynamic therapies are influenced by developments in mainstream psychotherapy, such as the emphasis on the brevity of therapy and the manualisation of the therapist's work. For example, time-limited therapy has influenced the

development of focal psychoanalytic and psychodynamic treatment manuals (e.g. Luborsky, 1984; Strupp & Binder, 1984). More recently, handbooks were devoted to different psychoanalytic and psychodynamic approaches addressing different types of psychopathology (e.g. Barber & Crits-Christoph, 1995).

Empirical investigations of psychotherapy and psychodynamic constructs

Several psychodynamic constructs have been examined in empirical investigations. Probably the most studied construct is that of the therapeutic alliance (e.g. Bordin, 1979). There are different conceptions of this construct, the majority of which were elaborated by psychoanalytic theoreticians (see Horvath & Bedi, 2002). Several instruments exist that assess the quality of the alliance as perceived by therapists, clients and external raters. In general, the therapeutic alliance (especially as experienced by the client) appears to be a significant predictor of psychotherapy outcome (Martin, Garske, & Davies, 2000; Horvath & Bedi, 2002).

Interpretation as the main treatment tool of psychodynamic therapists is also well studied. Interpretations seem to be differentially effective depending on the client's quality of object relations (the lower the quality, the more counterproductive are interpretations of transference; see Crits-Christoph & Connolly-Gibbons, 2002), though this may be moderated by the quality of interpretation (Høglend et al., 2006). The empirical overview of Crits-Christoph and Connolly-Gibbons (2002) suggests that, especially in brief therapies, interpretations should focus on central interpersonal themes, but not necessarily as manifested in transference.

Significant attention in empirical research is also devoted to investigations of transference (the expression of the client's central interpersonal functioning in the relationship with the therapist) and psychodynamic case formulation (Luborsky et al., 1993). Good evidence shows that it is possible to capture empirically the client's problematic central interpersonal stance after only a few sessions in therapy (we will discuss this more closely in Chapter 3). It has also been shown that this stance is mirrored in the client's relationship with the therapist (Luborsky & Crits-Christoph, 1990). Furthermore, it has been proven that in successful psychodynamic therapies this stance changes into a more constructive form (Crits-Christoph & Luborsky, 1990).

Countertransference has also been empirically investigated. It has been shown that countertransference emanates from the therapist's unresolved conflicts, even though it is moderated by the client's behaviour and therapy-related factors (Gelso & Hayes, 2007). Once the countertransference is present, it may be difficult for the therapist to maintain appropriate therapeutic distance from the client, although it does not always have to affect the therapy negatively (Gelso & Hayes, 2007). The central feature that was studied with regard to countertransference is its therapeutic use. The factors that seem to contribute to its therapeutic use are:

(1) the ability of the therapist to be aware of problematic inner experience together with the ability to understand its roots;
(2) the therapist's healthy personality structure (self-integration);
(3) the therapist's efficient anxiety management;
(4) the therapist's empathy; and finally
(5) the therapist's ability to conceptualise interaction in the therapeutic relationship (Gelso & Hayes, 2002, 2007).

These are some of the psychodynamic constructs that have received the attention of psychotherapy researchers. Investigations of others (e.g. defences) can be found in the volumes dedicated to research on psychodynamic therapies (see Miller et al., 1993).

Attachment theory and its impact on current psychotherapy

Psychoanalysis is also the study of human development and the influence of childhood experiences on adult functioning (Bateman & Holmes, 1995). This part of psychoanalysis has influenced current psychotherapy as well (see, for example, work of developmental analysts such as Bowlby (1988) and Stern (1985)). A practical application not only in the theory of psychopathology, but also in therapy, is the construct of attachment of John Bowlby (1988). This construct tries to capture the quality of the affective bond between mother and child as well as the quality of the later adult's interpersonal relating. Originally, Ainsworth (1989) empirically showed that there are three forms of infant attachment, and each depends on the infant's experiences with the caregiver: (1) secure attachment, (2) avoidant attachment, and (3) resistant or ambivalent attachment. This conceptualisation was further complemented by the fourth category of disorganised/disoriented attachment (Main, 1995). There are several conceptualisations of adult–relating in close relationships that correspond with child-relational stances (see Hesse, 1999; Holmes, 2001). An example is the conceptualisation of Kim Bartholomew (1997), where she distinguishes four forms of attachment in adults:

(1) *secure attachment* – the person perceives others as trustworthy and has a positive sense of self;
(2) *preoccupied attachment* – the person seeks acceptance in others and internally does not have a positive sense of self;
(3) *fearful attachment* – the person does not perceive others positively and does not have a positive sense of self; and
(4) *dismissing attachment* – the person has a positive sense of self, but does not see others as trustworthy.

