The Practice of Counselling and Psychotherapy

THE PRACTICE OF COUNSELLING AND PSYCHOTHERAPY

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CONTENTS

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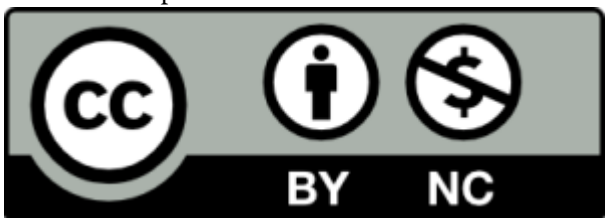

The University of Queensland, St Lucia QLD, Australia

We acknowledge the Traditional Owners and their custodianship of the lands on which this project originated. We pay our respects to their Ancestors and their descendants, who continue cultural and spiritual connections to Country. We recognise their valuable contributions to Australian and global society.

A Guidance Through Time by Casey Coolwell and Kyra Mancktelow © The University of Queensland

About the artwork

Quandamooka artists Casey Coolwell and Kyra Mancktelow have produced an artwork that recognises the three major campuses, while also championing the creation of a strong sense of belonging and truth-telling about Aboriginal and Torres Strait Islander histories, and ongoing connections with Country, knowledges, culture and kin. Although created as a single artwork, the piece can be read in three sections, starting with the blue/greys of the Herston campus, the purple of St Lucia and the orange/golds of Gatton.

The graphic elements overlaying the coloured background symbolise the five UQ values:

- The Brisbane River and its patterns represent our Pursuit of excellence. Within the River are tools used by Aboriginal people to teach, gather, hunt, and protect.
- Creativity and independent thinking is depicted through the spirit guardian, Jarjum (Child in Yugambeh language), and the kangaroo
- The jacaranda tree, bora ring, animal prints, footprints and stars collectively represent honesty and accountability, mutual respect and diversity and supporting our people.

Learn more about The University of Queensland's Reconciliation Action Plan.

AUTHORS

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Dr Denis O'Hara has been working as therapist, educator, and researcher for over 30 years in Australia and overseas. He has written extensively on various topics within the fields of psychology, counselling and psychotherapy with particular interest in such topics as the problems of the self, hope studies, trauma, ADHD and the professionalisation of counselling and psychotherapy. He is the current director of the Master of Counselling at The University of Queensland.

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Dr Kate Witteveen has been a mental health academic and practitioner for over 20 years. Her teaching and research interests include working therapeutically with young people, trauma, and ADHD, and her clinical work has a particular emphasis on female experiences with burnout, neurodivergence, and trauma. She is currently a Lecturer in the Master of Counselling at The University of Queensland.

FOREWORD

Judith Murray

It is a privilege to be asked to write a Foreword to this book. It is a wonderful achievement and true gift to those who will learn and become part of these professions. The book offers knowledge, insights and skills to the practice of therapy. But perhaps more profoundly it offers a deepening understanding of the often imperceptible, but fundamental aspect of therapy. This aspect is what makes therapy actually work to meet the needs of clients. This is the process of how it occurs.

As discussed in this book, literature clearly tells us that offering truly meaningful care to people struggling with life challenges may be less about what we do, and more about who does it and how they do it. Meaningful care may be more about what we bring to the encounter as people and how we skilfully, respectfully and kindly we offer our care.

Not for a minute does this suggest that we reduce our endeavours to develop our skill, our knowledge and test our work and assumptions. To strive to build the science of what we do is fundamental, and in itself, a gift we offer to people in need.

At times we call it 'imposter syndrome'. But there is a great difference between feeling an 'imposter' from a sense of inadequacy within ourselves; and feeling less than adequate in the face of the awe we develop in realizing that as we learn more, we know how much we can still learn. That sense of being an imposter rather drives us forward with humility and anticipation to learn more, to challenge ourselves and to grow ourselves and our professions.

But science with its research, its evidence and its interventions will never alone be enough to reach people in truly meaningful ways. To do this we need to put our science within the deeply amazing, yet often confusing, and less confined world of people who meet at a moment in time. We may name them 'client' and 'therapist'; but in that moment they are two humans meeting at this point in time on their own journeys in life. Together they interact and together they work toward change. One brings a science, skills and a willingness to know and assist. The other brings a challenge, some pain, some strengths and a deep and unique experience of themselves. And it is here they meet and true therapy begins.

This book and the knowledge it brings and the art it will encourage in you is about making that interaction in that moment truly matter. As you combine your clear science with the more intuitive art of what you do, you change the language and change the moment. Therapy becomes a living breathing dynamic process occurring between two people, both flawed and both strong in their own ways at this time of meeting.

A therapeutic alliance becomes a 'knowing' and a shared vision and knowledge. History taking or intake interviews become accepting humbly an invitation into the experience and the story of another. Interventions become shared means of moving toward a greater sense of wholeness and safety for a person facing upheaval. A technique becomes a step both can see is able to be taken toward an end that both share as of value. A client becomes a person who in this moment struggles but holds a potential for renewal. A

therapist becomes a knowledgeable encourager of change. A session becomes a collection of moments of potential movement and wonder and relief and challenge. A goal becomes the understanding of a personal need.

In reading this book you will make the process of therapy come alive and be as it was always meant to be. I commend those who have written it and I commend each of you for reading it and wanting to be part of these professions.

I wish for you every sense of fulfilment in the years you will spend caring for others in their time of need.

Judith Murray

PREFACE

Denis O'Hara

The 'Practice of Counselling and Psychotherapy' is a collaboration among the counselling educators in the Master of Counselling program at the University of Queensland. As a counselling team we saw the need to provide a text which reflected the content and priorities of our program, and more broadly of the practice of counselling and psychotherapy. Each counselling program is informed by a philosophy of practice. Being conscious of the foundational principles and values of a program of study is essential because in the end we practice what we actually believe, not necessarily what we espouse. Hopefully what we espouse and what we convey to students via our teaching and practice are closely aligned.

This book covers a range of content that is relatively common in the field, but it also adds knowledge and a focus which is peculiar to the shared views and values of our staff team. The content of some of the eleven chapters will be familiar to many mental health professionals. What might be less commonly encountered in a text on counselling and psychotherapy is a strong focus on what it is to be a self, especially a self that is grappling with the challenges of life. The phenomenology of two or more people (client and counsellor) in a deep and personal encounter is examined in these pages. Said another way, our focus is on the *process of therapy* – what actually happens in therapy. We need theory to inform us, but we also need a way of being which reaches the person of the client. Hopefully in these pages we have managed to convey something of what it is to genuinely *be* with another in the context of therapy.

Denis O'Hara

1.

WHAT IS COUNSELLING AND COUNSELLING PSYCHOLOGY?

Denis O'Hara

"Psychotherapy is a cyclical process from isolation into relationship." – Irvin D. Yalom

Key Takeaways

This chapter introduces the field of mental health and briefly explores the different philosophical influences on the mental health professions.

- The notion that counselling and counselling psychology are expressions of the intersection between *art* and *science* is highlighted.
- How scientific evidence is understood from different perspectives and how evidence provides support for the practice of counselling and its benefits for clients is introduced.
- The notion of 'the self' is examined and declared a central focus of counselling.
- The importance of active listening in the process of facilitating psychological support and therapeutic change is positioned as a fundamental feature of the counselling process.

Introduction

It can be quite challenging to distinguish between the similarities and differences of the mental health professions as often there is significant overlap in the type of services provided by each. This is reflected in a common confusion over distinguishing between, a psychiatrist, a psychologist or a psychotherapist, as each term sounds very similar. To add further to the muddle, there are differences between clinical psychologists, counselling psychologists and other types of psychologists. The word 'counselling' is problematic as well because many professions such as social workers, occupational therapists, mental health nurses, psychologists, and counsellors all provide counselling. This raises the question, 'Is the counselling that each profession provides the same thing or are there differences?'

Another important issue is the regulation of these various professions. Do practitioners from each profession go through the same regulatory processes? What do governments understand to be the differences between these professions and what does this mean in terms of such issues as cost and remuneration? Some of these questions we will not answer here as the answers vary depending on country and jurisdiction. However, we will aim to provide some sense of the mental health landscape.

Well before the modern era of health care, people were supported in their mental health by a range of social networks ranging from family members, community elders, teachers, priests, rabbis, imams and pastors. These forms of community support are generally referred to as pastoral care. By the beginning of the twentieth century the natural sciences had begun to influence the mental health field, introducing new ideas and roles. Before the emergence of the natural sciences, the dominant theoretical foundations of the helping professions were from philosophy and theology. Psychology for example, largely emerged from philosophy and has progressively drawn on other disciplines such as medicine, education, neurobiology, developmental studies, and sociology, combining in a synthesis of what we understand as the discipline of psychology today. Counselling similarly draws on these academic disciplines and adds other fields such as career guidance, and relationship counselling. There has always been a large overlap between the various mental health professions which has contributed to the professional potpourri described above.

Famous names from early in the development of the mental health field include such people as Sigmund Freud, Carl Jung, Willaim James, John B. Watson, and B. F. Skinner with these theorists representing just a small portion of notable contributors. These early twentieth century developers were either psychiatrists (medical doctors) or psychologists. The twentieth century was a boom period for the development of psychological theories and by the mid twentieth century the field had begun to diversify its range of theories. By this time, the dominance of Freudian psychoanalytic theory and the behaviourism of Watson and Skinner had begun to be challenged by the humanistic theories of Abraham Maslow, Carl Rogers, and others.

The world wars of the twentieth century also had an important impact on the development of the mental health field. The returning soldiers from both wars presented with a range of mental health conditions that challenged existing theories and treatment approaches. The famous case of soldiers returning from the First World War with what was then called ‘shell shock’ captured the attention of clinicians just as did the problem of marriage breakdown, addictions, and career malaise after the Second World War. Up until the Second World War and apart from the wider field of pastoral care, most of the professional titles in mental health were linked to either medicine or psychology. After the Second World War the demand on mental health services increased enormously and to help meet the demand, the services of educational and guidance counsellors were enlisted. It was this demand that saw the emergence of counselling psychology and counselling as professions in their own right (Dryden, 1996).

One of the notable differences between mental health professionals is their different philosophical foundations. These different philosophical foundations can be identified in a variety of ways, but one such designation relates to the relative emphasis placed on the natural sciences. Medicine and clinical psychology rely principally on the natural sciences and on what is referred to as the scientist-practitioner model. Counselling psychology and counselling draw on a combination of humanistic philosophy and the natural sciences, and this combination of influences is sometimes referred to as the reflective-practitioner model.

Both scientist-practitioners and reflective-practitioners draw on knowledge from the natural sciences and from reflection on knowledge gained from clinical practice. The difference, it might be argued, is the relative emphasis placed on these knowledge sources (Blair, 2010; Douglas et al., 2016; O'Hara & O'Hara, 2015).

Counselling as Art and Science

One way of capturing the idea that counselling draws on both science and clinical experience is to say that counselling is a combination of *art* and *science*. In other words, to be an effective therapist working with a wide range of clients and presenting issues requires the practitioner to apply their scientific knowledge in a way that respects their own style and personality, and respects the needs and personality of the client and the specific contexts in which therapy is conducted. As human beings are so complex it is not uncommon to notice in clinical practice that a therapeutic strategy or intervention that was effective for one client is not effective for another even though the individual clients presented with the same 'problem' or symptoms. In fact, interventions used with one client for a defined problem may be effective one day and not another. In other words, while we know from research a great deal about neurobiology, personality, emotions, and human behaviour, the application of such knowledge requires a deep appreciation of the person in the moment, and in context. The awareness required here is an appreciation of *variability*. Counselling is as much about knowing *what* and knowing *how* as it is about knowing *when*. To put it simply, as counsellors we might know a lot about human functioning and psychological strategies but knowing how and when to apply them is quite another thing. The problem of *what, how* and *when* can only be adequately addressed when we appreciate the fact that counselling is really a combination of art and science. Albert Einstein well understood the combined significance of art and science when he stated,

> "After a certain high level of technical skill is achieved, science and art tend to coalesce in aesthetics, plasticity, and form. The greatest scientists are artists as well" (Einstein Archives, 33, 257).

Science and Evidence

A foundational principle of science is that evidence needs to be established to assert a claim about facts or truth. The means by which such facts are established is via the scientific method. Ideas gain the status of facts or even 'truth' when they can be verified. This is done by proposing hypotheses and testing to see if they stand up to scrutiny especially via re-test reliability. The scientific method has provided the world with wonderful insights into the workings of the nature and the universe. Having said this, the scientific method is not as straightforward as is often portrayed. One of the reasons for this is that there are so many variables that must be controlled to provide sufficient certainty that what the scientist thinks is causing an event is actually doing so. For example, due to the complexity of life, it is usually the case that there are many factors involved in any phenomenon. Recognising this reality researchers acknowledge the influence of mediating and moderating variables. In other words, while there may be a main or primary cause for a phenomenon, it might not be direct in its effect. For example, if we were exploring the effect of age on job satisfaction,

we might find that education level is a mediating variable. So, while we might say that age had a particular general effect on job satisfaction, this might not be as certain due to variability in education levels. Another important point to note about the veracity of evidence is that the scientific method recognises that there is no perfect one-on-one correspondence, that is, there is always the issue of variability. Hence, in statistics we always allow for a degree of error.

Types of Evidence

As science is one of the foundational planks of counselling and psychology, it is worth commenting briefly on the nature of evidence that science provides for the work of therapy. The type of evidence can be divided into two overarching categories, evidence about the *outcomes* of therapy and evidence about the *process* of therapy.

Outcome Research

People come to therapy with a wide range of presenting issues and conditions, and these range from what might be referred to as general life problems encountered by people to problems that are very serious, causing significant distress requiring skilful professional care. Presenting issues describing general life problems are usually highly amenable to resolution or at least to positive change. More serious problems usually require a longer process of recovery that is designed to meet the specific needs of the person. Whether the problem is of a more common or general nature or is a disruptive issue or disorder, all require an appropriate applied process of therapeutic engagement.

Outcome research essentially asks, "How effective was the therapy?" and potentially "What are the changes that occurred as a result of therapy?" These two questions can be asked at two levels: at the level of the individual and at the level of the population of people experiencing a similar problem or issue. Understanding the various outcomes of therapy is obviously very important to the profession because we want to know how effective therapy is and what strategies and processes work best for the problem change or resolution. While data from an individual case is valuable in this enterprise of understanding the relative effectiveness of therapy, it is data gained from large samples of the population that provide the most convincing evidence that the processes and strategies of therapy have been effective or not.

There are many different approaches to designing research with approaches reflecting the type of information sought. One way of framing or categorising designs that aim to provide information about outcomes is to divide approaches into two types: *correlational* and *experimental.* Correlational designs provide information about how different variables or factors are related to each other. For example, it would be helpful to know if people presenting with depression as opposed to those presenting with an anxiety condition are more or less likely to expect that therapy will provide a positive outcome. Similarly, we know that hope is a good predictor of likely progress in therapy and therefore identifying factors or strategies associated with the installation of hope would presumably support positive change.

An experimental design focuses predominantly on how variables influence each other. The researcher manipulates one variable (the independent variable) and observes the effect on another variable (the

dependent variable). For example, for someone presenting with panic disorder is it more effective to provide exposure experiences or to provide cognitive challenges to maladaptive thoughts? By applying different experimental conditions to a large sample of people with panic disorder we are likely to gain insight into the approach that works best.

Process Research

While outcome research does provide information about what is involved in delivering outcomes, it does not provide a detailed account of what is occurring in the specific processes active in producing these outcomes. For example, we may know that exposure therapy can be effective for certain anxiety conditions, but we may not know why exposure therapy is effective – we are largely blind to the actions involved. Process research aims to remedy this knowledge lack by seeking to understand the intricate actions and processes involved in the change process.

Counselling and psychotherapy researchers have developed a range of research methodologies designed to delve into the minute processes involved in human psychological functioning. This type of research is usually very detailed and typically enlists a much smaller number of research participants than outcome research due to the volume of data that results from such data gathering methods as interviews, demonstrations, and in-vivo experiences. The wonderful benefit of process research is that it has the potential to identify and explain why certain outcomes are produced in therapy.

Considering the Nature of the Self

It would not be surprising to suggest that a central focus of counselling psychology and counselling is 'the self' of the client. Our clients/patients come to us with a wide array of problems and issues, generally referred to as 'problems in living', and such problems obviously concern their person or self. Of course, at both philosophical and practical levels such a focus assumes we have a clear conception of what is 'the self'. The notion of the self has intrigued philosophers, theologians, psychologists, and other commentators for centuries. While we don't propose to solve this age-old question in this course, it is important, if we are going to be working in therapy with 'the self' of the other, to have some perspective on this fundamental question. To begin our considerations, it will be helpful to provide a brief overview of different views of the self. Later we will highlight key elements that we think it will be helpful for therapists to pay particular attention to.

One common way of beginning a discussion on the nature of the self is to ask the question, "Are you the same person today as you were ten years ago?" Of course, this is a trickier question than at first it might seem. This is because we can answer both 'yes' and 'no' to this question. If we say 'yes', we might cite an example of meeting a friend who we have not seen for years who immediately recognises us as the same person they knew years before. Equally, we ourselves or a close friend might say that 'no', we have actually changed in some way. Maybe we are less inclined to be impatient and now display an increased degree of tolerance not common to us in relationships previously. A key issue here is whether there is a central or

cohering self, that is, some dimension or structure that holds our continuity of being over time while still allowing for change. Obviously, our friend still recognises us not just physically but personally even after many years – something about our 'self' has stayed constant. Alternatively, if we emphasise the changes in us over time, we might argue that there no such coherent, stable self, rather a miscellany of multiple selves experiencing life as series of perceptions and events (Fonseca & Gonçalves, 2015; Gallagher, 2000; Metzinger, 2009).