Attachment theory complements object relations theory, plus there is a wealth of empirical material to support it. Attachment is not only about interpersonal functioning

in close interpersonal relationships, but it also characterises affect regulation in children and later in adults and it leads to the creation of working models of human relating for a child (and later adult). It has direct application to psychotherapy. The type of attachment is important not only for the case formulation, but also for the manner of relating that the therapist can offer to the client, so it can help to regulate the client's emotional experiencing as well as the client's coping outside the therapy. Another implication is in the area of work with people who have suffered trauma in childhood that has led to the formation of problematic attachment. The evidence suggests that reflective functioning may be impaired in people with such experiences (see review in Bateman & Fonagy, 2004) and therapy then needs to focus on its development.

Current empirically supported psychodynamic approaches

There are a number of psychodynamic approaches that have been researched and whose effectiveness has been assessed (see Box 1.1). One of the most studied approaches is *supportive-expressive psychoanalytic psychotherapy,* which has been described in the form of a therapist's manual by Lester Luborsky (1984; Luborsky & Luborsky, 2006; see also Book, 1997). The efficacy of this therapy was assessed in the treatment of methadone patients (see Woody et al., 1983; Luborsky, Woody et al., 1995). Studies have also verified its effectiveness in the treatment of cocaine dependence (Crits–Christoph et al., 1999), depression (Luborsky, Mark et al., 1995), or generalised anxiety disorder (Crits–Christoph et al., 1995). Supportive–expressive psychoanalytic therapy focuses on clients' understanding of psychopathological symptoms and their own core conflictual relationship themes that should lead to the overcoming of those symptoms and problems in interpersonal relating.

Box 1.1   Examples of empirically studied or developed psychodynamic therapies (as broadly defined)

- *Supportive-expressive psychoanalytic psychotherapy (studied in relation to addictions)* (Luborsky & Luborsky, 2006).
- *Psychodynamic-interpersonal therapy (depression)* (Hobson, 1985).
- *Mentalisation-based treatment of borderline personality disorder* (Bateman & Fonagy, 2004).
- *Interpersonal therapy for depression* (Weissmann, Markowitz, & Klerman, 2000).

Psychodynamic-interpersonal therapy (Hobson, 1985), which also incorporates experiential components, was successfully tested in the treatment of depression (e.g. Shapiro

et al., 1994). This therapy was assessed with regard to its effectiveness in training therapists of different theoretical orientations (Guthrie et al., 2004). It is an interpretative form of therapy, looking at the relationship between the felt experience and interpersonal interactions.

Recently, another form of psychoanalytic treatment received attention thanks to its empirical testing and comprehensive theoretical outline. It is a mentalisation-based treatment of borderline personality disorder, which is marked by an intense emotional instability (Bateman & Fonagy, 2001, 2004). This approach requires partial or full hospitalisation and includes the services of broader medical personnel. Individual and group psychotherapy are key in this approach. Psychotherapy focuses on the identification of intentions in the client's functioning as well as on a reading of the intentions of the people with whom the client interacts (this process is called mentalisation). The ability of reflecting on one's own experiencing and intentions in the interaction is, according to mentalisation theory, missing in the people with borderline features.

Interpersonal therapy (Weissmann, Markowitz, & Klerman, 2000) may be broadly considered as a therapy akin to psychodynamic approaches. This therapy, after it was tested in a collaborative research trial sponsored by the American National Institute of Mental Health (Elkin et al., 1989), gained broad publicity. It conceptualised depression as an interpersonal problem concerning one of the following: bereavement, interpersonal disputes, change in the life role, or loneliness. The therapy is adjusted according to the type of interpersonal problem. This therapy was later tested for other problems, such as eating disorders (Wilfley et al., 2002).

Recommended reading

It is not possible to give a proper account of current (empirically informed) psychodynamic psychotherapy. More can be found in the following books:

Barber, J.P. & Crits-Christoph, P. (eds) (1995). *Dynamic Therapies for Psychiatric Disorders (Axis I).* New York: Basic Books.
Kaslow, F.W. & Magnavita, J.J. (2002). *Comprehensive Handbook of Psychotherapy: Vol. 1. Psychodynamic/Object Relations.* New York: John Wiley.

Cognitive-behavioural approaches

Cognitive-behavioural approaches follow the behavioural tradition in psychology (Pavlov, Watson, Skinner, Thornedike, Hull, Mowrer and others). The pioneers in its development were, for example, Eysenck, Lazarus, Wolpe (behavioural therapy in the 1950s), Ellis (rational-emotive therapy in the 1960s), Beck (cognitive

therapy in the 1970s), etc. An explicit link between behavioural and cognitive therapy was introduced by Michael Mahoney, in his book *Cognition and Behavior Modification* (1974), and by Donald Meichenbaum, in his book *Cognitive Behavior Modification* (1977).

The cognitive-behavioural paradigm evolved through the merging of the behavioural and cognitive traditions in psychotherapy. However, not all of the proponents of these respective approaches approved this development (e.g. Eysenck). Behavioural approaches traditionally built on learning theory from general psychology. They adapted the principles of classical conditioning (Pavlov, 1927/1960), reciprocal inhibition (Wolpe, 1968 – anxiety can be suppressed by the activation of a counteracting physiological process such as relaxation), the two-factor theory of anxiety (Mowrer, 1960 – not only the anxious reaction itself, but also that avoidance contributes to anxiety), operant conditioning (Skinner, 1953 – voluntary behaviour can be conditioned through its consequences), social learning theory (Bandura, 1977 – learning through modelling behaviour), and so on.

The behaviour tradition closely linked any clinical developments with experimental research. Laboratory experimental research led directly to the development of clinical procedures from the very beginning (see the work of the authors mentioned above). The refinement of basic psychological knowledge then led to refinements in the therapeutic approach. This is still true. Nowadays, much attention is given to ongoing research, and treatments informed by this research are being developed (e.g. Barlow, 2002; Mineka & Zinbarg, 2006).

Cognitive approaches to therapy emphasised automatic thought processes. The basic premise of these approaches is the assumption that the meaning which is given to a stimulus influences emotional experiencing and behaviour. Psychotherapy therefore needs to focus on changing the faulty beliefs influencing the interpretation of stimulus. For example, Albert Ellis postulates that irrational beliefs influence the perception, interpretation and emotional experiencing of stimuli. Therefore, his goal for therapy is to use discussion to develop an effective philosophy without irrational beliefs (see Dryden & Ellis, 1988). Aaron Beck (Beck et al., 1979) emphasises the influence of problematic automatic thoughts and cognitive errors that influence emotional experiencing and these therefore need to be challenged and replaced in therapy. He postulates that these thoughts and errors stem from beliefs based on negatively or catastrophically interpreting previous experiences.

Although cognitive therapy developed from clinical experience relatively independently of parallel developments in cognitive science, its empiricist nature was always open to new findings from experimental cognitive psychology (cf. Ingram & Siegle, 2010). Thus, appraisal studies, perception research, thinking and, more recently, emotion studies have found their place in the ever-evolving application of cognitive-behavioural therapies (cf. Barlow, 2008). Studies from cognitive neuroscience are also finding their way into informing the cognitive (as well as behavioural) strategies used in treatment (cf. Ingram & Siegle, 2010).

Craske (2010) provides a succinct account of the theoretical and empirically informed developments that are present and are combined in current cognitive-behavioural therapies. She points out how classical conditioning is currently being enriched by knowledge concerning relevant mediating factors, such as the predisposing characteristics of a person, a specific aversive event and the person's reactions to the event. She stresses current knowledge of the role of automatic as well as conscious cognitive processes in the development of conditioned reflexes. Similarly, she summarises how cognitive processes contribute to the development of contingency-shaping behaviour. Craske demonstrates how perceived or experienced self-efficacy is important for learning and successful therapy. She shows how cognitive appraisal is shaping emotions and behaviours, but also how these feed back to the development of beliefs and schemas.

Similarly, as learning theory can be complemented by cognitive theory, thus cognitive therapy theoreticians can complement their own predominantly cognitive approach by using behavioural techniques. Indeed, some cognitive-behavioural therapies put more emphasis on behavioural aspects (e.g. Craske & Barlow, 2007), whereas others place greater significance on cognitive aspects, such as Mahoney (1988, 2003) or Guidano and Liotti (1988). Currently, there are a variety of cognitive-behavioural therapies (cf. Dobson & Dozois, 2010), some of which also utilise concepts from other theoretical approaches (e.g. Castonguay et al., 2005). The emphasis on research and good evidence of their effectiveness, as well as an emphasis on specificity in the description of procedures, may be contributing to their speedy adoption and growing popularity.

Defining cognitive-behavioural approaches

As mentioned above, cognitive-behavioural therapies represent a broad range of approaches. Dobson and Block (1988; also Dobson & Dozois, 2010) see cognitive-behavioural therapies as those therapies that are built on the following assumptions:

(1) cognitive activity influences behaviour;
(2) cognitive activity can be monitored and changed; and
(3) desired behavioural change may be influenced by cognitive change.

Looking at these characteristics from the perspective of more behavioural approaches, one could add:

(4) behavioural change can influence cognitive change.