In the Western history of ideas there are a range of views on the nature of the self. Ancient Greek philosophers such as Plato suggested that the 'true self' is the divine intellect or '*nous*'. This *nous* or eternal *form* was thought to be unified in its eternal state but could also be expressed materially. Plato thought that one of the ways to discern or explain the nature of something is to identify its 'telos' or goal or final purpose. For the human person this was the full emergence or expression of the divine/innate self. The Judeo-Christian understanding of the self has had a significant influence on Western thought. Such a view is founded on the belief that people are made in God's image and as such have a divine core or God-given essence. While the person does change and grow over their lifetime, it might be thought of as the progressive budding or flowering of the original essence that provided the potential for the full emergence of the self. Another influential theorist was Immanuel Kant who believed the self was that which provides transcendental (pre-existing) unity of thoughts and perceptions. In Kantian ethics the self is autonomous, consistent and free when it conforms to rational principles inherent in the universe (Kant, 1781). In different ways each of these early thinkers had a conception of the self that, at least in part, reflected the view that there is a soul or pre-existing *nous* which in some way imbued the life of material form. In other words, common to all of these views is a belief in an essential self of some kind.

With the emergence of the scientific revolution, and a shift from the predominance of rationalism (theoretical explanations) towards empiricism (evidence via measurable data), the focus shifted to exploring and explaining the natural world – matter. Intellectuals such a Descartes and Locke began to consider that rather than a soul or non-material eternal form that enlivens persons, it is consciousness that animates the physical being. Of course, this progressively led to the current focus on neuroscience and its explanations of consciousness.

Other approaches reject the idea of an essential or central self. For example, existentialists have largely taken the view that there is no essential self, rather a freely emerging self, based on our responses to our experiences. Satre was famous for the statement 'existence precedes essence', meaning that no foundational nature (essence) exists before experience and that we human beings through consciousness create our own values and meanings (Johnson, 1967). Postmodern thinkers in a somewhat different way reject the notion of essence as well, positing the idea of multiple selves. There are various approaches to understanding multiplicity. Social constructionists like Kenneth Gergen argue that self is really an amalgam of the social and cultural narratives one is surrounded by and integrates into one's consciousness in varying degrees. Other approaches focus on individual psychology, recognising that as we accumulate experiences we are continually changed. Hence, the self of the past is a different self to the present and different again in the future. Other postmodern variations on this theme agree that, while there are multiple selves, what has been erroneously perceived as a core self is not a substance or essence but a process, a process of organisation of the experiences of the multiple selves (Gergen, 2011; Radden, 2011).

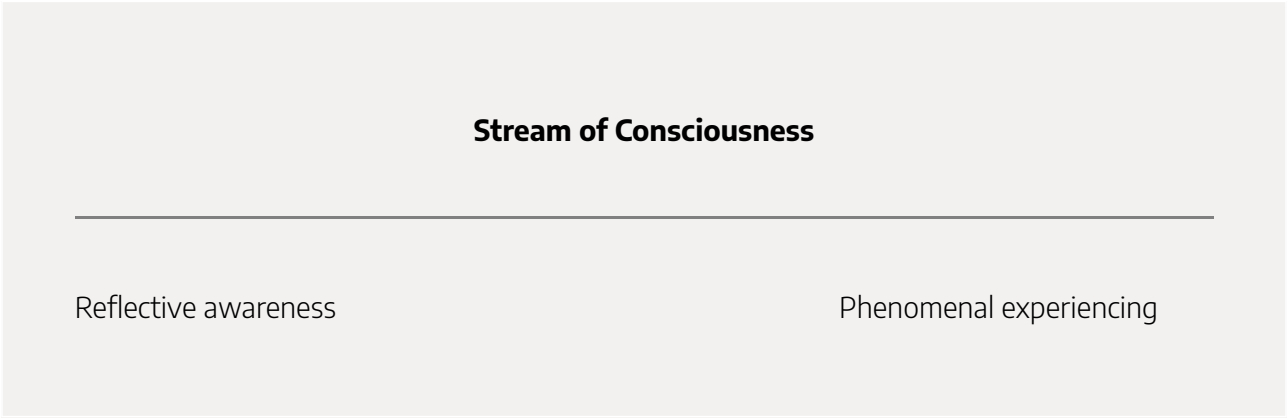
This very brief overview of the notion of 'the self' has focused on highlighting different definitions or views of what the self is and less on its function. Whether the self is conceived of as having some pre-existing or given essence or is principally an emergent set of processes, in everyday life we still do make reference to selfhood. While the language we use to refer to the self, such as true self, genuine self, or personality, may vary, we at the very least naturally hold a notion of 'the self'.

Self as Content and Process

People come to see a counsellor for two main reasons, psychological *support* and the facilitation of *therapeutic change*. The difference between support and therapeutic change is something we will explore later. However, whether our focus in counselling is support or change, it raises the question "What is being supported or changed"? Given our foregoing discussion, it is obvious that we are referring to the individual's self. The foci of *support* or *change* however, raise the question of not just 'what' but 'how'. How does a person gain support or enable psychological (life) change? Clearly when we consider the issues of support and change, we are interested in the dynamic processes of the self.

One of the first psychologists to delve into the nature and processes of the self was William James (1890). James said that the self was a 'stream of consciousness', an ever-flowing stream of experiencing. Experiencing here refers to both thoughts and images as well as subjective feeling states. James saw this flow of consciousness on a continuum between an experiencing self or 'phenomenal self' and a 'reflective self'.

Figure 1. *Stream of Consciousness*



This is an interesting conception of the nature and functions of the self as it highlights a continual movement between experiencing and awareness. In other words, while we are always in the process of experiencing being, whether that be in terms of bodily processes, emotional states, or nonconscious neurological and chemical processes, we only periodically become aware of some of these processes and thoughts. To only experience without awareness would be just as problematic as only being aware without experiencing.

James' approach to understanding the nature of self and consciousness also involves the idea of self as both *subject* and *object*. This reflects the view that there is a self that is both having an experience and a self that is reflecting on experience. James referred to the experiencing self as 'me' (objective self) and the reflecting self as 'I' (subjective self). Another way of thinking of this is to consider 'me' as the aspect of

self that is observed and identified by the outer world while the self as 'I' is my inner self or my conscious awareness of self (Wozniak, 2018).

At this point it is important to ask what has this got to do with counselling? The short answer is, quite a lot. To stimulate some early thoughts, consider the proposition that quite disturbed people – those for example, presenting to therapists with overly strong affect or whose thoughts are disturbing them or who cannot seem to control their social behaviour very well – might have a problem regulating the movement between experiencing and awareness. We have all had the experience of speaking with someone who talks non-stop, seemingly never really stopping to reflect on what they say or how it might affect the listener. It feels like they are living a 'stream of consciousness'. They are in the moment of experiencing without pausing long enough to reflect on their experience. In other words, life is their experience; that is, life is what they feel. If they feel it, it must be real or true. Now this is not to disparage feelings and emotions (we'll explore these more in later chapters). What we experience or feel, is central to being a human being. However, just as our experiences and feelings can overwhelm us, so too can our thoughts. When there is a lack of balance between the two, we tend to encounter 'problems in living'.

The Art of Listening

One of the central skills that effective therapists have is the ability to deeply listen. Listening is different from hearing. We may hear what a person says physiologically but not have listened. To hear is relatively automatic but listening is an active process. Research has confirmed that listening is a multidimensional process involving:

a. cognitive
b. affective
c. behavioural/verbal
d. behavioural/non-verbal
e. behavioural/interactive dimensions (Halone, et. al., 1998).

There are at minimum several key elements involved in listening. Barthes and Havas (1985) outline three levels of listening:

- alerting
- deciphering
- understanding.

In **alerting**, we are responding to cues in the environment like noise, light, and movement.

In **deciphering**, we are detecting patterns in the environment for the purpose of adding a level of meaning. For example, when we hear a car engine coming up the driveway, we know that a member of the family has returned home.

In **understanding** we go beyond interpreting to realising that what we say affects the other person. In

this respect, genuine listening requires us to suspend judgement on what the other is communicating so that we attend to and grasp what they are saying rather than what we presume they are saying.

Effective listeners have a developed ability to suspend their own need to interject unnecessarily so that the other has room to speak. While in many ways this all seems obvious, effective listening is surprisingly difficult to do.

These dimensions and elements of listening are present in any encounter between people, whether that be in the family, at work or socially. The same elements are present in counselling. One of the differences, though, in counselling is that the counsellor is paid to listen. In other words, they need to be really good at it. Without the ability to listen effectively, it is impossible to understand the nuances of the client's problem. Not only that, effective listening also involves making space for the other to speak. The 'making space' part of interpersonal communication is a challenging sub-skill to acquire. For example, when a counselling client comes into the room for the first time, how do we help them feel comfortable enough to begin telling their story? What do we do to support them in continuing the conversation? To what parts of the conversation do we pay particular attention? One way of developing our listening capability is to break down some of the skills of communication into manageable parts. Any communication is made up of sub-components which can be identified. This fact is very helpful for it enables us to practise and develop these sub-skills. There is a danger though, in breaking down communication into component skills. We can be distracted by the sub-skills leaving them separate and atomised without integrating them into a flowing coherent whole. A useful musical analogy is learning scales. Being able to play scales makes us technically proficient but it doesn't mean we can play a concerto. In the end playing a concerto requires technique joined with interpretation, form and feeling. One of the aims in this book is to help you to develop your communication skills so that you become a deep and active listener. We'll explore some of the sub-skills of communication but always with the view of integrating them in such a way that your communication and deep listening flows like a concerto.

Questions for Reflection

1. What would you say is the difference between incidental counselling and counselling? What are the problems in answering this question?
2. What would be an aspect of the practice of counselling that you would consider falls into the category of being an artist?
3. Effective therapy engages with the self of the other. What do we mean by that statement?
4. We all do something well in relation to communication. What are your best

communication skills? In what areas would you like to improve?

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://uq.pressbooks.pub/practice-counselling-psychotherapy/?p=5#h5p-2

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2.

COMMON AND SPECIFIC FACTORS OF CHANGE

Denis O'Hara

"We must accept finite disappointment, but never lose infinite hope." – Martin Luther King, Jr

Key Takeaways

This chapter introduces the notion of therapeutic change and some of the elements that support change.

- The research on common factors of change is provided and especially the idea that the 'common factors' undergird all psychological and behavioural change.
- Specific factors of therapeutic change are differentiated from common change factors but with a recognition that common and specific factors work together.
- A higher order level of change in the form of principles of change is identified.
- The importance of hope within the change process is addressed.

Introduction

People come to counselling for two main reasons: for s*upport* and for *psychological change*. While both these aims are important, they require a different application of skills. Providing support for counselling clients involves a range of processes and actions such as, listening deeply to individuals' concerns, providing emotional support, psychoeducation, and offering links with wider community services. Many people have not had the chance to receive proper support in their existing relationships. As a result, being empathically heard and understood by a therapist during therapy may be the first time they experience this. The opportunity to tell one's story and for it to be received compassionately is, in itself, a profoundly healing experience. However, as well as emotional support, clients often are seeking significant changes in their life. This change may be external in terms of their living situation, work environment, or in their relationships.

As well as external change, clients often seek internal change. People commonly come to counselling with the realisation that something about themselves needs to change. This usually involves a shift in their self-perspective or insight into life patterns that are not life-giving. The task for the therapist is to know how best to effectively support people in their life circumstances and to help facilitate personal change when it is sought.

Therapeutic Change

How do people change? This is the proverbial 64-million-dollar question. The short answer is, in lots of ways. Just as people are complex, so too is the change process. Multiple disciplines have sought to answer this question and as a result we have a great deal of understanding about the change process. Of course, understanding many aspects of the change process doesn't mean we always apply our knowledge effectively in the moment, but it does mean we have a solid base from which to embark on a change journey with our clients.

Academic research and theorising about the change process has resulted in the development of a wide range of psychological theories about human functioning. The twentieth century, in particular, saw the development of many theories that purport to provide a map of the change process. As these theories were being developed and applied, therapists tended to prefer certain theories over others. Hence, some therapists would describe themselves as either psychoanalysts, behaviourists, humanists, or social constructionists, among others. Therapists tended to be quite committed to their preferred theory often thinking that it was objectively the best explanation of human functioning and therefore of the psychological change process. This meant that where two people with essentially the same presenting problem sought help – one consulting a psychanalyst for example, and the other a behaviourist – it was likely that both practitioners would espouse the superior benefits of their own psychological theory. This commitment to a particular theory over others tended to result in turf wars and relative claims about the effectiveness of different approaches.

Interestingly, as research into psychotherapy progressed, by the late-middle twentieth century a curious phenomenon was observed by many researchers and practitioners. When research on psychological conditions, was conducted, (e.g. depression), researchers noticed that studies comparing the application of different theories to depressed clients often resulted in similar outcomes. Hence, a cohort of depressed people in a study applying cognitive behavioural therapy, gained similar outcomes as studies applying psychodynamic therapy. At first this was confusing as these therapies looked quite different in their respective strategies and processes. How could such different approaches result in similar outcomes?

Common Factors

As more and more similar findings emerged, researchers proposed that there must be elements of these different therapies that were common among them. While there were many differences between therapies, maybe there were more commonalities than was first thought. This proposition spurred research into these

potential 'common factors' of therapeutic change. Common factors research has now existed for over forty years and many factors common to the change process have been identified. The list of common factors is itemised slightly differently depending on the particular study. One early and influential writer, Jerome Frank (1963/1993) identified four essential common factors of effective psychotherapies:

1. an emotionally charged confiding relationship with a helping person;
2. a healing setting;
3. a rationale, conceptual scheme, or myth that provides a plausible explanation for the client's symptoms and prescribes a ritual or procedure for resolving them; and
4. a ritual or procedure that requires the active participation of both client and therapist and that is believed by both to be the means of restoring the client's health (pp. 40–43).

Another influential study by Michael Lambert (1992) also identified four similar common factors. These were:

1. extratherapeutic factors (or client factors);
2. the therapeutic relationship;
3. theory/technique;
4. hope and expectancy.

The recognition of the influence of common factors in therapeutic change was well captured in the humorous statement attributed to the dodo bird in Alice in Wonderland who said, "Everybody has won and all must have prizes". In other words, all bona fide theories, well applied, produce similar outcomes. While there is strong evidence for what is referred to as the 'Dodo Bird Effect', there remains unanswered questions regarding specific mechanisms of change whether they be more detailed aspects of recognised common factors or whether they are more specific in nature beyond what is common. In reality there are many common factors and these can be grouped in a variety of ways. Whether some of these factors are more efficacious when applied to specific presenting conditions or not is still under investigation. One study which sought to group an expanded collection of common factors into categories was conducted by Grencavage and Norcross (1990). They identified eight-nine common factors and grouped them into five categories:

- patient characteristics (e.g., positive expectations/hope, actively seeking help)
- therapist qualities (e.g., enhancing hope, empathic understanding)
- change processes (e.g., catharsis, the acquisition and practice of new behaviors)
- treatment structure (e.g., use of techniques or rituals and a healing setting)
- relationship elements (e.g., development of the alliance) (Grencavage & Norcross, 1990, p. 374; Eubanks & Babl, 2024).

As the field of psychotherapy has sought to further understand the mechanisms of psychological change,

these and other factors continue to be studied in depth. Hence, there have been a range of studies exploring what characteristics clients bring to therapy (Bohart & Tallman, 2000; Fuertes, 2022; Gelso & Kline, 2022; Holdsworth et al., 2014). The nature of the therapeutic relationship has been studied from many perspectives providing strong evidence that it is one of the most influential factors in the change process (Borden, 1979; Gelso, 2011, 2022; Horvath, 2009). While theory has been recognised as being less influential than was previously thought, it still is an important factor. New and existing theories continue to be developed, often with a focus on a particular population or set of conditions. Finally, as noted by Frank as early as the 1960s, hope for change is an influential factor and continues to be studied to better understand its effects in the change process (Larsen & Stege, 2010; O'Hara, 2013; Synder, 2002).

Specific Factors

While there is evidence for the action of common factors of therapeutic change, there remains debate as to whether certain presenting conditions require more than the application of common mechanisms of change. This view is conceptualised in two mains ways. The first is that certain conditions need a greater focus and application of existing common factors than others. For example, there is evidence that some presenting problems rely less on the therapeutic relationship than others (Zilcha-Mano et al., 2019). One could certainly imagine that for some practical problems encountered by mature and well-adjusted individuals the relationship factor is less so than for others who are less certain about themselves and who have encountered more traumatic experiences. The second way of conceptualising specific factors is to argue that the more dysfunctional the presenting problem, the greater the need for highly targeted interventions. An example of such a presentation is personality disorders. While therapists working with people who struggle with challenging symptoms, such as dissociation, high levels of emotional reactivity, and cognitive distortions, will certainly employ the common factors of change, they will also employ strategies that are highly specific to the situation, such as metabolised countertransference, behavioural activation or memory reconsolidation.

Common and specific factors have largely been considered as separate in nature and this has certainly been evident in the research. However, recently, there is recognition that rather than conceptualising these factors as separate, it is more useful and accurate to consider them to be mutually interacting. This makes intuitive sense as each person coming to therapy brings their own unique set of strengths and limitations and each presenting problem is experienced by people uniquely, requiring a tailored approach to meet each respective need (de Felice et al., 2019).