The theory of personality in the cognitive-behavioural paradigm takes into account the fact that human experience consists of four elements – physiology, cognition,

behaviour, and emotion – and that a change in any of these elements brings change to all others (Scott & Dryden, 1996). Cognitive-behavioural therapies (CBT), then, are trying to change the negative interplay of those elements by promoting changes to cognitive processes and behaviour.

Cognitive processes that CBT targets include cognitive errors (e.g. dichotomous thinking, over-generalisation, mind reading, personalisation) and automatic cognitive schemes that stem from problematic core beliefs (e.g. DeRubeis & Beck, 1988). The main technique used to tackle the cognitive process contributing to client difficulties is cognitive restructuring (see Chapter 7). Problematic behaviour is also targeted. Behavioural interventions consist of self-monitoring, relaxation, behavioural activation, exposure, skills training, social modelling, etc., and may target either physiological symptoms or behaviour (see Leahy, 2004; many are presented in Chapter 7). The therapy is structured, based on a behavioural, cognitive and functional analysis of the client's problems (e.g. Craske & Barlow, 2007; see Chapter 3). The working style is collaborative, with the emphasis being placed on a high-quality alliance between the client and the therapist. Therapy aims to increase the client's self-efficacy through mastery of problematic behaviour, cognitive processes and emotions. This is achieved by engaging in a number of cognitive, physiological experiencing and behaviour-targeting tasks (see above). Furthermore, the in-session tasks are supported by homeworks that are used throughout the therapy.

Current empirically-supported cognitive-behavioural approaches

The term 'cognitive-behavioural therapy' is often understood as a synonym for empirically supported or evidence-based therapy. This 'misunderstanding' is well deserved as the majority of outcome studies in psychotherapy examine cognitive-behavioural therapies. The research not only focuses on the outcome of CBTs, but also on the relative effectiveness of its partial components (e.g. cognitive restructuring, exposure, relaxation). The different forms of research also examine the efficacy of CBTs. Indeed, when one examines a handbook compiling evidence-based interventions for specific disorders (e.g. Fisher & O'Donohue, 2007), one can see that it predominantly consists of CBTs.

The most researched and well known form of CBT for a specific disorder is *cognitive therapy for depression* (Beck et al., 1979). This therapy is probably the most researched psychotherapy as to its effectiveness (Hollon & Beck, 2004). The method of cognitive restructuring that comes from this therapy is present in almost every CBT approach. The efficacy of Beckian cognitive therapy is also studied for many other disorders (Hollon & Beck, 2004).

Cognitive-behavioural approaches dominate especially in the treatment of anxiety disorders. *Panic-control treatment*, a form of CBT applied to panic disorder (Craske & Barlow, 2007), is an example of one of the most efficacious psychological interventions

that exist (Barlow et al., 2000). *Exposure and prevention of rituals* (Franklin & Foa, 2008) is one of the most researched and efficacious therapies for obsessive–compulsive disorder. Thomas Borkovec (Borkovec & Costello, 1993) leads a longstanding programme investigating the efficacy of CBT for generalised anxiety disorder. Similarly, Brown, O'Leary and Barlow (2001) are developing a form of CBT applicable to post-traumatic stress disorder (PTSD) (see also Foa, Hembree, & Rothbaum, 2007). Marsha Linehan (1993) developed and studied dialectical–behavioural therapy for borderline personality disorder. One can find an overview of research studies on CBTs, for instance, in the surveys provided by Hollon and Beck (2004), Emmelkamp (2004), or Kazdin (2004).

Box 1.2   Examples of empirically studied or developed cognitive-behavioural therapies

- *Cognitive therapy for depression* (Beck et al., 1979).
- *Panic-control treatment (panic disorder)* (Craske & Barlow, 2007).
- *Exposure and prevention of rituals (obsessive-compulsive disorder)* (Franklin & Foa, 2008).
- *Prolonged exposure therapy for post-traumatic stress disorder* (Foa, Hembree, & Rothbaum, 2007).
- *Dialectical-behavioural therapy for borderline personality disorder* (Linehan, 1993).

Recommended reading

There is a huge amount of literature on cognitive–behavioural approaches. The reader may choose among different books depending on his/her own preferences. Two informative, research-informed accounts can be found, for instance, in:

Barlow, D. (ed.) (2008). *Clinical Handbook of Psychological Disorders: A Step-by-step Treatment Manual* (4th edition). New York: Guilford Press.
Kaslow, F. W. & Patterson, T. (2002). *Comprehensive Handbook of Psychotherapy: Vol. 2. Cognitive-Behavioral Approaches*. New York: John Wiley.