Principles of Change

Another variation on key mechanisms of change is that proposed by Goldfried (1980, 2019). In an attempt to acknowledge the common factors and specific factors, Goldfried proposed what might be regarded as a higher-order level of change in terms of principles of change. He proposed the following five common principles:

- fostering the patient's hope, positive expectations, and motivation;
- facilitating the therapeutic alliance;
- increasing the patient's awareness and insight (e.g., awareness of connections between thoughts, feelings, needs, actions);
- encouraging corrective experiences (i.e., encouraging patients to take risks and engage in new behaviors that lead to a shift in cognitions and emotions);
- emphasizing ongoing reality testing (i.e., helping patients to process corrective experiences and consolidate positive changes by recalibrating their expectations and self-views to be in line with their new reality).

The idea here is that no matter the therapeutic approach being employed, change will be dependent on the application of the above principles. How these principles may be applied will vary but that they are applied is essential to the change process.

The Importance of Hope

One of the recurring common factors is hope. The significance of hope is understandable, for without hope and an expectation that one's problem can either be resolved or improved, there would seem little benefit in seeking help. So, there is generally strong agreement that hope is an important factor in healing and change. One of the difficulties, though, with hope is that it is not always an easy concept or experience to grasp. What do we even mean by hope and what does it look like? This question takes on further significance when we consider not just individual differences but also cultural differences. Is the concept of hope a transcultural concept or is it considered differently in different cultures? It is beyond the scope of this book to explore this question in detail although it is worthy of note that in recent years hope has been the subject of cross-cultural research finding both transcultural features and unique cultural perspectives (Himmelberger et al., 2022; Zhang et al., 2023).

One comprehensive definition of hope is provided by Dufault and Martocchio (1985) who define hope as 'a multidimensional lifeforce characterized by a confident yet uncertain expectation of achieving a future good which, to the hoping person, is realistically possible and personally significant' (p. 380). In this definition we see that hope is an energy or lifeforce that moves us towards a future good. When we feel confused or depressed it is difficult to see the future in a positive light and a lack of a hopeful outlook tends to decrease our energy. It might be understood that this energy forms part of what in other contexts is referred to as personal agency. Agency is the belief that we have power to influence our life and the world around us.

Researchers have identified at least three different forms or types of hope. Nursing researchers have proposed two forms of hope: *generalised hope* and *particularised hope.* Similarly, psychology researchers identify two forms of hope referred to as *basic hope* and *goals focused hope* (Trzebiński & Zięba, 2004; Synder 2002). Generalised or basic hope is that foundational belief in the importance of trust in self, others, and the world. This is not a naïve trust but one gained through affirmative experiences leaving one with a positive view of life in which exploration and appropriate risk-taking are supported. Particularised hope

is a goal-focused hope in which future goals are set and pursued. According to Synder, goal focused hope involves setting clear goals, developing a range of routes or pathways towards these goals and also having motivation to achieve the goals. If any one of these three elements is missing, hope is limited. Sometimes our goals are blocked or at least are very difficult to achieve and at such times a basic or generalised hope provides comfort and a foundation for ongoing risk and exploration. Synder (2000) found that high-hope people have better mental health, have an ability to find a breadth of routes towards their goals, and tend to be more resilient when goal achievement is blocked.

O'Hara and O'Hara (2021) have proposed a third type of hope which they call *transformative hope*. Sometimes even though we have a solid psychological foundation of trust and therefore a positive life view, we can find our goals unattainable for reasons beyond ourselves or find ourselves in circumstances beyond our ability to directly control. In such situations it may not be the goals that have to be changed or the situation or circumstances but ourselves. In other words, sometimes our hope is founded on an inner change. This change may be found in a new way of relating to the insurmountable problem or a new way of seeing ourselves.

Implications for Practice

We believe that common and specific factors of therapeutic change should be considered as being mutually supportive and complementary. It is helpful to think of common factors as the bedrock of effective counselling practice to which we may add specific strategies depending on the need. Having said that, before we can consider the application of a particular therapeutic strategy, we must first join with the client to effectively hear their story and establish a solid therapeutic relationship. The following is a brief overview of key things to consider, especially in the early phases of therapy.

Establishing a Collaborative Stance

A collaborative stance is essentially the view that therapy is about the client and not the therapist, or clever psychological theories. It is quite a risk for a person to come to therapy as they don't know us and don't really know if we are going to be able to help them. It behoves us to respect the trust they place in us. We are more likely to be of service to our clients when we seek to join with them in a relational journey of exploration. While we as therapists have certain expertise, the client also has expertise in their own lives. If we approach clients with this recognition and respect for who they are and what they bring to therapy, we will possess an attitude of collaboration. A collaborative stance is evidenced in deep listening, joint problem definition and case formulation, and in empowering the other.

Facilitative Interpersonal Skills

Facilitative interpersonal skills (FIS) are those skills that therapists have and apply in establishing and maintaining the therapeutic relationship. They are considered to be different from general social skills

although overlapping. A key difference between social skills and FIS is that those with FIS are able to apply interpersonal skills in the immediate moments of therapy in an effective manner. FIS include the skills of verbal fluency, emotional expression, persuasiveness, hopefulness/positive expectation, warmth/acceptance/understanding, empathy, alliance-bond capacity, and alliance rupture repair responsiveness (Anderson, et al., 2019). A focus on FIS developed out of the concept of common factors with an expectation that therapists with greater FIS would be more able to develop and maintain a therapeutic relationship with clients and as such provide increased therapeutic outcomes. It is thought that FIS is a transtheoretical factor and as such contributes to better outcomes no matter the counselling theory being employed. Several studies have provided support for this view, demonstrating that therapists with high levels of FIS do tend to provide increased therapeutic outcomes (Anderson et al., 2016; Schöttke et al., 2017).

The research on FIS affirms the importance of developing FIS in counsellor training and throughout one's career. Considering the importance of FIS in achieving effective client outcomes, therapists—whether in training or already practising—would benefit from reviewing and refining their mastery of these skills.

Client Factors

Another issue to consider when working with people is what the individual, couple or group bring to therapy. People are a mix of natural strengths and limitations, and these can be evidenced in many forms. The following list is a sample of qualities that clients bring to therapy:

- Readiness for change
- Personality and attachment style
- Coping style
- Attitude towards therapy
- Culture
- Resilience
- Expectation
- Psychological mindedness
- Demographic characteristics (Cooper, 2008; Duncan et al., 2022)

One of our essential tasks as therapists is to pay close attention to these various client factors because we know that as we work with client strengths and limitations, the outcomes of therapy are likely to be more effective.

Reflective Questions

1. Consider your development of Facilitative Interpersonal Skills (FIS) and rate the level of skills as they currently stand.

Facilitative Interpersonal Skills

FIS	High	Good	Developing	Limited
Verbal fluency				
Emotional expression				
Persuasiveness				
Hopefulness				
Warmth/acceptance				
Empathy				
Alliance/bond capacity				
Alliance rupture repair				

2. When you think about therapeutic change and how you might practice as a therapist, what change process or pathway to change naturally comes to mind for you? Is that how change has occurred in your life?
3. Would you expect to work with a client presenting with intractable depression in the same way as another person presenting with depression that has only appeared recently for the first time. Why? What might you do differently?

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3.

AN INTRODUCTION TO NEUROBIOLOGY FOR COUNSELLORS

Kate Witteveen

"A healthy mind is a mind that creates integration within the body and its brain, and within relationships with other people and the planet" (Siegel, 2019, p. 229).

Key Takeaways

- An understanding of the brain, the nervous system, and the mind are foundational to the work of the counsellor.
- This understanding extends beyond the structure of the brain and nervous system, to how the various parts of the body and mind individually and collectively contribute to human experiences through the processing and interpretation of sensory information.
- Scientific advances are constantly updating our knowledge and understanding of the brain, so it is imperative that counsellors continue to engage with current literature.
- Integration within the individual, and between the individual and others, is a key indicator and facilitator of mental health and wellbeing.

Introduction

As counsellors, it is essential to have a working knowledge of brain and nervous system structure and function, because these have implications for all facets of our work with clients. As technological and scientific advances provide more clarity about the ways in which neurobiology intersects with all aspects of the human experience, it is crucial that we, as professionals, continue to remain informed about how an understanding of neurobiology can inform and enhance our professional practice (Gilbert, 2019).

When thinking about the brain and nervous system and their respective processes, it is reasonable to assume that the structures of the brain and the functions they perform are relatively well understood. To

some extent, this is correct, and we will be exploring precisely these structures and functions later in this chapter. However, it is also correct to note that our understanding of the ways in which these structures and functions are interconnected with one another, and with the individual's outer world, is continuously expanding (Poeppel & Idsardi, 2022; Siegel, 2020).

This expansion of knowledge is contributing to not only understanding what is happening within the individual, but also what is happening between separate individuals when they are in communication with one another. As counsellors, it is this interconnectedness of the inner and outer experience that is foundational to our practice, and thus, ensuring we have a foundational knowledge of neurobiology is crucial to our capacity to continue to develop our ability to provide effective support to our clients (Hertenstein et al., 2021).

Our understanding of neurobiology and its influence on counselling necessarily begins with a consideration of the basic structure of the brain and nervous system. In the next section, we will learn about the macro-structure of the brain and the functions associated with each structure. We will do this, however, keeping in mind that none of these structures are solely responsible for any given function, and there is increasing evidence to suggest that it is the connections between structures (Smith et al., 2015), and the integration of the inner and outer environments that are the greatest contributors to our experiences (Siegel, 2020), as opposed to the structure or function of any individual area of the brain. We will begin our exploration of neuroanatomy with an introduction to the nervous system.

Theoretical/Conceptual Foundations

The Nervous System at a Glance

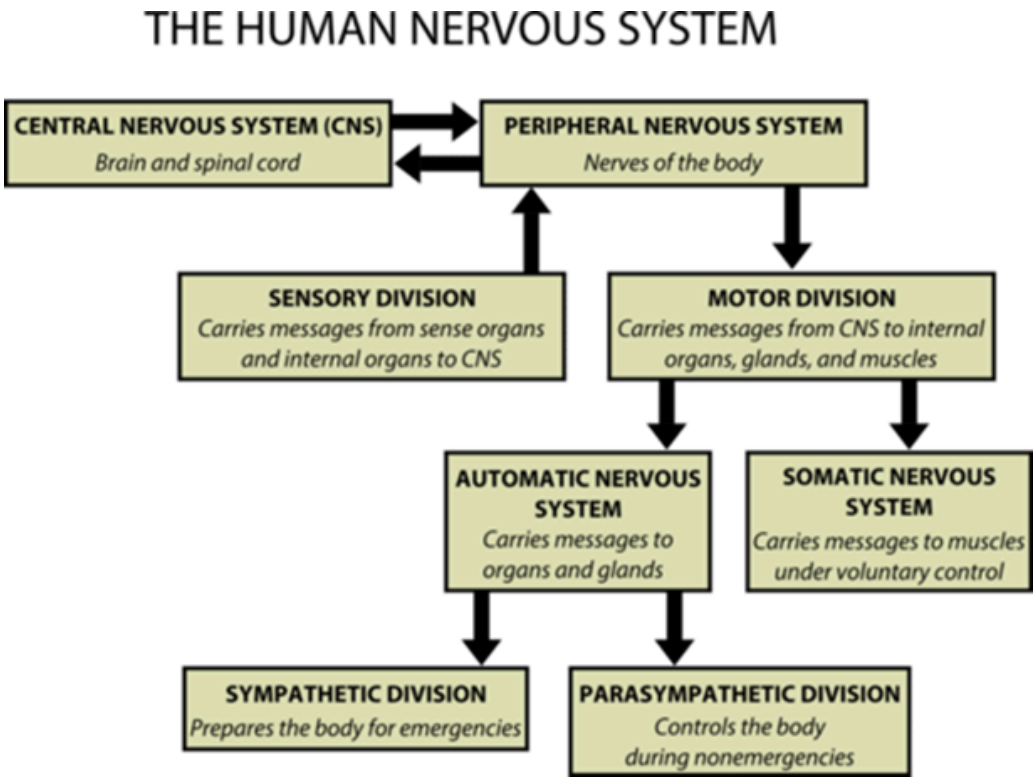
The nervous system is comprised of several complementary yet distinct subsystems which, together, are responsible for the functioning of the body. A detailed account of the nervous system is beyond the scope of this chapter, but we will consider a brief overview of the basic structure and function of the nervous system, as a foundation for understanding how it is implicated in the counselling process. If you are interested in a more thorough explanation of the nervous system, you may like to consult Bazira (2021).

At a macro level of organisation, the nervous system is comprised of two subsystems, namely the central nervous system (CNS) and the peripheral nervous system (PNS). Together, the brain and the spinal cord form the CNS, while the PNS is comprised of all of the other nerves within the body. The PNS serves as the connection between the CNS, the rest of the body and the external environment, and is responsible for sensory and motor functioning. Within the PNS, the somatic nervous system controls voluntary movements, and the autonomic nervous system is responsible for involuntary functions. (Waxenbaul et al., 2023)

The two subsystems within the autonomic nervous system include the sympathetic nervous system, which is responsible for responding to stimuli that could represent a threat (the fight, flight, freeze or fawn response) (Sherin & Nemeroff, 2011), and its complementary subsystem, the parasympathetic nervous

system which returns the body to homeostasis when the threat has passed (the so-called rest and digest function) (Waxenbaul et al., 2023). The structure of the nervous system is depicted in Figure 1 below.

Figure 1. *The Human Nervous System*



"The Human nervous system", by Laura Guerin, CK-12 Foundation, licensed under a Creative Commons Attribution-NonCommercial 3.0 licence

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://uq.pressbooks.pub/practice-counselling-psychotherapy/?p=41#h5p-19

We will revisit the nervous system later in this chapter when we learn about Polyvagal Theory (Porges, 2022; Porges et al., 1994) and Interpersonal Neurobiology (Siegel, 2020) as frameworks that are helpful for understanding the implications of neurobiology for mental wellbeing generally, and counselling more specifically. For now, you are encouraged to spend a few moments familiarising yourself with the overall structure and general functioning of the nervous system, as this is foundational to the remainder of this chapter.

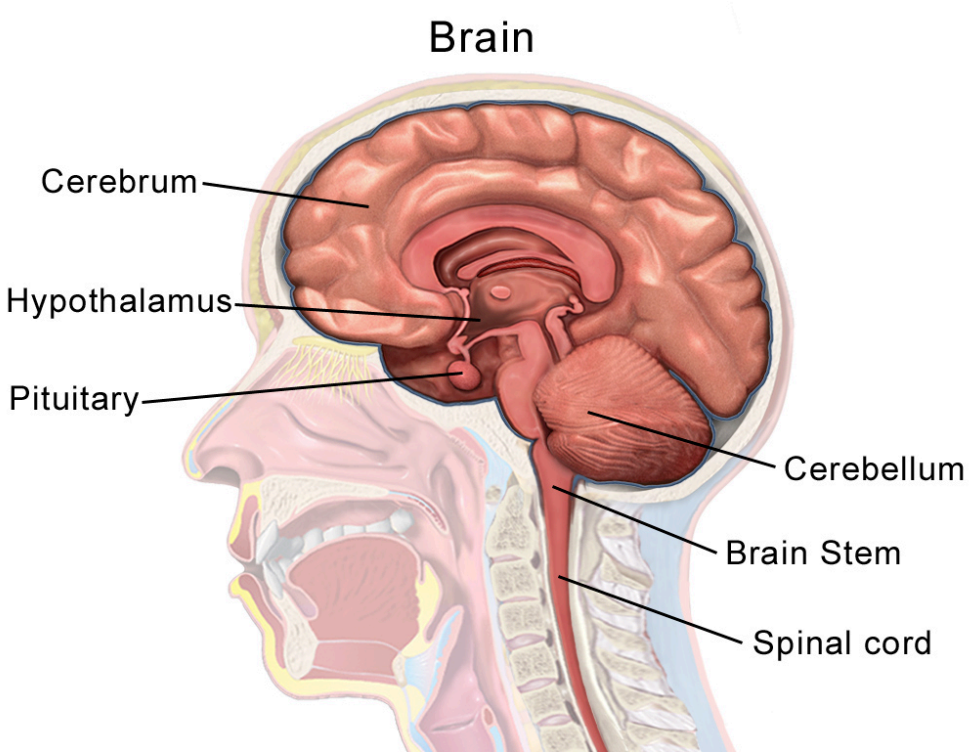
Macro-anatomy of the Brain: Brain Stem, Cerebellum, Cerebrum and Cerebral Cortex

The brain stem, which is located at the base of the skull and connects to the top of the spine, is responsible for the basic functions associated with being alive, namely breathing and heart rate (Maldonado &

Alsayouri, 2023). The cerebellum is located just above the brain stem and is implicated in coordinating movement, balance, vision, and the acquisition of motor skills (Jimsheleishvili & Dididze, 2023).

The cerebrum is the largest part of the brain, and is responsible for many functions, including conscious thought, processing sensory input, language, memory, movement, learning and emotions (Bui & Das, 2023). The cerebrum is divided into the left and right hemispheres and contains the lobes of the brain. The outer layer of the cerebrum is the cerebral cortex, which consists of folds (sulci) and raised areas (gyri) which give it a wrinkled appearance (Maldonado & Alsayouri, 2023). The brain stem, cerebellum, cerebrum, and cerebral cortex are depicted in Figure 2 below. Although not labelled, the cerebral cortex is depicted as the surface area of the cerebrum.