Humanistic and existential approaches

Humanistic, experiential and existential approaches represent a great variety of different theoretical models. They are grouped together, especially in reviews or edited books

(e.g. Rice & Greenberg, 1992; Cain & Seeman, 2002), but in reality they are quite distinct. According to Cain (2002), humanistic approaches, in the broader sense of the word, define: the *view of the person* (e.g. actualising, having free choice and responsibility, being unique, searching for meaning); *values* (respect for the right to self-determination and diversity); an *actualising tendency* (postulated as the underlying motivational tendency to maintain the self and to fulfil its potential); *relational emphasis* (the healing quality of relationships); *phenomenology* (knowing through one's own direct experience); *self* (sense and reflection of one's self); *emotions and meaning* (their centrality in behaviour).

Probably, the most practised of the humanistic approaches is person–centred therapy (the older term being client-centred therapy), which stems from the work of Carl Rogers. The roots of this therapy can be dated to 1942 when Rogers published the book *Counseling and Psychotherapy*. The theory of psychopathology of this approach, as formulated by Rogers (1959), assumes that the child is born with an innate actualising tendency that leads the child's development. The child actualises his or her self through assessing what is good for him or her on the basis of organismic valuing process. Developmentally, the child's self-experiences and self-perceptions form his or her self-concept, which is further actualised. As the child also has the need for the positive regard of significant others, the significant others' reactions (conditions of worth) may be more important than the child's own organismic valuing process. Thus, self-concept, based on the conditions of worth rather than on the basis of one's own organismic process, develops and is pursued. The conditions of worth then determine whether self-experiences are allowed to be brought into awareness (they may be distorted or denied) and so incongruence between the self and the totality of experiencing develops. This is then a source of problematic functioning.

The theory of therapy thus puts an emphasis on the healing power of the therapeutic relationship and the client's inherent potential for growth. It assumes that the client in a safe, authentic, unconditional and empathic relationship will be less defensive and gradually more accepting of his or her own experiencing self (Rogers, 1957, 1958, 1959). In practical terms, the emphasis is put on the quality of therapeutic interviewing, which conveys healing attitudes of acceptance and empathic understanding through responding empathically to the feelings and personal meanings in the client's explorations of his or her own experiences. Empathy also includes responses to aspects of the client's experiencing that are not fully in the client's awareness.

Gestalt therapy is another influential humanistic approach. Its originator, Frederick Perls (Perls, Hefferline, & Goodman, 1951), emphasised the healing power of awareness and dialogical relationship. The theory of personality (Yontef & Jacobs, 2005) assumed that people exist through differentiation and contact with others. The person grows through assimilating what leads to development and through rejecting what is not helpful. The boundary between one's self and environment (especially one's interpersonal environment) should be permeable (openness) but firm (autonomy), allowing for experiences of connection, but also of separate identity. The main problem, as seen by Perls, is in the inflexibility of organismic self-regulation in the interaction with one's environment, which is caused by a limited awareness of one's

own experiencing and one's own needs. Awareness is hindered by defences such as confluence (fusion with the other), isolation (detachment), retroflection (self-self treatment instead of interaction), introjection (assimilating environment), projection (attributing aspects of the self to the environment), and deflection (avoidance of contact) (Yontef & Jacobs, 2005). The theory of therapy assumes that in a dialogical relationship the client will have a space to broaden awareness (contact) of his or her own experiencing, will accept responsibility for his or her own experiencing and will experiment with it. For that purpose, several experiential techniques, such as the use of chair dialogues, were designed. The techniques are used to put thoughts or feelings into action and to increase awareness.

Experiential approaches stemming from client-centred therapy (e.g. the focusing-oriented therapy of Gendlin) and emotion-focused therapy of Les Greenberg and his collaborators (Greenberg, Rice, & Elliott, 1993; Greenberg, 2002) also put emphasis on the exploration of experiencing and on broadening of the client's awareness. Emotion-focused therapy can especially be perceived as a further development of person-centred and Gestalt therapy (and effectively also their merger). This therapy was based on a programmatic research into experiential therapies. In its theory, it postulates that emotional experiencing has central informative power in human functioning. It sees human functioning as a dialectic between (1) sensory and visceral information, emotions and emotion schemes (including cognitive representations and meanings) and (2) conceptualisation of self. The emphasis is put on the healthy dialectical-constructive processing of experience. The therapy focuses on the unpacking of primary adaptive emotions and the transformation of primary maladaptive emotion schemes by accessing primary adaptive emotions. For that purpose, empathic relationship and active experiential interventions are used. We will look at them in Chapter 7.

Existential therapies consist of several independent approaches (Cooper, 2003, 2008b), for example *Daseinsanalysis* (Binswanger, Boss), *Logotherapy* (Frankl), American *Existential therapy* (Yalom, May), British *Existential analysis* (van Deurzen-Smith, Spinelli). The common feature of these approaches is the understanding of human suffering as the natural reality of life and not as psychopathology. Problems are seen to stem from encountering the givens of life (e.g. the inevitability of death, real anxiety encountered in life), and the meaning of life is an antidote to psychopathology.