Figure 2. *Brain Anatomy*



Left and Right Hemispheres and Hemispheric Lateralisation

As previously identified, the cerebrum is comprised of two hemispheres (left and right) which are connected to one another by the corpus callosum. Integral to our understanding of the brain is the concept of hemispheric lateralisation, which relates to the recognition that each hemisphere is implicated in different ways of processing information (Rogers, 2021). Historically, it was believed that brain asymmetry and lateralisation were unique to humans, but it is now understood to occur in other species and to have identifiable evolutionary benefits (Güntürkün et al., 2020), including more efficient and effective cognitive processing capacity (Rogers, 2021).

Although there are multiple approaches to conceptualising, identifying, and explaining the ways in which the hemispheric lateralisation of the brain informs information processing, there is general agreement that the left hemisphere is associated with skills such as language, logic and mathematical

functions, and the right hemisphere is associated with visuospatial and creative functions (McHenry et al., 2013). However, it has been suggested that this delineation of hemispheric functions is overly simplistic (Ross, 2021), and that it may be useful to conceptualise the different functions as relating to specificity and focus (left hemisphere) and breadth and flexibility (right hemisphere) (McGilchrist, 2010).

For our purposes, it is helpful to recognise that the two hemispheres appear to engage in distinct yet complementary information processing approaches that are communicated cross-laterally by the corpus callosum (McHenry et al., 2013). This cross-lateral communication has been identified as an important mediator of mental health outcomes (Siegel, 2019), and the corpus callosum appears to be highly vulnerable to adverse events, particularly during early developmental periods (Teicher et al., 2004). Taken together, these findings suggest that, irrespective of the specific hemispheric lateralisation of functions, cross-lateral communication is critical to mental health, and the size and functioning of the corpus callosum is crucial to all aspects of information and emotional processing (Siegel & Drulis, 2023).

Lobes of the Brain

In addition to being divided into the left and right hemispheres, the cerebrum is further divided into four lobes, namely the occipital, parietal, temporal and frontal lobes. Each lobe has a left and right structure, contained within the two hemispheres (Maldonado & Alsayouri, 2023). The occipital lobes are located at the back of the skull, just above the brain stem. The occipital lobes contain the primary and secondary visual cortices and are involved in visual processes (Rehman & Al Khalili, 2023). Brain imaging has also shown that the occipital lobes are active during dreaming (McHenry et al., 2013).

The temporal lobes are located at the sides of the skull. Both the left and right temporal lobes are implicated in learning, with the left temporal lobe emphasising verbal learning and the acquisition of language, and the right temporal lobe more involved in learning non-verbal information and interpreting facial expressions (Patel et al., 2023). There are several structures within the temporal lobes that are implicated in cognitive and emotional processing and are thus particularly relevant for counsellors.

For example, the hippocampus is important in the creation of declarative memories, and the amygdala is involved in various key functions including the processing of emotionally laden stimuli (including fear, aggression, reward processing and motivation) (Patel et al., 2023). While acknowledging that the functions of the hippocampus and the amygdala are highly sophisticated and nuanced, if we accept the basic premise that the hippocampus is involved in memory and the amygdala is involved in emotion, it is unsurprising to learn that these two parts of the brain are implicated in a range of psychiatric diagnoses, including addiction and post-traumatic stress disorder (Patel et al., 2023).

The parietal lobes are located above the temporal lobes and behind the frontal lobe. These areas are involved in the perception and integration of sensory information and generating responses to stimuli (Dziedzic et al., 2021). The parietal lobe is responsible for assessing where you are in relation to other objects (proprioception), as well as perceiving temperature, pressure, vibration, and pain (Jawabri & Sharma, 2023).

Finally, the frontal lobes are located at the front of the skull. As the most recently evolved part of the brain, the frontal lobes are responsible for higher order cognitive functioning, such as reasoning, logic,

problem-solving, decision making, attention, intelligence, motor functions and other voluntary behaviours (Collins & Koechlin, 2012). Firat (2019) proposed a hierarchical model to describe the ways in which the frontal lobe influences human behaviour and social connectedness. The levels within that hierarchical model include:

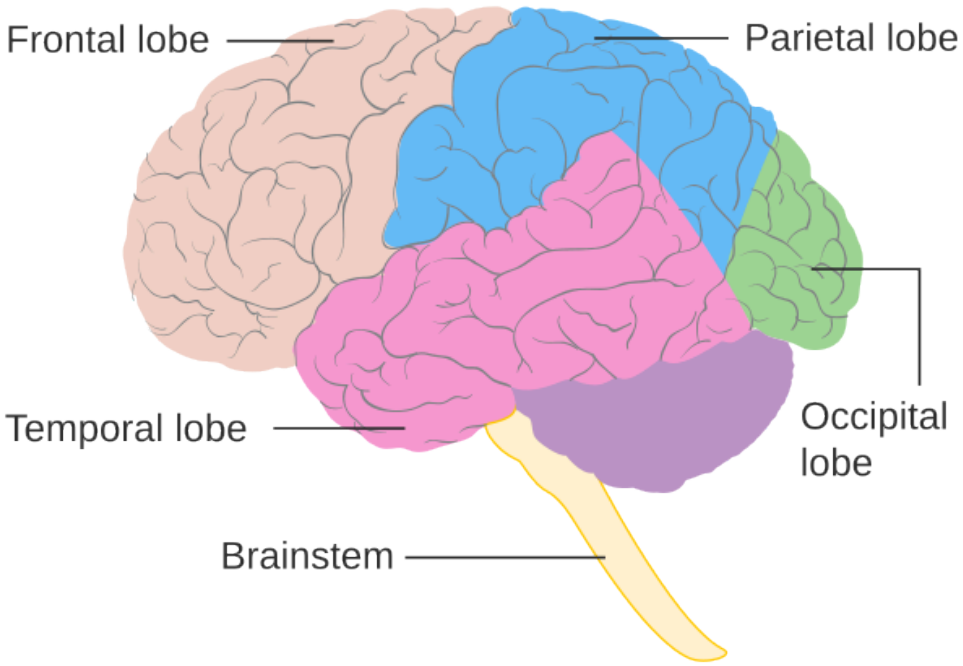
(a) Voluntary, controlled behaviour including motor functions;

(b) Motivation and emotional regulation; and

(c) Higher-order executive functioning.

The location of each of the lobes of the brain can be seen in Figure 3 below.

Figure 3. *Lobes of the Brain*



The Limbic System

The limbic system is a group of structures that collectively regulate behaviour, emotions, memories. The limbic system recognises threats and activates the autonomic nervous system to respond to those threats. As described by Kaushal et al. (2024), the main structures and functions of the limbic system are:

Hypothalamus

The hypothalamus links the nervous system and the endocrine system and is involved in maintaining homeostasis. Like a thermostat, the hypothalamus regulates the body's functioning such as body temperature, blood pressure, hunger and thirst, mood and sleep. The hypothalamus functions by creating hormones or signalling to the pituitary gland that hormones need to be released. It is part of the stress response system known as the HPA-axis, which we will discuss in a moment.

Thalamus

The thalamus processes sensory information (with the exception of smell) and contributes to memory, planning and emotions. The thalamus can be likened to a postal service sorting centre, where the information packages are received (in the form of sensory inputs) and distributed to the relevant address/location in the brain for action. The thalamus is involved in relaying sensory and motor information, prioritising attention, the awake/sleep cycle, thinking and memory.

Amygdala

The amygdala is involved in various key functions including the processing of emotionally laden stimuli (including fear, aggression, reward processing and motivation). The amygdala plays an important role in detecting danger and is essential to survival. Among other functions, the amygdala contributes to the connection of memories and emotions.

Hippocampus

The hippocampus is important in the creation of short-term and long-term declarative, visual-spatial and verbal memories, and is foundational to the ability to learn. The hippocampus works with the amygdala in the connection of emotions to memories.

When we consider that the hippocampus is involved in memory and the amygdala is involved in emotion, it is unsurprising to learn that these two parts of the brain are implicated in a range of psychiatric diagnoses, including addiction (Fang et al., 2022) and post-traumatic stress disorder (Kamiya & Abe, 2020).

Pituitary Gland

Known as the "master gland", the pituitary gland is responsible for the creation of a number of different hormones including adrenocorticotropic hormone (ACTH) which tells the adrenal gland to make hormones. This process occurs when threats are detected, and forms part of the HPA-axis.

The HPA-Axis

The HPA-axis is comprised of the hypothalamus, pituitary gland and the adrenal glands. When a threat is detected by the autonomic nervous system, the hypothalamus releases corticotrophin releasing hormone (CRH). This is the signal for the pituitary gland to release ACTH which, in turn, signals to the adrenal glands to release cortisol (the stress hormone) (Herman et al., 2016).

In a typically functioning nervous system, the release of cortisol serves as a negative feedback loop, signalling to the hypothalamus to stop the production of CRH, and allowing the parasympathetic nervous system to restore homeostasis. In individuals who have experienced prolonged stress or adversity, this negative feedback loop may become impaired, and the sympathetic nervous system response continues unnecessarily (Juruena et al., 2021). HPA axis dysfunction can have significant health consequences,

including immune system dysfunction and inflammation, as well as mental health conditions such as mood disorders and PTSD (Haahr-Pedersen et al., 2020).

This consideration of the anatomy of the brain has been intentionally brief and simplified. The purpose of this section was to introduce you to the macro-anatomy of the brain, together with some of the general functions associated with the various regions of the brain. If you are interested in learning more about how neuroanatomy and neuroscience inform counselling, you may find the text by Wilson (2014) of interest.

Helpful hint. An easy way to remember the location and function of the parts of the brain is to consider the evolutionary development of the brain. As a general principle, the more primitive structures associated with basic functioning are located at the back of the skull, and the more evolved structures that are associated with higher-order functions are located at the front.

The Brain: Other Key Characteristics that are Foundational to Therapy

Many historical theories of human development emphasised the growth and development of the brain across childhood and adolescence, with less consideration given to changes that may occur in adulthood (Babakr et al., 2019). However, understandings of brain development across the lifespan have changed dramatically, as innovative technologies have expanded and enhanced the ways in which we can measure brain structures and monitor brain activity (Mateos-Aparicio & Rodriguez-Moreno, 2019).

A pivotal finding that has influenced all disciplines interested in the study of the brain, is the ability of the brain to adapt and change, known as neuroplasticity (Fuchs & Flügge, 2014). Of particular importance were early imaging studies which identified patterns of neuronal death associated with illnesses such as Parkinson's and Alzheimer's disease, but also the growth of new neuronal pathways, known as neurogenesis (Kuhn et al., 2001).

In the early 2000s, studies began to emerge which suggested that, rather than being complete by the conclusion of adolescence, the brain continued to grow and develop in young adulthood, culminating in a 'mostly' fully developed brain, as operationalised by the development of the prefrontal cortex, by the age of 25 (see, for example, Arain et al., 2013; Tierney & Nelson, 2009).

However, recent data have emerged that suggests the brain continues to change across the lifespan, to a much greater extent than previously believed (Bethlehem et al., 2022). For example, a seminal study conducted by Bethlehem et al. (2022) examined an aggregated sample of 123,984 MRI scans from 101,457 participants, ranging in age from 115 days post-conception to 100 years of age. This extensive data set indicated that, although there was less evidence of neuroplasticity in older adults compared to younger adults, the brain continued to exhibit neuroplasticity across the lifespan.

When considering the location and type of neuroplasticity observed in older adults, it was proposed that the apparent reduction in neuroplasticity across middle and older adulthood could be a product of neuroplasticity becoming more strategic, rather than a diminished ability of the brain to adapt (Bethlehem et al., 2022). These findings are very recent, and this is a rapidly expanding body of knowledge, which will undoubtedly continue to evolve in the coming years.

For our purposes, the key implication of this section is that the brain continues to be impacted by the individual's environment and life circumstances across the lifespan (Glasper & Neigh, 2019) and neuroplasticity and neurogenesis do not cease at the age of 25 (Bethlehem et al., 2022). These characteristics of the brain are foundational to the work of therapy (McHenry et al., 2013), as they inform our conceptualisation and understanding of our clients' situations, as well as the opportunities for meaningful intervention.

Although there are identifiable periods of sensitivity that may render individuals more vulnerable to negative impacts of adverse circumstances (Siegel, 2019), there are measurable changes in the structure and functioning of the brain that can occur as a result of a range of experiences and circumstances right across the lifespan (Akil & Nestler, 2023; Gonda et al., 2022; Thumfart et al., 2022). As such, adverse experiences do not simply result in subjective feelings of distress and, equally, therapy does not simply help individuals to subjectively feel less distressed. Rather, both the adverse events and the therapeutic interventions have the capacity to alter the individual's neurobiology (see, for example, Petrocchi & Cheli, 2019). Some potential mechanisms for this impact are proposed by two theories we will consider in the next section, namely Polyvagal Theory (Porges et al., 1994; Porges, 2022) and Interpersonal Neurobiology (Siegel, 2020).

A Framework for Understanding the Connection Between Neurobiology and Counselling

A substantial body of literature has established relationships between adverse experiences and measurable changes in the structure and functioning of the brain (Hosseini-Kamkar et al., 2023). These findings provide evidence of the effect of the external environment on an individual's neurobiology. Further, there is also evidence to suggest that an individual's neurobiology has quantifiable impact on their external environments, including their relationships with others (Siegel & Drulis, 2023).

A number of theories have been developed to account for these bidirectional relationships. In this section, we will examine two influential theories that provide complementary frameworks for explaining the mechanisms by which an individual's inner and outer experiences are mutually influencing. These theories are Polyvagal Theory as proposed by Porges (1994) and Interpersonal Neurobiology as proposed by Siegel (2020).

Helpful hint. You may recall that earlier in this chapter, we considered an overview of the nervous system. That overview of the nervous system is foundational to the following sections, so you may like to refresh your memory about the structure and function of the nervous system before proceeding to the next section.

Key Principles

So far in this chapter, we have explored the macro-structure of the brain and its associated functions. We will now briefly consider two major theories that describe the mechanisms by which our nervous systems influence our experiences and interactions with others, namely Polyvagal Theory and Interpersonal Neurobiology.

Polyvagal Theory and Interpersonal Neurobiology share an emphasis on explicit and measurable relationships between neurobiological functioning and wellbeing. They also provide helpful insights into the ways in which our understanding of neurobiology can inform our counselling practice. A comprehensive exploration of these theories is beyond the scope of this chapter. However, in the following sections we will introduce some key principles associated with these theories to illustrate how they are helpful in making the link from neurobiology to the counselling context.

Polyvagal Theory

Polyvagal Theory has its foundations in neurobiology and neurophysiology. It is a multifaceted theory which offers (a) a descriptive model of the mammalian nervous system; and (b) a series of hypotheses which have the potential to contribute to enhancements of mental and physical health (Porges, 2021). In its simplest form, and most relevant to counsellors/therapists, Polyvagal Theory provides an explanatory framework for the mutually influencing relationships between perceptions of safety, neurophysiological functioning, emotional responses, social interactions, and physical and psychological health outcomes.

Foundational to Polyvagal Theory is the idea that, rather than safety being a subjective experience, "feelings of safety have a measurable underlying neurophysiological substrate" (p. 2). These feelings of safety are the result of the subjective interpretation of nervous system indicators derived from internal and external cues, which can be understood within a hierarchical model of self-regulation (Porges et al., 1994).

The hierarchy of safety cues begins with internal neurophysiological processes and progresses to the evaluation of external cues (Porges, 2022). The processes of neuroception and co-regulation are fundamental to this hierarchical model and represent key concepts within Polyvagal Theory (Porges et al., 1994). Together, the concepts of a hierarchical system, neuroception and co-regulation help to explain the relationship between neurophysiology and emotional and behavioural outcomes, as follows:

1. **Hierarchy of the autonomic nervous system** – In states of autonomic nervous system arousal, access to higher brain centres (i.e. the prefrontal cortex) is reduced, in favour of the mechanisms responsible for managing the perceived threat to survival (i.e. the limbic system). In this way, we lose our capacity to problem solve and regulate our emotions effectively when our autonomic nervous system is in a state of mobilisation or immobilisation. It is not until the nervous system is returned to homeostasis that we can access those higher centres and engage meaningfully in social interactions.
2. **Neuroception** – According to Polyvagal Theory, neuroception is an unconscious process whereby the autonomic nervous system scans the inner and outer environment to identify risks (Porges, 2009). This discernment of risk is communicated instantaneously through the nervous system, and influences behaviour, thoughts, and feelings without conscious awareness.
3. **Co-regulation** – When two people are in communication with one another, each holds the capacity to influence the nervous system arousal of the other. In Polyvagal Theory, this mutually influencing process is known as co-regulation. Our social engagement system enables us to send messages of threat or non-threat to others via our facial expressions, movements, and vocal intonations.

Table 1 provides an overview of the hierarchical model of self-regulation, proposed by Porges (1996).

Table 1. *Hierarchical Model of Self-Regulation*

Level	Processes
Level I	Neurophysiological processes characterised by bidirectional communication between the brainstem and peripheral organs to maintain physiological homeostasis.
Level II	Physiological processes reflecting the input of higher nervous system influences on the brainstem regulation of homeostasis. These processes are associated with modulating metabolic output and energy resources to support adaptive responses to environmental demands.
Level III	Measurable and often observable motor processes including bodily movements and facial expressions. These processes can be evaluated in terms of quantity, quality, and appropriateness.
Level IV	Processes that reflect the coordination of motor behaviour, emotional tone, and bodily state to successfully negotiate social interactions. Unlike those of Level III, these processes are contingent with prioritised cues and feedback from the external environment.