Current empirically-supported humanistic and existential approaches

Humanistic and existential approaches, with the exception of person-centred therapy, were never dominating empirical research on psychotherapy. Even the research in person-centred psychotherapy is rather a historic reality of 1940 to 1970 (though, as we will see below, there is some resurgence in it). Traditionally, it was mostly process research that dominated in this paradigm, though outcome studies were also conducted. The process research focused on Rogers' postulated qualities of the therapeutic

relationship, on the depth of experiencing, significant events in the therapeutic process, and other fruitful therapeutic processes (see Rennie, 2002; Sachse & Elliott, 2002). Many process research instruments were developed in this tradition (e.g. Barrett–Lennard's Relationship Inventory (Barrett-Lennard, 1986); Experiencing Scale (Klein et al., 1969); Client Vocal Quality Scale (Rice & Kerr, 1986)). Outcome research had already started in the 1950s (e.g. Rogers & Dymond, 1954). The studies fulfilling current standards show that person–centred therapy is promising in the treatment of depression (e.g. King et al., 2000) and, to a certain extent, in the treatment of panic disorder with agoraphobia (Teusch & Bohme, 1999). Elements of this therapy were shown to be useful in the treatment of adolescents with depression (Birmaher et al., 2000) and also in psychotherapy for schizophrenia (Tarrier et al., 2000).

The outcome of motivational interviewing, a derivative of person–centred therapy for working with addictions (Miller & Rollnick, 2002), but also with other problems (Arkowitz et al., 2008) is very well studied. The review of 26 randomised trials (Burke, Arkowitz, & Dunn, 2002) shows it to be an effective intervention (cf. also Babor & Del Boca, 2003).

Emotion–focused therapy (in its individual form it is also known as process–experiential therapy (see Greenberg, Rice, & Elliott, 1993); for its application with couples, see Greenberg & Johnson, 1988; Johnson, 2004; Greenberg & Goldman, 2008) is empirically well supported. Apart from the fact that it builds on the research tradition in person–centred therapy, this therapy was developed on the basis of process research and was tested as to its outcome (see the overview in Elliott, Greenberg, & Lietaer, 2004). In its individual form, it is the best established as a treatment for depression, though it has also been tested for other disorders such as PTSD. Its couples' application is one of the most studied couples therapies (Sexton, Alexander, & Mease, 2004).

Box 1.3   Examples of empirically studied or developed humanistic therapies (as broadly defined)

- *Motivational interviewing (addictions)* (Miller & Rollnick, 2002).
- *Emotion-focused therapy (couples, depression)* (Greenberg, 2002).

Recommended reading

Research–informed accounts of humanistic therapies can be found in:

Cain, D. & Seeman, J. (eds) (2002). *Humanistic Psychotherapies: Handbook of Research and Practice*. Washington, DC: American Psychological Association.

Kaslow, F. W., Massey, R. F., & Massey, S. D. (2002). *Comprehensive Handbook of Psychotherapy: Vol. 3. Interpersonal/Humanistic/Existential*. New York: John Wiley.

Eclectic and integrative approaches

Eclectic approaches are typical in the *ad hoc* use of techniques coming from different theoretical approaches (technical eclecticism). A typical criterion for the use of some techniques is the client's problem or personality (e.g. internalising or externalising clients). Integrative approaches, on the other hand, try to bridge and assimilate different existing therapeutic theories into meta-theories that are coherent but draw on originally independent theories. A form of eclectic or integrative work is very popular. For example, a survey among American therapists shows that between 30% and 50% of them identify themselves as eclectic–integrative practitioners (see Prochaska & Norcross, 2003; Norcross, 2005).

There are several approaches to psychotherapy integration (Norcross & Goldfried, 2005). Some look at the common factors present across the theoretical approaches, some look at the ways of combining techniques from different approaches, some try to formulate transtheoretical principles that bridge different theoretical approaches and, finally, some look at different approaches that can be assimilated into the primary orientation of a therapist. An example of the common factors model is the work of Jerome Frank (Frank & Frank, 1991), who suggested that the similar effectiveness of different therapeutic approaches (cf. Wampold, 2001) can be explained by the common factors they contain. He assumed that the effective components are:

- an emotionally charged relationship with the helping person;
- the healing context of psychotherapeutic care;
- the meaningful explanation of the patient's problems and required psychotherapeutic care; and
- the ritual – the therapeutic procedure.

Another approach to psychotherapy integration is that of technical eclecticism. A significant contribution from this perspective was made, for instance, by Larry Beutler and his colleagues (Beutler, Clarkin, & Bongar, 2000; Beutler & Harwood, 2000). Beutler, in his prescriptive therapy, collects empirically-supported therapeutic principles regardless of their theoretical origin. The idea is that the therapist will be able to use them regardless of his or her own original therapeutic orientation.