Note. From "Physiological regulation in high-risk infants: A model for assessment and potential intervention" by S. W. Porges, 1996, *Development and Psychopathology*, *8*(1), p. 52. (https://doi.org/10.1017/S0954579400006969). Copyright 1996 by Cambridge University Press. Reprinted with permission.

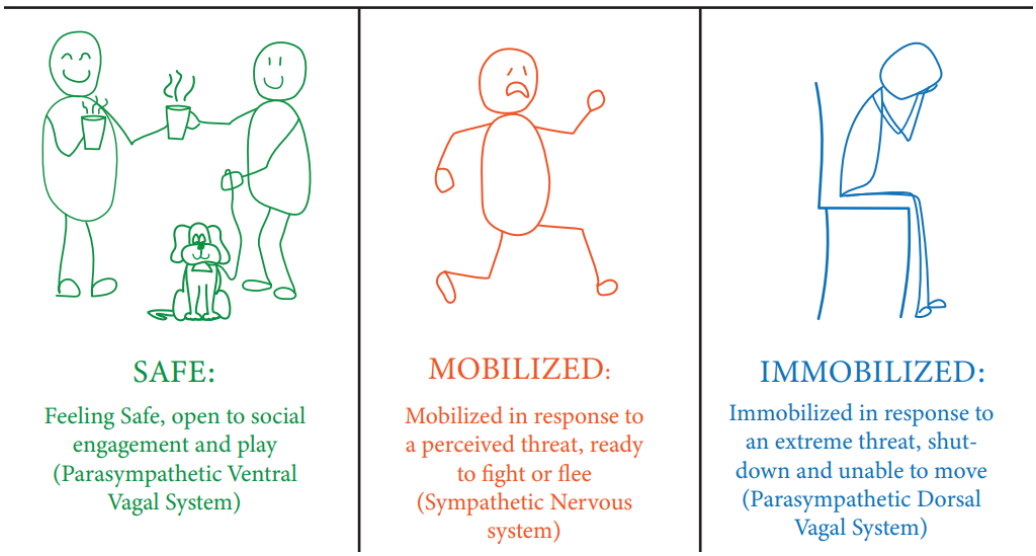
According to Polyvagal Theory, the interpretation of the cues attained from each of the levels in the hierarchical model of self-regulation result in three main response states, as follows:

1. **Fight-or-Flight/Mobilisation** – occurs when a threat is perceived.
2. **Collapse/Immobilisation** – is associated with feeling numb or disconnected from the external environment in situations of overwhelm or powerlessness.

3. **Social engagement/Ventral vagal** – occurs when we feel relaxed and open to social interactions.

Figure 4 depicts these responses and the physiological and emotional states associated with them.

Figure 4. *Polyvagal Theory Responses*



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https://uq.pressbooks.pub/practice-counselling-psychotherapy/?p=41#h5p-18

Implicated in these responses is the **vagus nerve** (also known as the tenth cranial nerve), which facilitates rapid communication between the brain and organs (Porges et al. 1994). The vagus nerve is involved in key functions related to these response states, including regulating heart rate, breathing, digestion, and emotional responses. Measurable differences in vagal nerve tone have been associated with each of the response states (Porges et al. 1994) and there is a growing body of research evaluating the effectiveness of vagal nerve stimulation for a range of health conditions, including physical and psychological disorders (Goggins et al., 2022; Porges, 2023). We will explore the implications of Polyvagal Theory for counselling practice in a subsequent section.

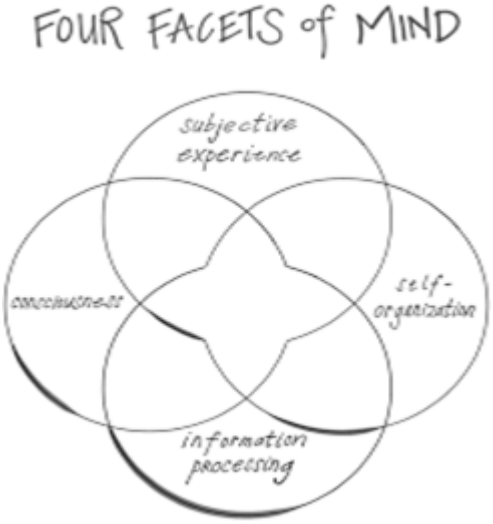
Interpersonal Neurobiology

Interpersonal Neurobiology (Siegel, 2020) can be understood as a conceptual framework influenced by many disciplines that informs and advances understanding of mental and physical health and wellbeing. Interpersonal Neurobiology incorporates influences from several disciplines, including mathematics, physics, biology, psychology, linguistics, sociology, and anthropology (Siegel, 2019).

Foundational to Interpersonal Neurobiology is the question, "What is the mind?" and, drawing from a range of disciplines, it is proposed that energy is the basis of the mind (c.f. the structure of the brain). Further, Interpersonal Neurobiology purports that the mind can be considered both a conduit and a constructor of energy flow. Energy may take the form of sensory inputs or information (energy with meaning) and is the delivery mechanism of intra- and inter-individual communication. (Siegel, 2019)

Models of the mind derived from other disciplines have typically included three elements: subjective experience, consciousness, and information processing. A key addition of the conceptualisation of the mind as presented by Interpersonal Neurobiology is the idea of self-organisation (Siegel, 2019). According to Interpersonal Neurobiology, self-organisation relates to the capacity of the system to optimise its own functioning by responding to cues (i.e. energy) received by the system. An effective self-organising system is capable of integration, which is the process of accommodating the simultaneous differentiation of, and linking between, separate parts of the system. The four facets of the mind, as proposed by Interpersonal Neurobiology are represented in Figure 5.

Figure 5. *The Four Facets of the Mind*



Note: "The multifaceted mind" from "The mind in psychotherapy: An interpersonal neurobiology framework for understanding and cultivating mental health" by D. J. Siegel, 2019, *Psychology and Psychotherapy: Theory, Research and Practice*, *92*(2), p. 228. (https://doi.org/10.1111/papt.12228). Copyright 2019 by The British Psychological Society. Reprinted with permission.

This model suggests that the mind can be best understood as a system that is comprised of four facets, which relies on the flow of energy (in the form of sensory inputs and information) for its function. Pivotal to that system is its capacity to organise and act upon those energy inputs in meaningful ways. Interpersonal Neurobiology hypothesises that integration, whereby the elements of the system are simultaneously differentiated from one another and linked in meaningful ways, is the mechanism by

which self-organisation is possible. According to Siegel (2019), "If the mind is, in part, the emergent self-organising process that regulates the flow of energy and information, then integration would be the mechanism of a healthy life" (p. 229).

Further to this, Siegel and Drulis (2023) propose that integration is a key indicator of mental health. When the mind adapts and incorporates energy inputs reflexively and in ways that sustain self-organisation, that system (including the body and the mind) is optimised for healthy functioning. When integration is not effective, and the processing of energy inputs is either too rigid or too chaotic, poor health ensues. Siegel (2019) proposes that many diagnostic categories within the Diagnostic and Statistical Manual of Mental Disorders (DSM) can be understood through the lens of rigid or chaotic (and therefore ineffective) attempts at integration.

The hypothesis that integration is a mechanism for optimising health has been found to be a helpful framework for understanding the health of the mind, body, and brain on an intrapersonal level. It has also been extended as a mechanism for optimising health in relationships, communities, and even in the context of the planet's ecosystems (Siegel & Drulis, 2023). A growing body of evidence also supports the utility of integration as a framework for understanding the aetiology and presentation of a range of disorders (Zhang & Raichle, 2010) and as an explanatory mechanism for some of the quantifiable impacts on the brain that have been observed in the aftermath of adverse life events, such as developmental trauma (Teicher et al., 2003; Teicher et al., 2004; Teicher et al., 2016; Teicher et al., 2020).

Taken together, these studies indicate that, in addition to structural anomalies in the brain being associated with psychiatric diagnoses, there is evidence of reduced connectivity between brain structures, which can be understood as disrupted or failures of integration. This disrupted integration can account for trauma-related sequelae, such as explicit memories being absent or fragmented while implicit memories may be intrusive and impactful on functioning (Siegel & Sieff, 2015). In this context, it can be inferred that there was a lack of integration between the parts of the brain responsible for encoding the explicit memory and the parts of the brain that encoded the emotional experience (Siegel, 2019). Further support for the hypothesis that integration is a helpful mechanism for understanding healthy and unhealthy functioning can be found in the conclusions of the Human Connectome Project, which identified the interconnectedness of the brain was associated with every measure of wellbeing included in that study (Smith et al., 2015).

Implications for Practice

In our preliminary consideration of the macro-anatomy and functioning of the brain and nervous system, together with an introduction to Polyvagal Theory and Interpersonal Neurobiology, we have learned some key principles that demonstrate measurable links between an individual's neurobiology and their inner and outer experiences. Together, this body of knowledge suggests a range of implications for how we can engage meaningfully and supportively with our clients in a therapeutic context. Although it could be suggested that this knowledge is relevant to all aspects of the counselling process, a few key implications will be noted below.

Cultivating Connection

By identifying the mechanisms by which neurobiology influences, and is influenced by, the external environment, we can appreciate the importance of monitoring our own nervous system activation, as well as that of our clients'. Recognising that the ideal state for meaningful engagement, as identified by Polyvagal Theory, is social engagement/ventral vagal, we can take steps to ensure that, prior to each session, our neurobiology is aligned, to the greatest extent possible, with this state.

Consistent with the basic tenet of Interpersonal Neurobiology that energy is the mechanism by which all inner and outer experiences are conveyed, we can acknowledge that the energetic exchange that occurs between client and counsellor will be mutually influencing. It is also helpful to remain cognisant of this throughout each session, and to take steps to down-regulate if we notice ourselves becoming heightened. Interpersonal Neurobiology offers a useful acronym (PART) that captures the ideal conditions under which meaningful connection can occur, as follows:

- **Presence** – being open to what is arising as it arises
- **Attunement** – focusing with respect on the differentiated inner experience of members of a relationship
- **Resonance** – alteration of the internal state of members of a relationship such that they influence one another, yet retain their differentiated nature as they become linked
- **Trust** – the state within a person or within a relationship of being open to others without defensiveness (Siegel, 2019, pp. 233-234).

Facilitating Understanding of the Story Behind the Story

In addition to paying attention to our own and our clients' neurophysiological indicators during a counselling session, our understanding of neurobiology has implications for understanding our clients' stories. When we hear our clients' stories, and apply our knowledge of neurobiology to those stories, we can develop testable hypotheses about our clients' experiences.

For example, applying knowledge of the impact of adverse events on the development of memories and the ways in which the structure and function of the brain can be affected by trauma, provides important insights into the ways in which our clients may have experienced and made sense of their experiences, as well as the potential consequences of those events. This is not to suggest that we are seeking to overlay a diagnostic framework onto our clients' stories. Rather, understanding the neurobiological implications of adverse events at different times across the lifespan can expand our capacity for supporting our clients.

Using the "Integration" concept as an Organising Principle for Case Conceptualisation and Treatment Planning

As identified by Siegel (2019), the concept of integration offers a helpful framework for understanding health within and between individuals. The core tenet of integration is that it represents a complex

system's capacity to accommodate the differentiation of individual components within the system, as well as linkages between those differentiated parts, to facilitate effective functioning of the system. This dual process of differentiation and linkage can be applied across nine key domains that contribute to health, as follows:

- **Consciousness** – The experience of differentiating the knowing from the knowns of what we are aware of and then linking to one another.
- **Bilateral** – The honouring of the differentiated functions of the left and right hemispheres and then linking them together, especially as the left has a narrow deep-dive focus of attention and the right a broader, context embracing focus.
- **Vertical** – Linking the body's signals and the lower neural regions of the brainstem and limbic area to the higher cortical regions' involvement in the experience of consciousness.
- **Memory** – Linking the differentiated elements of implicit memory to the autobiographical and factual experience of explicit memory processing.
- **Narrative** – Making sense of memory and experience such that one finds meaning in events that have occurred and how they made an impact on one's life across time.
- **State** – Respecting the differentiated states of mind that make up the wide array of clusters of memory, thought, behaviour, and action that are the nature of our multilayered selves and then finding a way to honour and link them without losing their essence.
- **Interpersonal** – Honouring one another's inner experience while linking in respectful, compassionate communication.
- **Temporal** – The capacity to represent 'time' or change in life and reflect on this 'passage of time' leading to many differentiated ways of experiencing crucial existential themes in life: finite versus timeless, transient versus permanent, predictable versus unpredictable, life versus death.
- **Identity** – The sense of agency and coherence that may be associated with a feeling of belonging, one that can be encased by the skin or broadened across space and time" (Siegel, 2019, p. 235).

Although an in-depth exploration of each of these domains is beyond the scope of this chapter, it is worth noting the ways in which this conceptualisation of integration across these domains is consistent with our knowledge of neuroanatomy, neurophysiology, and the tenets of Polyvagal Theory, and can inform all facets of the counselling process, including case conceptualisation and treatment planning.

Conclusion

This chapter has presented some key aspects of neurobiology, as they are applicable for counsellors. It included an overview of the structure and functioning of the brain and the nervous system, and outlined two helpful theoretical approaches that draw from a range of disciplines to provide descriptive models and generate testable hypotheses regarding the interplay between neurobiology and human functioning.

It is not suggested that this is an exhaustive overview of these topics, or that these are the only theories that are relevant and applicable to counsellors. Rather, it was intended to introduce these key concepts

as foundational knowledge, and you are encouraged to explore beyond this chapter. To that end, some recommended readings are listed below. You are also encouraged to consider how the contents of this chapter is complementary to the other theories and approaches discussed in this book, and to recognise the importance of integrating this knowledge across all facets of your counselling practice.

Reflective Questions

1. Why is it important for counsellors/therapists to have an understanding of neurobiology?
2. Reflect upon the quote from Dan Siegel at the beginning of this chapter. Why do you think this quote was chosen to preface this chapter?
3. How would you describe the ways in which our nervous system influences our social interactions (and vice versa)?

Optional Activities

1. *Search for and implement either a breathing exercise or a vagal nerve exercise to practise regulating your nervous system.*

As we have learned in this chapter, the ability to regulate the nervous system is a powerful and effective means of reducing stress and enhancing our capacity to engage in meaningful social interactions. With that in mind, there are many simple exercises that you may like to utilise yourself, in preparation for your client work, during sessions to support your clients, or you can recommend them to your clients as part of their between-session homework.

Irrespective of how you choose to use these exercises, they are a helpful addition to your therapeutic toolbox, both for regulating your own nervous system so you are ready to engage fully with your clients, and as a way of providing clients with strategies for self-regulation. There are many exercises you can use in this regard, and in many ways, you are limited only by your imagination.

The idea is to engage in a practice that calms your body and mind and brings you to the present moment. This can be as simple as taking a few slow, deep breaths (and it is even better if you do so with your eyes closed, as that will signal to your nervous system that you are safe), or engaging each of the senses in turn, by identifying what you can see, hear, smell, touch and taste. Another great option, which is informed by Polyvagal Theory, is vagal nerve stimulation exercises. There are many options for this, and a simple internet search for “vagal nerve

exercises" will provide you with a wide array of videos and other resources to guide you through these exercises.

2. *Reflect upon a challenging interpersonal encounter you have experienced.*

Apply your knowledge of Polyvagal Theory and/or Interpersonal Neurobiology to that situation and consider how those theories provide a deeper or more meaningful understanding of the interaction.

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4.

PERSON-CENTRED THERAPY

Denis O'Hara

"The good life is a process, not a state of being. It is a direction, not a destination." – Carl Rogers

Key Takeaways

- Person-centred therapy is based on strong phenomenological foundations as are other humanistically informed approaches. Phenomenology highlights the importance of paying attention to experiencing in-the-moment.
- Carl Rogers privileged the idea of the self-actualising process believing that human beings have a profound capacity for orientating their life towards wellbeing if they are supported by a facilitative environment.
- A person's self-concept is influenced by their internal experience of self and especially their experience of self within relationships. The real or genuine self seeks to continue growth and development throughout life, and this is facilitated, in part, by envisaging the ideal self.
- It is essential that therapists have both an empathic 'way of being' with clients and effective skills of communication.

Introduction

Humanistic theory of counselling and psychotherapy incorporates several substantial theories that share common philosophical assumptions and practice principles. While the term 'humanistic' captures many fundamental dimensions of these theories, it can also be a term that adds confusion. When we speak of humanistic theory, we are not referring principally to humanistic philosophy, although there is a strong link between humanistic philosophy and humanistic psychological theories. Our aim here is not to delve into humanistic philosophy, rather to explore one of the earliest and most prominent of the humanistic theories of counselling and psychotherapy, **Person-centred Therapy**.

By the 1940s, the dominant theories of psychotherapy were analytic in nature with the most dominant of these being Freud's psychoanalysis. Other derivatives of psychoanalysis included such approaches as Jungian theory, Adlerian individual psychology, and the ego psychology of Erikson. All these theories were based, in part, on the influence of the unconscious on human behaviour, and by various means sought to free people of unhelpful confusions about the self, brought about by harmful relational experiences. A fundamental assumption in these approaches was that unless insight was gained into past experiences, identity, and relational deficits, then the unconscious material would unduly affect functioning in the present. In other words, human behaviour was to some degree determined by the unconscious.

By the 1940s Carl Rogers lead a major directional turn in psychology by promoting the importance of human self-determination. While Rogers did not reject the idea that the unconscious influenced human behaviour, he disagreed with earlier theorists that human beings were largely determined by the unconscious. Consistent with humanistic philosophy, Rogers believed that human beings had much more power of self-determination than many thought and that free will and choice were fundamental to health and wellbeing. Like Maslow, Rogers agreed that if the hierarchy of human needs could be met, then the individual would naturally orientate themselves towards self-actualisation.

A key influence in Rogers' thinking, apart from humanistic philosophy, was the emerging science of phenomenology. Thinkers like Hursserl (1931) and Heidegger (1959) highlighted the importance of experience and consciousness. One of the central foci of phenomenology is attending to experience in the here-and-now for the purpose of becoming intimately aware of one's existence. In everyday life we can have some awareness of our experiences without really reflecting on them. In phenomenology, the aim is to become aware of the essential nature of experience. In other words, as we are more able to attend to ourselves, that is, our experience of being in the world, we become more conscious. In phenomenology this is referred to as the 'phenomenological attitude' and it appealed to Rogers as he saw its potential to inform psychotherapy.

However, Rogers recognised that while human beings had the capacity to become more conscious in life, this often did not occur or did so to a limited degree. In other words, the organismic process, of paying attention to self and experience for the purpose of moving in the direction of self-actualisation, was often blocked or attenuated. Rogers believed that such blockages originated in the individual's experience of self in relationship to others. He argued that instead of seeing ourselves as naturally worthy and good, we experienced ourselves as being evaluated based on our performance, what Rogers referred to as *conditions of worth.* Whether we were being actively evaluated by others or not, the issue is we experience ourselves as being evaluated and found wanting. This negative self-evaluation may have arisen from a negative word from parents or carers, teachers, friends or others. Rogers believed that when we experience our self-worth as conditional it affects our self-concept resulting in blocks to ongoing self-actualising.

A child's formative years are seen as highly influential in internalising values and in developing self-concept. This is different from the psychodynamic idea that we internalise the experiences and conceptualisation of specific others like parents and caregivers. Both approaches refer to introjection of primary life experiences, but the person-centred view highlights the development of more generic values and conceptions of the self. Within the framework of the self-actualising process, self-concept is understood by Rogers to be paired with an ideal self-concept. This is the self that one is desirous of

becoming. The present or 'real self' is often compared to the 'ideal self' with the hope that notions of the ideal self will act as motivation for further self-actualisation.

One of the challenges in moving towards self-actualisation is the existence of a confused or inaccurate self-concept brought about by conditions of worth internalised from one's developmental experiences. One of Roger's great innovations was the identification of key blockages or restraints on this self-actualising process. All things being equal, if blockages to the self-actualising process are removed, then the person would naturally realign their growth trajectory. Based on this logic, Rogers reasoned that if supportive conditions were provided, the individual would gain increased conscious awareness and begin to move in a self-affirming direction. To this end, he identified six fundamental conditions that must be present for an individual to feel supported and to re-engage in what he called their *organismic valuing process*. These six conditions are:

1. That two persons are in [psychological] contact
2. That the first person, whom we shall term the client, is in a state of incongruence, being vulnerable and anxious.
3. That the second person, whom we shall call term the therapist, is congruent in the relationship.
4. The therapist is experiencing unconditional positive regard toward the client.
5. That the therapist is experiencing an empathetic understanding of the client's internal frame of reference.
6. That the client perceives, at least to a minimal degree, conditions 4, and 5, the unconditional regard of the therapist for him, and the empathic understanding of the therapist (Rogers, 1957, p. 96).

Emotions, Motivation and Incongruence

Human beings are relational beings and as such it could be said that an individual does not exist outside of relationship. It is certainly true that the human infant cannot exist without the support of others. More fundamentally though, human beings have a deep need to see themselves in the eyes of others. It is this relational connection that frames the nature and process of the emerging self of the child. Humanistic theory is sometimes called organismic theory because it focuses on the growth and development of the organism. A plant, animal or human being moves through various phases of growth nurtured by its environment. As noted above, limitations in this environment can stunt growth just as facilitative conditions can support growth. Humanistic theory posits that human beings are naturally oriented towards growth and development. In person-centred theory this natural motivation towards growth is supported by our inner experiences, especially our emotions. According to Sanders and Hill (2014), our emotions contribute to motivation in several ways. Emotions are involved in:

- the origination and production of needs and wishes which push behaviour
- the intensity of needs and wishes, determine the strength and resilience of the behaviour (Sanders & Hill, 2014, p. 76).

The centrality of emotions and feelings within Rogerian thought is well acknowledged although the distinction between emotions and feelings is less clearly delineated. Rogers understood emotions as referring to the physiological functions underpinning feelings, and feelings were more the symbolised experience of having an emotion (Stiles & Horvath, 2017). Personal change occurs when we are able to be present to our experience, especially in the form of feelings and in doing so symbolise them or integrate them into our awareness in new ways. This organismic perspective reflects a deep appreciation for meaning linked to the whole of a person, rather than it being principally linked to cognitive abstraction. With this understanding Rogers sought to join with the experience of the client in a deeply empathetic way so that he could more accurately reflect back to the client their own experience, thus providing them with the opportunity to symbolise it and therefore move the experience from an unreflected state to reflective awareness. The importance of joining deeply with the organismic experience of the other is well highlighted by Rogers in the following statement:

> Another question I ask myself is: Can I let myself enter fully into the world of his feelings and personal meanings and see these as he does? Can I step into his private world so completely that I lose all desire to evaluate or judge it? Can I enter it so sensitively that I can move about in it freely, without trampling on meanings which are precious to him? Can I sense it so accurately that I can catch not only the meanings of his experience which are obvious to him, but those meanings which are only implicit, which he sees only dimly or as confusion? (Rogers, 2011, p. 87).

We see in this quote both Rogers' emphasis on maintaining an unconditional regard for the other and also the importance of being deeply empathically available. What is also implicit in this statement is how psychological change is a process of experiencing an incongruence between *experience* and *awareness*. As an individual becomes aware of their experience, their feelings and interoceptions, it is more likely that they will notice the inner incongruence. This direct experience of personal incongruence makes possible the re-making of meaning, of realigning the organism with the valuing process. Rogers (2011) expressed this process of change by stating, "The incongruence of experience and awareness is vividly experienced as it disappears into congruence" (p. 217). A contemporary of Rogers famous for developing *Focusing* therapy, Eugene Gendlin, captured essentially the same organismic view of the change process by stating that in change we move from *felt sense* to *felt meaning* (Gendlin, 1969).

While all six conditions of change need to be present to facilitate the therapeutic change process, the three conditions of *unconditional positive regard, empathy,* and *genuineness or congruence* are most often highlighted as the s*ine qua non* of person-centred therapy. While each of these conditions sound logical and straightforward in principle, the provision of these conditions is quite challenging for the therapist to provide.

Unconditional Positive Regard

The notion of positive regard for the client sounds in many ways to be self-evident if therapy is to progress well. While this may be true, it is not always as easy as it may sound. This is because people come to see therapists with a wide variety of problems, personalities, cultural backgrounds, worldviews and life

experiences, to name a few points of diversity. While much of what is presented in therapy is common to human experience, how people identify, organise, prioritise and express their values can differ significantly. It is not possible for therapists to feel a natural affinity for all their clients yet the need to offer positive regard is seen as essential. Notably, recent neuroscientific research has acknowledged that at some level whether conscious or otherwise, people can read the subtle nonverbal-cues of another. The discovery of mirror neurones is a good example of how human relating is communicated on multiple levels (Penagos-Corzo et al., 2022; Rasmussen & Bliss, 2014).

The provision of *unconditional positive regard, empathy,* and *congruence* provide an environment in which previous conditions of worth are less likely to influence the client. In other words, a genuinely supportive environment in which the person is able to attend to their deep experiencing in-the-moment will likely free them to become aware of the incongruence between the *real* and *ideal self* and reorientate them towards self-actualisation.

Empathy

McLeod (2013, 178) noted that

"The importance attributed to empathic responding has been one of the distinguishing features of the person-centred approach to counselling. It is considered that, for the client, the experience of being 'heard' or understood leads to a greater capacity to explore and accept previously denied aspects of self".

When therapists think of the person-centred approach, it is usually with the significance of empathy in mind. When Rogers first promoted this idea it was seen as novel and even unscientific. However, since then empathy has been studied in depth demonstrating that it is indeed an important part of the therapeutic relationship and therefore of the change process. One of the difficulties though in operationalising empathy is that it is somewhat difficult to define especially in terms of a distinction between a state or way of being and a skill. Some in the therapeutic community have highlighted the state of empathy and others the skills of offering empathy. Barrett-Lennard (1962), a colleague of Rogers and a notable Australian academic, highlighted the importance of the communication of the experience of empathy in a way that it is received by the client. It may be possible to be empathic but not communicate one's empathy. Barrett-Lennard developed and researched what he referred to as the *empathy cycle* wherein empathy was first experienced by the therapist, then communicated in such a way that the client gained an awareness of the therapist's deep empathic connection with them.

Congruence

Congruence is the act of being genuine both internally with oneself and interpersonally with others. While this may seem an obvious and laudable aim, it is not always easy to achieve. Obviously, clients do not want their therapists to withhold thoughts and ideas they may have about them and their presenting problem. We all want a real and genuine encounter with another, especially when there is a marked degree of vulnerability involved. However, it is not responsible of therapists to express every thought they may

have about their client and their concerns. Therapists often need time to make sense of what is happening for the client, in general, and of what is happening in the room in any given moment. There is a gap between processing and communication.

It may also be challenging to maintain genuineness when the therapist disagrees with the client's point of view or behaviours. What is it to be genuine in such circumstances? Congruence or genuineness is first about self-awareness. We have first to be aware of our own thoughts and feelings before connecting with another. We cease to be congruent in our communication when we are not in touch with ourselves. Congruence does not mean we are obliged to express everything we think or feel, but it does require of us to be *real* in the therapeutic encounter. It is true that people will often sense if another is being real and genuine. Congruence produces a feeling of deep connection as sense of 'we are in this together'. When this feeling is present, the process of therapy is clearly underway.

The Therapeutic Process

Given the key principles of person-centred therapy, what does the therapeutic process look like? Rogers was very helpful here in delineating seven stages of the therapeutic process. He emphasised though that the process was not limited to seven stages because everyone's experiencing and accessing of their phenomenological experience varies requiring many iterative steps along the way towards increasing self-actualising.

Stage 1: Communication is only about externals. In this stage the person is not really in touch with their phenomenological experiencing and relate to their experience conceptually and behaviourally not experientially. In this stage feelings and meanings are not recognised or owned.

Stage 2: Expression begins to flow in non-self topics. As the person realises they are being heard and valued in therapy, they begin to relax a little and start to share about a range of topics descriptively but not linked clearly to feelings. Problems are still seen as being external to the self.

Stage 3: A further freeing of expression including about self as object. As the experience of therapy increases to be positive a further freeing of expression is evidenced. Included in this expression now is stories that include the self as the object of focus but not clearly linked to the feelings of the self. The closest the client may come to identifying feelings is the feelings of others about them or past feelings they may have had but not present feelings.

Stage 4: Feelings are now described although as objects in the present. The safety of therapy now allows the client to begin to refer more directly to feelings and experiences but still with some concern or even surprise that they are 'showing up'. There is not yet quite the readiness to explore these feelings and related meanings.

Stage 5: Feelings are expressed in the present. "Feelings are very close to being fully experienced" (Rogers, 1961, p. 203). There is now an increasing ownership of feelings.

Stage 6: An inner flow and linking of feeling With experience and meaning is now experienced. The immediacy of experience is allowed and directly experienced and accepted.

Stage 7: Feelings are fully experienced and trusted and act as referents to past and present

meaning. The person now is able to be fully present to their experience and is able to work with moments of 'felt sense'. Felt sense being deeply appreciated leads to felt meaning and free expression of the self.

Eugine Gendlin and Focusing

Gendlin was an important contributor to humanistic therapy and especially to person-centred therapy. As noted earlier, he developed an approach to therapy called 'focusing'. Like person-centred therapy, focusing therapy is based on phenomenology and the centrality of experiencing. Gendlin highlighted the principal need in the 'phenomenology of the moment' of attending to the 'felt sense'. Gendlin was a philosopher and therapists and believed that the 'felt sense' was more than recognition of emotion or feelings but went beyond feelings to a deeper inner sense of the whole person especially via the somatic. He believed that within the body and within deep attention to experiencing we could access more of what the body knew or more accurately what the organism knew of itself. Gendlin's ideas were complementary to Rogers' and as such the importance of attending to the felt sense was shared by both psychotherapy pioneers. Gendlin outlined six steps in the focusing process in which one might gain access to felt sense and move towards increasing felt meaning.

Step 1. Clearing the space. The first priority in this step is to relax and begin to pay attention to inner experience, to feelings and the body.

Step 2: Felt sense. Begin to focus on a particular problem but without analysing it simply paying attention to what being aware of the problem elicits inside of you.

Step 3: Handle. Focus on the quality of this unclear felt sense? Allow a word, a phrase, or an image come up from the felt sense itself. Stay with the quality of the felt sense till something comes into awareness.

Step 4: Resonating. At this point the idea is to connect the felt sense with a word, phrase or image.

Step 5: Asking. Now one asks the felt sense, word or phrase (tentative meaning) to help reveal what the problem is about or connected to or moving towards. Be aware of potential shifts in feeling and meaning.

Step 6: Receiving. Receive whatever comes with a shift in an open relaxed manner. Pay attention to any shifts or personal release, even if only small (Gendlin, 2007).

Visit Focusing Oriented Therapies for videos on this therapy.

Implications for Practice

Micro-skills of Communication

One of the principal qualities in Rogers' approach to practice is what might be referred to 'a way of being'. When viewing videos of Rogers conducting therapy it is obvious that he held a highly empathic, genuine stance towards the client. Of course, this stance reflected the idea of the 'core conditions' required for therapeutic change to occur. Rogers even stated at one point that these 'core conditions' were sufficient in and of themselves for change to take place. Without delving into the debate about whether this non-directive approach was actually sufficient for change, Rogers in his own practice certainly highlighted the

importance of a particular stance or way of being that was critical to the therapeutic encounter. This view is probably best reflected in his understanding of empathy as a state of being and less a skill to master.

Watch Carl Rogers on Person-Centered Therapy (Kanopy, 1h11m, UQ login required).

One of the difficulties of appreciating and prioritising an attitude or stance towards therapy as Rogers did, was that an attitude or way of being is not so easily taught. By its nature a way of being is developed within the context of one's personality, educational and life experiences. Therapists bring who they are to the whole therapeutic enterprise. So, while the theory of person-centred therapy could be taught, the practice of it was and is more challenging to convey.

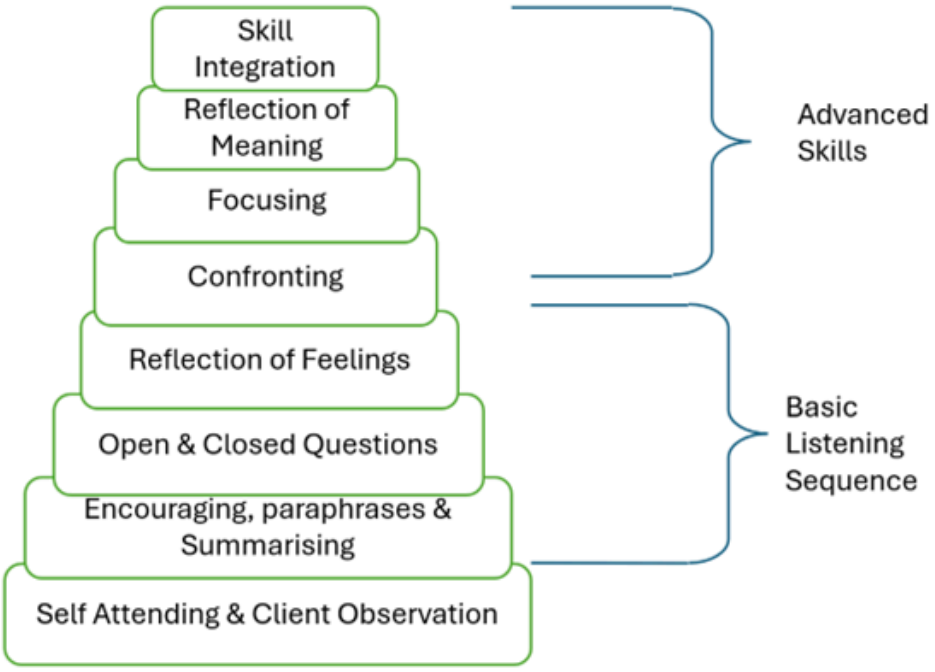
Two researchers who were colleagues of Rogers' at Chicago University in the days when the theory was being developed and researched, Charles Truax and Robert Carkhuff (1967), approached the problem of teaching the person-centred approach by highlighting the skills in human communication. A skills approach to connecting with clients has several benefits but also some limitations. Some of the benefits are that:

- Micro-elements of communication can be identified specifically and therefore measured
- Students can practise applying respective micro-skills and then draw them into a fluid integrated sequence of communication
- Deficits in communication skills can be remedied.

With this view in mind, Truax and Carkhuff developed an approach to teaching the essentials of person-centred therapy by focusing on micro-skills of communication. Their approach to teaching psychotherapy has had influence far beyond person-centred theory and is now commonly taught across counselling program, no-matter the primary theoretical orientation. Of course, the debate about whether therapy is primarily a set of skills or a way of being has never really gone away. In the view of the authors, being an effective therapist definitely is about the person of the therapist and their way of being but is also about having a developed set of communication skills – the two go together. If 'being' is disconnected from the application of skills, skills simply become technique lacking genuine relational connection.