Some integrative approaches combine two or more traditional schools of therapy. An example of such a therapy developed in the UK is cognitive-analytic therapy (Ryle, 2005). This therapy primarily combines the psychoanalytic and cognitive-behavioural traditions. Many, originally psychoanalytic, concepts stemming from the object relation tradition are translated into cognitive and behavioural ways of working. The therapist assumes an active role in promoting change and insight.

Transtheoretical approaches to psychotherapy integration attempt to come up with an overarching theoretical structure that coherently integrates different theories.

An example is the work of Klaus Grawe (2004), who outlined his model of psychological therapy as targeting psychological symptoms (by using cognitive and behavioural techniques) and also the underlying conflicts that lead to them (by using psychodynamic and experiential techniques). Another example of a transtheoretical model is the work of Prochaska and Norcross (2003; see also Prochaska & DiClemente, 1983). Their model combines processes of change (e.g. consciousness-raising, relief, environment re-evaluation, self-re-evaluation) with the stages of change (precontemplation, contemplation, preparation, action and maintenance) and different levels of change (symptoms and problematic situations, cognitive processes, interpersonal, family and intrapersonal conflicts). According to these authors, integrative therapy should consist of the different application of processes of change in different stages of change at the appropriate level of change.

Another approach to psychotherapy integration is assimilative integration (Messer, 1992; Lampropoulos, 2001). This approach assumes that the therapists integrate the principles or techniques of other theoretical orientations with the orientation that the therapists prefer or in which they were trained. This integration can be based on research evidence of those principles and techniques. For some examples of how assimilative integration can be spelled out, see the assimilative psychodynamic therapy of Stricker and Gold (2005) or the assimilative cognitive-behavioural therapy of Castonguay et al. (2005).

Research-informed integrative and eclectic approaches

As mentioned above, some of the eclectic and integrative approaches are trying to use research evidence as the basis for their approach to therapy. An example is prescriptive therapy (Beutler & Harwood, 2000; the other name for this approach is Systematic Treatment Selection (Beutler, Clarkin, & Bongar, 2000)), an application of the idea of gathering principles of therapeutic change informed by research from different theoretical orientations. This approach is described in several books (e.g. Beutler, Clarkin, & Bongar, 2000; Beutler & Harwood, 2000) and an edited volume (Castonguay & Beutler, 2006). One of the first guidelines to its use is presented in the 'prescriptive' recommendations for the treatment of depression by Beutler, Clarkin, & Bongar (2000). They looked at the patients' characteristics, the treatment characteristics, and how they could be combined. They summarised the treatment of depression into basic and optimal principles of therapy for depression, which can be used by the therapist regardless of their therapeutic orientation.

Another research-informed approach to psychotherapy integration is the psychological therapy of Klaus Grawe (2004). Grawe identified two levels of intrapsychological processes leading to mental disorders. On the first level is the person's effort to reduce internal conflicts and on the second level is the development of a disorder that stems from these conflicts. The main implication for psychological therapy

is the importance of addressing both levels of the problem. The whole model of psychopathology is informed by basic psychological science as well as by dynamic system theories. The theory of therapy is again backed up by empirical research. It consists of three components:

(1) the *activation of resources* of the patient (activation of what is functional in the patient as well as support provided by the therapeutic relationship);
(2) the *destabilisation of parameters of psychological disorders through specific interventions* (these interventions may focus on problematic experiencing, problematic cognitions, or problematic behaviour); and
(3) the *modification of motivational schemata* that led to the development of the disorder (this is achieved through their clarification and corrective experiences).

In its practical application Grawe's (2004) model combines strategies from several theoretical orientations. It offers a structured case conceptualisation that follows an articulated theory and also draws on a variety of tasks and techniques from experiential, psychodynamic and cognitive-behavioural therapies.

Recommended reading

Kaslow, F.W. & Lebow, J.L. (2002). *Comprehensive Handbook of Psychotherapy: Vol. 4. Integrative/Eclectic*. New York: John Wiley.
Norcross, J.C. & Goldfried, M.R. (eds) (2005). *Handbook of Psychotherapy Integration* (2nd edition). New York: Oxford University Press.

Variables that are important for the effect of psychotherapy

Apart from the developments within specific theoretical frameworks, current psychotherapy research that shapes therapeutic practice also cuts across theoretical orientations and covers variables relevant for any theoretical approach. For instance, there are several client variables that have been shown to be predictors of psychotherapy outcome. An example is the severity of psychological difficulties, which is a strong and consistent predictor (for reviews, see Garfield, 1994; Asay & Lambert, 1999; Clarkin & Levy, 2004). Other variables that are consistently reported in the reviews of empirical evidence on client variables (Asay & Lambert, 1999; Clarkin & Levy, 2004) are, for example, motivation to change, ego strength, psychological mindedness, capacity of relating, ability to identify a focal problem. Important factors are also the availability of social support and other forms of help (Asay & Lambert, 1999).