One of the most notable current proponents of the importance and benefits of micro-skills training for counsellors is the husband-and-wife team of Allan Ivey and Mary Bradford Ivey. Different editions of their text "Intentional Interviewing and Counseling" have been used in counselling programs for over thirty years. The Iveys and their associates drawing on the earlier work of Truax and Carkhuff developed a skills framework that has helped teachers and students of counselling to develop their communication skills and their capacity to develop and maintain the therapeutic relationship. The Iveys outline a hierarchy of micro-skills best illustrated in the skills pyramid below.

Figure 1. *Microskills Hierarchy*



Adapted from "The microskills hierarchy: A pyramid for building cultural intentionality" in "Intentional interviewing and counseling: Facilitating client development in a multicultural society" by Allen E. Ivey, Mary Bradford Ivey, and Carlos P. Zalaquett (2022). Cengage.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://uq.pressbooks.pub/practice-counselling-psychotherapy/?p=52#h5p-16

Communication skills are organised into two levels: the basic listening sequence and advanced skills in which all aspects of communication are integrated. It is instructive that the first skills listed are a combination of, firstly, attending to one's own behaviour and, secondly, to the observation of the other. It would not be inconsistent to say that the therapist should not just attend to their own behaviour but their way of being. The therapist's presence in the room with the client is of paramount importance. Presence is much more than the skills one possesses; it is about all that the therapist is as a person including their knowledge and skills.

At first glance the list of communication microskills might appear almost mundane. Everyone knows about paraphrasing for example, at least, in principle. However, the offering of a paraphrase within the counselling context wherein it is offered accurately and in a timely manner and in a 'certain' way, is much harder to do than one might think. A paraphrase says to the client "I am really listening and tracking with what you are saying – I'm really interested". Another author who highlights the importance of microskills is Gerlad Egan (Egan & Reese, 2019). Egan makes an insightful observation that a well-timed paraphrase is a form of basic empathy. This is true because when we offer a paraphrase we are intimating our interest in the client and their story.

Reflection of feelings is the next skill in the hierarchy and one of the more difficult skills to master. Reflection of feeling is often a misunderstood skill as it can be interpreted as a technical recognition that

an emotion is present. For example, if a therapist conveys that they recognise that the client is experiencing some anger, it can be offered as an abstract idea or as a fellow feeling. While it is fine to acknowledge the technical presence of an emotion, it is quite different to feel the client's emotion and in an empathic manner offering back this feeling to the client. In other words, "I feel the anger that you are feeling". When therapists reflect feelings, it often has significant effect. This may be the case for several reasons. One, while the therapist may recognise the feeling state of the client, the client may not, and now the reflection helps them get in touch with their own emotions. Two, the recognition that another feels what you are feeling can be a profound moment of connection between people due to the deep sense of empathy provided.

From a Rogerian perspective, therapists who possess the skills of the Basic Listening Sequence and a facilitative way of being with clients, provide a highly therapeutic environment in which psychological change is likely to occur. It is certainly true that often the most profound thing that we can do as helping professionals is to listen deeply to our clients. The notion of 'deep listening' has resonance across cultures and reflects an insight that many indigenous cultures have had for generations (Atkinson, 2002). As counsellors our first task is to listen deeply. It is only as we listen that direction for change emerges. To help clients find the pathway of change we also have to help clarify and focus the counselling discussion. Sometimes this entails offering a challenge or helping maintain a keen focus on the problem at hand. The word 'challenge' can sometimes infer a blunt note of disagreement. Gerald Egan (Egan & Reese, 2019) is instructive here again when he suggests that a challenge should always be offered empathetically and in fact can be thought of as a form of advanced empathy. This is because to challenge an idea or practice of another with the right attitude actually implies a deep caring for the other.

Communication microskills have to be taught to some degree as discrete skills. However, the reality of any genuine interlocution is that it should be a seamless exchange of ideas and feelings. We only break communication down into its component parts to clarify and practise them. Skills training like any skill development requires practice and then a reintegration into the whole. A pianist practises scales not so that they are good at scales on their own but so that they can play a concerto seamlessly. Similarly, we practise communication skills so that they provide a seamless interchange in the moments of counselling.

Person-centred and Experiential Therapies

Person-centred therapy while a well-developed and celebrated approach in its own right, has had a profound effect on counselling and psychotherapy as a whole. Rogers was one of the earliest researchers to highlight the centrality and importance of the therapeutic relationship and of the role of empathy within therapy. His championing of the phenomenological paved the way for other approaches to draw on experiencing-in-the moment as a foundational concept. Other humanistic therapies such as focusing, gestalt and existential therapy all share this emphasis on the phenomenology of experience as central to the therapy process. Today while there are several different person-centred associations worldwide, it is common to find therapists who share this phenomenological foundation combine organisationally seeing themselves as what is sometimes referred to as the "Tribes of the Person-centred Nation" (Cooper, 2024).

Reflective Activity

Questions for Reflection

1. What are key tenets of the view of the person within the person-centred approach to therapy?
2. Of the six core conditions which do you feel will be most challenging for you to provide? Why?
3. What aspects of the approach resonated with you and what parts did you find limited or confusing?
4. Rogers articulated stages in the therapeutic process based on people's capacity to attend to their experience in-the-moment. How might this approach be substantially different to approaches such as CBT or solution-focused therapy?
5. How might we differentiate between emotions and feelings? What is the difference?

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5.

EXISTENTIAL AND GESTALT THEORY: MAKING CONTACT AND JOINING

Jim Schirmer

"In what is called 'individual psychotherapy', two people meet and talk to each other with the intention and hope that one will learn to live more fruitfully." (Lomas, 1993, p. 5)

Key Takeaways

- Existential and gestalt therapy helped to evolve our understanding of therapy through paying particular attention to how our self of self is in an ever-unfolding process of emerging in response to the experiences we have.
- This understanding leads to some important ideas to be integrated into the practice of therapy, including: (a) demonstrating a high regard for the client; (b) seeing therapy as a relationship between 'fellow travellers'; (c) the importance of subjective experience; and (d) attending to the here-and-now process of therapy.
- Practically, these ideas help to inform counsellors through stressing the importance of making contact and joining the client, especially in the crucial first session of counselling.
- In order to make contact and join with the client, counsellors need to develop skills such as: (a) attending behaviour; (b) observing and communicating content and experience; and (c) observing and communicating observations of process.

Introduction

In the previous chapter, you were introduced to the ideas of the pre-eminent humanistic theory of psychotherapy (person-centred therapy), and the legacy that this theory left to the practice of counselling and psychotherapy. This legacy includes a notion of a potential-seeking self, the impact of the relational conditions of the person's journey to actualise, and the importance of the relational environment of

therapy. The foundational interpersonal micro skills introduced help to establish the type of relational climate within which the client is most likely to grow towards their potential.

This chapter will build on this essential foundation and add layers of ideas and skills to integrate into the therapeutic process. Specifically, this chapter will consider two more major theories of therapy – existential and gestalt psychotherapy – and consider the contribution these theories made to modern counselling and psychotherapy. These legacies include:

- the regard for the person of the client
- therapy as a relationship between 'fellow travellers'
- the importance of subjective experience
- the value of the process (and not just the content) of the interaction.

This chapter will apply these ideas through introducing you to the processes and skills that you need for the important first session with a client. The chapter will discuss the aim of this session as 'making contact', which involves building trust through processes of presence, attunement and resonance (Siegel, 2010). To meet this aim, you will be introduced to important processes involved in joining the client (e.g. welcoming the other, clarifying hopes and expectations, inviting dialogue), and the skills of attending, observing process, and reflecting content and experience, which are crucial for that session.

Theoretical Foundations

The word 'psychotherapy' is derived from two Greek words: *therapia*, meaning 'healing', and psyche. The word psyche is more difficult to translate, but broadly speaking is used to describe that invisible life-force that animates the body of a living thing. As such, it is variously translated 'breath', 'soul', 'life', 'mind' and 'self'.

Consequently, anyone who is a practitioner of this process of healing the mind/soul/self (i.e. a psychotherapist) will to some degree need to ask themselves a question like 'What is the self?' This is, of course, the type of question that defies simple answers, and great individuals and traditions of thought have offered a variety of profound responses.

Still, at the risk of over-simplification, one major contrast in ways of thinking about self surrounds whether the self is *fixed* or the self is in *flux*. For someone who sees the self as fixed, there is a 'true self' or 'real self' that is essential to who the person 'really' is. In contrast, a person who sees the self as in flux regards the self (who the person is) as an emerging synthesis between the person and their experiences over time. In this latter conceptualisation, the self is depicted as being like a river. That is, while there is a continuity, regularity and recognisability to the river, it is also constantly flowing and changing. Thus (as the saying goes), you never step into the same river twice, for the river has changed in the meantime.

The following discussion examines two theories that see the self as emergent – an ever-unfolding, constantly flowing process of becoming.

Key Ideas of Existential Psychotherapy

Paul Gilbert, the founder of compassion-focused therapy, is quoted as saying, "You are living a life that is not of your choosing." This sentence succinctly encapsulates the cornerstone idea of existential philosophy and (by extension) existential psychotherapy. The idea is that the existence that you are experiencing was not chosen; you did not choose to exist, and neither did you choose the nature of your existence. Yet here you are. Against all probability, you exist.

Moreover, as a highly conscious being, you also have the ability to be aware of and to reflect on your existence and your experience of it. In particular, you have to contend with those parts of experience that cause you discomfort, pain, and angst. In classic existential theory, these include things like the inevitability of death, the lack of inherent meaning in the world, the experience of separateness and isolation, and living with the responsibility of exercising freedom and choice (Yalom, 1980).

What existential therapy posits is that whenever someone is coming to therapy, at some level they are confronting the nature of their existence. That is, within any story that you hear as a counsellor or therapist, there will likely be threads to that story that represent themes of meaninglessness, loss, finitude, guilt (for choices made or not made), loneliness, demoralisation, powerlessness, or even just some encounter with destiny, fate or luck. For example, a client who is dissatisfied with their relationship might at one level also be reflecting on their finite existence and stressing about the limitations of staying with one person their whole life. Or a client with a crippling fear of public speaking might in part be reacting to the possibility of rejection by others as a life-or-death scenario, and thus an existential threat.

As you can see, existential therapy does not locate the problem in the person that comes to therapy. Rather, it sees the suffering of people as emerging from their experience of wrestling with the realities of their existence. However, the theory and the therapy are not fatalistic: people are not just doomed to suffer. Rather, therapy in the existential tradition aims to help people to live more courageously, honestly, meaningfully and skilfully, even in the face of the unavoidable challenges and suffering of life. Van Deurzen (2002), puts it like this:

> "Assisting people in the process of living with greater expertise and ease is the goal of existential work. Learning to face the inevitable problems, difficulties, upsets, disappointments and crises of existence with confidence is what it is all about. Discovering endless sources of enjoyment and wonder in the process is the usual by-product of this venture" (p. 19).

In summary, while existential therapy sees our problems as emerging from living a life that is not of our choosing, it also sees our hope in choosing to live our life according to what is personally meaningful, even in the face of that which we cannot control.

Key Ideas of Gestalt Therapy

If someone walked up to you right this instant and asked you what you were doing, you would most likely reply, "I am reading". If fate would have it that the person who asked you the question was a gestalt theorist, they then might have a few follow up questions:

- What is it like to read? You have used a single word to sum up a very complex activity. If you had to explain reading without using the word 'reading', how would you go about doing it?
- What else were you doing besides reading? There were no doubt other things going on. You were respirating, you were sitting (or standing, or walking, or lying down), you may have been thinking, you may have been daydreaming. How come, when you were asked what you were doing, you pushed all of those things into the background?
- When you think about your experience of reading, how much of your experience are you really in contact with? What parts of yourself and your environment might you have lost touch with during this experience?

As unusual as these questions might seem, they are all concerned with a matter of interest for psychotherapy, namely how we relate to the realities we experience. A starting point of gestalt theory is the observation that most phenomena we encounter are complex wholes made up of many parts. To use our example, the activity of reading is not a singular thing, but rather a complex, multifaceted experience.

While this is true, the theory would also observe that most of us do not engage with the events, activities and experiences of our lives in this way. Put bluntly, we tend to prefer simplicity to complexity. Due to this preference, we tend to do one of two things. The first thing we do is assess our understanding of something as total or complete. When we do this, we stop relating to it as it is with all of its parts and complexities, and instead just relate from our (over)simplified lens. Alternatively, we might assess our understanding of something as incomplete and subsequently only relate to it as 'unfinished business'.

In either case, the result is the same: we end up out of contact with our own experiences. In this way gestalt therapy explains that the reason behind distress that brings a person to therapy is that the individual is out of contact with a part of themselves, an important part of a relationship, or with an aspect of their experiencing. What the individual will present, therefore, is that they have placed some parts of their experience into the foreground, while other parts of their experiences have been pushed out of awareness.

Therapy in the gestalt tradition aims to bring people back into contact with parts of themselves, their relationships and their environment that are outside of their awareness and attention. The experience of therapy, then, is to help people get an experience of being in contact with the present moment, and through this experience to start to engage more fully with other parts of their life.

> [The aim is to] provide a means for interrupting the flow of self-talk, inviting us to return to 'now', 'here', 'the actual', in order to be more 'present'. Thereby, individuals can learn to notice and capture subtle feeling states that easily go unnoticed. They register themselves as alive physical beings; sensing, moving and feeling. They are ready to engage fully with others (Parlett, 2001, p. 44).

In summary, gestalt is a therapy of experience, which seeks to help clients to encounter themselves more completely and to live more fully.

Key Principles

Existential and gestalt psychotherapy leave a legacy of ideas that can be integrated into the practice of psychotherapy.

Honouring the Person

In both existential and gestalt psychotherapy, the therapist is called on to hold a high regard for the person that they are seeing. This goes beyond a matter of basic manners or civil respect. From an existential perspective, it is recognising that the person in front of you is a *unique event in the history of the universe*. In other words, the theory calls on us to reflect on the sheer improbability of the life and consciousness of the person in front of us, and to treat this person with the reverence that this deserves. (As an aside, the theory would equally call on us to reflect on whether we treat ourselves with the same reverence, regard and honour.) Therefore, the theory implores the practitioner to not reduce the person to a 'client', but rather to always respect that this person has experiences, hopes, fears, and an inner life that is as complex as your own.

In a similar vein, gestalt therapy draws on the philosophy of Martin Buber to discuss how therapists should relate to their clients. Buber distinguishes between two types of relating. One is to relate to someone as if they were an 'It': an object to be observed, studied or even used. This way of treating a person as an 'It' is common in functional or transactional relationships, where the other person is a means to help us get to an end that we seek. The other way is to treat someone as a 'Thou': an independent and unique self with a subjective experience which transcends our knowledge and understanding. This way of treating someone is close to the idea of reverence discussed above.

A Relationship of Fellow Travellers

One idea that existential and gestalt therapy introduce to the practice of psychotherapy is the idea that 'therapist' and 'client' are not essentially different, but rather fellow travellers in the journey of life. In this conceptualisation of therapy, the fact that both participants in therapy equally have to confront the problems of existence leads to a great levelling of the encounter.

Consider this famous metaphor for the nature of therapy and the role of 'client' and 'therapist', here articulated by Hayes et al.:

> "You and I are both kind of climbing our own mountains of life. Imagine that these mountains are across each other in a valley. Perhaps, as I climb my mountain I can look across the valley, and from my perspective, see you climbing your mountain. What I can offer to you as a therapist is that I can comment from my perspective, to give you my viewpoint from outside of your experience. It is not that you are broken; it is not that I am always skillful with my own barriers. We are both human beings climbing our mountains. There is no person who is "up," while the other is "down." The fact that I am on a different mountain means I have some perspective on the road you are traveling. My job is to provide that perspective in a way that helps you get where you really want to go" (2003, p. 81)

This image highlights two major insights about the therapeutic relationship. Firstly, it is a meeting between two humans who each have their own 'mountain' to climb. Being a therapist does not mean we are existentially better than our clients. We are still subject to all the same frailties, fears and limitations. Remaining in touch with our humanity helps to keep us humble and to continue to show honour and regard for the client.

Secondly, this metaphor also highlights the value of our role in the client's journey. The equalisation that occurs through seeing each other as 'fellow travellers' does not mean that we therefore have nothing new or different to offer. Rather, it is our different viewpoint and perspective that can be so useful to the client. By describing what we see from our viewpoint, we give the client more perspective which they can then merge with their own viewpoint to decide how they want to proceed up their mountain.

The Importance of Subjective Experience

Both gestalt and existential theory place a high value on paying attention to the client's subjective experience of their life. Some of this value comes from the theories' common philosophical roots in phenomenology, a branch of philosophy that examines our conscious lived-experience of what happens to us. Phenomenology is distinctive because it is less concerned with the 'reality' of what has happened, and more interested in how we have experienced it.

These theories translate this idea into the therapeutic environment by focusing as much on the subjective lived-experience of the client as on the objective facts of the situation. For example, think about the implications of the following scenario:

> Imagine that you practice psychotherapy in a town that has a large manufacturing industry. Due to changes in the economy, a factory has to be shut down, and hundreds of people are suddenly out of work.
>
> It just so happens that one morning you have three clients in back-to-back appointments. All of them have lost their job in the factory shutdown. The first client you see is highly depressed as a result of this, talks a lot about the impact on their family, and describes the change as a tragedy. The second client is excited, discusses how unhappy and trapped he had been in the job, and describes the change as an opportunity. The final client is angry, speaks extensively about the political and economic climate, and describes the change as an injustice.