Another significant area of research is studying the rate and reasons for clients' premature termination of therapy. For instance, it is important to know that 30–60% of clients drop out from therapy prematurely (Reis & Brown, 1999). The studies of the process that leads to drop-out showed that therapist inflexibility and a failure to recognise a rupture in the therapeutic alliance may be strong factors influencing drop-out (Rhodes et al., 1994). Another concept that helps in the understanding of prematurely ended and unsuccessful therapy is the model of stages of change of Prochaska, Norcross, and DiClemente (Prochaska & DiClemente, 1983; more recently see Prochaska & Norcross, 2002; see also the section on integrative approaches above). This assumes that the clients may be at a different stage of the change process when they enter therapy. Empirical findings (Arnkoff, Glass, & Shapiro, 2002) demonstrate that one of the moderating variables with regard to psychotherapy drop-out and outcome may also be the clients' expectations about therapy. The expectations may relate to the outcome of therapy, the client role in therapy, the length of therapy, and so on. Expectations may also include preferences of certain forms of therapy, the specific length of therapy or the therapist's age or gender.

This is not an exhaustive list of significant variables (see for example Norcross, 2002). For instance, the next chapter will explore the role of a good therapeutic alliance and the importance of the therapeutic relationship for the successful outcome of therapy. Other chapters will also rely heavily on research-generated knowledge. Psychotherapy and counselling research is a live scientific area that covers all possible clinically and theoretically relevant questions (cf. Cooper, 2008a; Timulak, 2008). Therapists of any orientation may find in it a breadth of information that can inform the way they engage in therapy.

Recommended reading

Cooper, M. (2008). *Essential Findings in Counselling and Psychotherapy*. London: Sage.
Timulak, L. (2008). *Research in Psychotherapy and Counselling*. London: Sage.

Knowledge relevant for conducting psychological therapy

When talking about current psychotherapy and counselling, one must also be aware of knowledge from other areas relevant to the provision of therapy. These are usually covered on training courses in clinical and counselling psychology, psychotherapy and counselling. The courses incorporate a knowledge of healthy and pathological psychological functioning, lifespan development, multicultural issues and general psychology (e.g. cognitive psychology, psychology of emotions, psychology of personality). A knowledge of psychopathology and of the language used in the mental health setting

(DSM–IV – American Psychiatric Association, 2001; International Classification of Diseases, ICD–10 – WHO, 1992) for describing human suffering is vital for communicating and retrieving important information. The texts and studies on the phenomenological experience of different problems and disorders can also be helpful (e.g. Wertz, 1985). A knowledge of common medical conditions that can present themselves in the form of psychological symptoms is useful too (Morrisson, 1999) as is an awareness of the psychological needs of somatically ill people (Kolbasovsky, 2008). In addition, it is important for therapists to know about alternative treatments (see Chapter 10) such as psychopharmacology, social support, self–help programmes (Patterson et al., 2006). On the other hand, therapists can learn a lot about human experience through art, personal experience (also in personal therapy), peer discussions, supervision, etc.

Recommended reading

The main texts on psychopathology:

American Psychiatric Association (2001). *Diagnostic and Statistical Manual of Mental Disorders* (4th edition). Text revision. Washington, DC: APA.
World Health Organisation (1992). *The ICD–10 Classification of Mental and Behavioural Disorders: Clinical Description and Diagnostic Guidelines*. Geneva: WHO.

The therapist's guides to psychopharmacology:

Beitman, B., Blinder, B., Thase, M.E., Riba, M.B., & Safer, D.L. (eds) (2003). *Integrating Psychotherapy and Pharmacotherapy: Dissolving the Mind–Brain Barrier.* New York: W.W. Norton.
Patterson, J., Ari Albala, A., McCahill, M.E., & Edwards, T.M. (2006). *The Therapist's Guide to Psychopharmacology*. New York: Guilford Press.

Medical conditions and psychological problems:

Kolbasovsky, A. (2008). *A Therapist's Guide to Understanding Common Medical Conditions*. New York: W.W. Norton.
Morrisson, J. (1999). *When Psychological Problems Mask Medical Disorder: A Guide for Psychotherapists*. New York: Guilford Press.

Multicultural issues in counselling and psychotherapy:

Sue, D.W. & Sue, D. (2008). *Counselling the Culturally Different*. Hoboken, NJ: John Wiley.