In this example, you have the same stimulus (phenomenon) of the factory shutdown, but three very different experiences of it. However, from the perspective of these theories, the therapist's job is not to work out the 'truth' of whether the closure of the factory is a tragedy, an opportunity or an injustice. Rather, the therapist will look to understand the experience of the client.

A gestalt perspective would add a further dimension. Rather than see the various experiences of the clients (e.g. tragedy, opportunity, injustice) as mutually exclusive, the therapist could conceivably understand them as *different dimensions of a complex whole*. In other words, the factory closure has a tragic element, an element that creates opportunity, and an element of injustice. Therefore, the differences between the clients' experiences are differences of emphasis; each client is focusing attention of one element of the reality, while pushing others into the background. As such, the therapist might look to understand both the focus and emphasis of the client, while also helping them get in touch with other elements of their experience.

Here-and-Now: The Importance of Process, not just Content

Students and new practitioners of psychotherapy often have to grapple with the complexity of the practice, especially with how much is going on in a single therapeutic conversation. Early on in careers it is quite natural to prioritise a focus on the content of the session, that is, the details of the narrative and information that the client is sharing.

While this is of course crucial, there is another major element to the session, which is often called *process*. Put simply, if content is what the client is saying, then process is how they are saying it. This includes a wide variety of things such as the client's body language, tone, emotionality, the depth of reflection, and emphasis (i.e. what they are prioritising in the story). Paying attention to process is also a focus on the nature of the interpersonal interaction of the session; for example, how open or guarded the client is, what parts of themselves they are showing to the therapist and what parts they are protecting, and the strength or fragility of the therapeutic rapport.

Practically, an awareness of process will enable a therapist to include what is happening here and now as information that may be explored in therapy. One of the major writers in existential psychotherapy, Irvin Yalom, summarises the nature and the value of the here-and-now in this way:

> "The here-and-now is the major source of therapeutic power, the pay dirt of therapy, the therapist's (and hence the patient's) best friend ... The here-and-now refers to the immediate events of the therapeutic hour, to what is happening *here* (in this office, in this relationship, in the *in-betweenness* – the space between me and you), and now, in this immediate hour." [Original emphasis] (Yalom, 2003, p. 47)

In other words, the facts and details given by the client are not the only material worth exploring in a session. Rather, aspects of how the client presents, relates and communicates may be significant for the therapeutic endeavour. For instance, if a client that has been talking freely suddenly falls silent, or if there are inconsistencies between different parts of the story, or if a client's hands suddenly clench into fists when talking about a person, or if the client only makes jokes whenever you ask about their marriage, it may be worth gently reflecting on or enquiring into these here-and-now moments. (Some information about how to practically do this will be included later in the chapter.)

Implications for Practice: Processes and Skills

The insights and ideas of these two theories help to inform the counselling practitioner in several ways. For the purpose of this chapter, however, we will focus on how these insights inform the counsellor in the first session of therapy. Research has demonstrated the importance of the first session of therapy. Specifically, the first session appears to have a crucial role in forming the therapeutic alliance, which in turn predicts future improvement in the client and improves engagement through minimising drop out from therapy (Sexton et al., 2005; Falkenström et al., 2013; Sharf et al., 2010).

This section will guide counsellors in the essentials of the first session, such as the goal of *making contact*, the process of *joining* with the client, and the skills of *hearing the story*.

The Goal: Making Contact

One way of framing the purpose of the first session is with the gestalt therapy idea of 'making contact'. While this is a nuanced theoretical concept, the essence of being 'in contact' is to be fully present to and engaged with the experiences and environment that are happening to you right now. In this way, the aim of 'making contact' in therapy happens concurrently in a number of ways:

- The therapist being present to and engaged with their own experiences and states of mind;
- The therapist and the client becoming present to and engaged with one another in the therapeutic environment; and,
- The client becoming increasingly aware of their experiences and relationships and thus engaging with them more authentically.

In his book *The Mindful Therapist*, Daniel Siegel (2010) explores what happens on a biological and neurological level when two people are in deep contact with one another. He lists three major processes: *presence, attunement and resonance*. Each of these processes provide the conditions for the next. That is, presence (an awareness and openness to the possibilities of the unfolding moment) provides the condition for attunement (an attentiveness to another person with a view of connecting with their inner world). Presence and attunement in turn create the conditions for resonance (the sense of two people joining together as an interconnected 'we'). Finally, all three of these processes (presence, attunement and resonance) create the possibility of trust – a state where a person is able to be honest and vulnerable due to the presence of a reliable and responsive other. These processes provide some broad directions on what we need to keep in mind in an initial session in order to 'make contact' with a client.

Making Contact through Presence

The capacity to make contact in therapy starts with presence. Obviously, the idea of being present is not just about being in the same room as the client. Most of us know the dreadful feeling of speaking with someone who is physically present but psychologically absent (through being distracted, self-absorbed,

unreceptive, etc.). The presence that we want to convey as therapists is quite the opposite. We want to be attentive, engaged, receptive and open.

Much of presence is communicated through non-linguistic means. Clients sense the therapist's attention and engagement through the therapist's body language, posture, eye contact, responsiveness, facial expressions, vocal qualities (e.g. tone, pitch, speed of speech), and proximity. Therefore, presence is a highly sensory experience, and one that cannot be 'faked'.

Consequently, cultivating presence begins with the therapist's mindset. It is about finding an internal space that Siegel describes as flexible, adaptive, coherent, energised and stable. It involves the therapist monitoring their own internal state. In particular, presence is often optimised when the therapist is in their 'zone of tolerance' – that is, in the energised zone between closed-off, rigid disengagement (on one side) and overwhelmed, chaotic hyperarousal (on the other side).

Making Contact through Attunement

The cultivation of presence provides the conditions for attunement: the therapist's capacity to perceive the client's psychological and relational worlds, and to move into a harmonious synchronicity with these. Here, the images that are connected to the word 'attunement' are helpful. You can think of attunement as being like 'tuning in' to a radio station or a WiFi network: it is about getting on the same wavelength as a client so that we can effectively exchange communication signals. You can also think of attunement as like an orchestra or a band tuning their instruments together, moving closer and closer together until they are creating harmony rather than discord. Similarly, the process of attunement should move the therapist and client into a harmonious rather than discordant climate of relating and communicating.

As you can see from these images, attunement is a process. It involves the repeated cycles of communication. Egan (2018) calls this 'turn taking'. These cycles of speaking and listening create a feedback loop where the therapist can gauge the strength of the attunement with each iteration.

Practically, this process requires both the therapist's attention and adaptation. To attune, the therapist must be paying attention to the client's style of communication; for example, their pace, tone, vocabulary, formality, energy and cultural norms. Through this attention, the therapist can get a sense of the client's psychological and relational patterns. From this, the therapist can adapt their own communication style to harmonise with the client.

Making Contact through Resonance

The combination of the therapist's presence and the process of attunement results in resonance, the feeling that two people are linked into an interconnected 'we'. The development of resonance has two key implications for contact in therapy. Firstly, in a relationship where there is resonance, there is an openness to the mutual influence of one another. Resonance means that we are receiving the other person into our own mind through engaging with their state of mind and trying to see their point of view. Our understanding of interpersonal neurobiology (see Chapter 3) shows how this even happens at a physiological level. While this state might not be symmetrical (i.e. the two people may do this at different depths), it is mutual inasmuch as a resonant relationship will have an influence of both parties.

Secondly, resonance means that the two parties are in contact as a functional relational system. This is a dynamic and ever-evolving system, but there is enough coherence that the two parts can function together as a whole. Significantly, they can work together to pursue a particular end or purpose. Therefore, in counselling, this state of resonance is crucial to create the conditions to pursue therapeutic goals.

Trust as the Outcome of Making Contact

Siegel puts forwards that the result of the culmination of presence, attunement and resonance is a relationship that is marked by trust. By trust, he means that the relationship has facilitated the kind of conditions that enable the type of honesty, vulnerability and risk-taking that are necessary for change.

This trust is the foundational basis for what therapeutic literature commonly calls the therapeutic 'alliance'. One of the most robust findings in psychotherapy literature is that the strength of the alliance is one of the best predictors of therapeutic outcome (Horvath et al., 2011; Falkenström et al., 2013). Given this, the counsellor's capacity to facilitate resonance and trust through their presence and attunement is foundational for all other therapeutic work.

The Process: Joining

If the aim of the first session is to make contact – that is, to use presence and attunement to build resonance and trust – then the process that is used is one of the counsellor and the client *joining* together in the therapeutic endeavour.

One of the simplest definitions of counselling comes from Lomas (1993), who defined individual psychotherapy as a process where "two people meet and talk to each other with the intention and hope that one will learn to live more fruitfully" (p. 5). This quote succinctly captures one of the essential features of the process of joining, namely, that it is a process that occurs between two (or more) individuals, who must come together to form a relational system. Therefore, it is safe to assume that each individual will bring their own perspectives, goals, concerns and subjective experiences to the encounter.

This assumption has been repeatedly supported by research. In particular, there is strong evidence to affirm that (broadly speaking) the counsellor and the client approach and experience the joining process differently. A synthesis of these findings across the research (Lavik et al., 2018, p. 348) showed that counsellors generally approach the joining process concerned with:

- balancing technical interventions and interpersonal warmth
- showing a genuine desire to understand
- openly supporting client agency
- adjusting to create a sense of safety
- paying attention to body language
- providing helpful experiences during the first session.

On the other hand, clients tended to value the following in the formation of the alliance:

- meeting a competent and warm therapist
- being understood as a whole person
- feeling appreciated, tolerated, and supported
- gaining new strength and hope for the future
- overcoming initial fears and apprehension about psychotherapy (Lavik et al., 2018, p. 348).

Practically, this process of joining involves a number of important elements:

- welcoming the other
- clarifying hopes, concerns and expectations
- inviting the client to share their story.

This section will discuss each of these three processes, before exploring some common variations in the structure and form that this joining process takes.

Processes of Joining: Welcoming the Other

The idea of 'welcoming the other' – to encounter another person in all of their individuality and subjectivity – originates in the philosophy of Levinas, but has also been argued as being a central value in the practice of counselling (Cooper, 2009). Orange (2016) calls this an act of therapeutic hospitality, and thus the counsellor acts somewhat like a good host. That is, in welcoming the client into the therapeutic space they have multiple aims, such as:

- helping the person feel at ease;
- orientating them to the space and helping them feel comfortable and safe; and
- showing respect and honour to the person and their needs.

Consequently, the counsellor is critically aware of the importance of these early moments of these relationships and the power of first impressions. In welcoming the client, the counsellor is attentive to small details in how they greet the client and introduce themselves, appearing prepared, professional and unhurried, and being able to readily connect with the client over small talk.

How welcome the client feels can even be influenced by how they have experienced the practice before they meet the counsellor. This includes factors like the website, the process of booking the session, the ease of access to the session (whether that's the location or the technology if the session is via telehealth), and the nature of the space in which therapy takes place.

In summary, in effectively welcoming your client, you can ask yourself two questions:

1. What might be happening that could lead the client to feel less safe?
2. What might I do to help the client feel more safe?

Processes of Joining: Clarifying Hopes, Concerns and Expectations

A distinctive part of the joining process is the exploration of the client's hopes, concerns and expectations. Each of these three areas has implications for the counsellor's goal of making contact with the client and forming an alliance of resonance and trust. Firstly, understanding the client's hopes enable the counsellor to find the major point of connection. In other words, the hopes are the client's energy for engaging in this therapeutic endeavour, and the counsellor wants to join onto these as an ally for this endeavour (O'Hara, 2013).

Equally, understanding the client's concern (or questions) about the process of therapy is crucial to the joining process. These concerns present potential barriers to the joining process, and having the chance to address these directly creates the possibility of overcoming these early. Finally, understanding the client's expectations about how therapy will run and how change will occur is vital to the joining process. Unclarified expectations carry the potential of causing discord rather than resonance, as the client and the counsellor approach the process in different ways.

Processes of Joining: The Invitation

At some point in the process, the counsellor invites the client to share their story and information about themselves. This invitation is not just a routine, utilitarian statement to get conversation going; rather, it is a moment where the counsellor can communicate their sincere desire to listen and to get to know the client. As Nelson-Jones (2008, p. 62), puts it, "permissions to talk are 'door openers' that give clients the message: 'I'm interested and prepared to listen'... Helpers are there to discover information about clients and to assist clients to discover information about themselves".

The invitation may be a simple question, such as:

> *What brings you in to see me today?*
>
> *I'm wondering whether you would be willing to share a little bit about yourself and about what's troubling you at the moment?*
>
> *What was it that led you to make the appointment to see me?*

Some practitioners might include a statement that helps to frame the invitation; for example:

> *There would no doubt be a lot on your mind, and lot for me to get to know in order to be*

able to find out how our time together might be useful for you. Where would you like to start?

If someone other than the client made the referral, it might be worth acknowledging that, as well as communicating that you are present to hear their story:

You were referred to see me by _____. I was wondering whether you could share with me how you see the referral from your point of view?

Remember that the invitation serves the larger goal of making contact and joining with the client. Sometimes clients might have trouble with knowing where to start. In this case, the process of joining will likely be supported by you offering reassurance and further guidance, such as in the following examples:

Sometimes it is hard to get started.

We've got time; there's no rush.

Maybe go back to the day that you made the appointment. What was on your mind that day?

On the referral it said you have been dealing with _____. Can you start by telling me a little more about that?

Practical Variations in Joining Processes

In practice, you may come across some key variations in how the first session is run. From practice to practice and from professional to professional, you will witness a spectrum of different approaches. One spectrum where you may see variation is the difference between a *structured* and an *unstructured* first session. A highly structured first session usually involves a series of prepared topics and questions to guide the information and flow of the session (for example, an intake interview). In contrast, an unstructured first session will allow the conversation to flow naturally and for a direction to emerge organically through the discourse.

Another spectrum that can commonly be seen in practice is the variation between *client-led* and *practitioner-led* sessions. The variation centres on who takes responsibility for the direction and order of the session. Individual practitioners generally have a preference for which way they would like to operate, but often have to also adapt to each client's expectations and communication style.

Each variation has its own strengths and limitations, and practitioners and agencies can at times be found to rigorously defend their preferences. For the purposes of your own development, it is sufficient to know that these variations exist and to come to discover your own preferred way of being, while also being responsive to the requirements of your practice context.

The Skills: Hearing the Story

In pursuing the goal of making contact through the process of joining, there is a range of key skills that counsellors regularly employ. This section will introduce you to the skills of:

- attending behaviour
- observing and reflecting content
- observing and reflecting experience
- observing and communicating process.

Skills: Attending Behaviour

As is widely acknowledged, only a small fraction of our communication occurs using words. We are constantly reading messages from things like bodily posture, gesture and behaviour, facial expressions (especially eye movement and behaviour), vocal qualities (volume, pitch, emphasis, pauses, etc.), physical proximity or distance, and other physiological cues (e.g. breathing rate, changes in skin colour, smell, muscle tension, etc.) (Egan, 2018). In fact, there are so many forms of non-verbal communication that entire dictionaries have been created to document the range of things that we observe every day but rarely take into our conscious awareness (Givens & White, 2021).

For the therapeutic goal of making contact through the process of joining, counsellors use what is commonly called attending behaviour; that is, non-verbal communication that shows attention and interest in the client. In brief, this is the type of behaviour that shows undivided attention to the client. While this might vary slightly depending on the style of the therapist, this often includes things like:

- having a relaxed or composed body (i.e. not fidgeting, distracted)
- facing the client and maintaining eye contact (while being aware of threatening or invasive eye contact)
- being aware of a comfortable physical proximity (not too close or too distant; being at the same height as the client)
- communicating interest through posture (e.g. leaning towards the client)
- having facial expressions, gestures and tone of voice that are responsive to the tone of the client's

story, and also congruent with what you are expressing.

Reflection questions

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://uq.pressbooks.pub/practice-counselling-psychotherapy/?p=168#h5p-13

Skills: Observing and Communicating Understanding of Content

Most people would know intuitively that while being present and attentive is necessary for the process of joining, it is not sufficient. Our clients need more from us than just our attention, and an essential part of that is to be *heard* and *understood*. Therefore, a further part of the joining process is the skill of observing and communicating understanding of the content of the client's story.

The first step on this is being able to identify the key elements of what the client has said. In other words, it is your ability to listen closely enough to hear the essence of what they are saying. At times, the client might give you a particular word or phrase that summarises most of what they are trying to say. In this case, it might be sufficient to reflect this back as closely as possible to the client's words.

In many instances, however, it will be up to the counsellor to find a way to encapsulate the key message of the story. For example, consider a client who might be saying the following:

> *I work four days a week, and Tuesday is my non-workday. But, believe me, it isn't a day off. Not when you're a mother of three kids. So, by the time I got them all to school – and my eldest is in high school, so there's two drop offs – I've already been awake for a few hours. And that's just the beginning. Washing, shopping, errands.*
>
> *Last week I got the car serviced, and that was a nightmare. Took longer than expected, so I was late to pick the kids up. And then, at six o'clock, when my husband walks through the door, the first thing he says to me is, "When's dinner?"*

If the client was speaking at an average rate, they would say that in about a minute or less, which goes to show how much information can be communicated in a short space of time. As the counsellor, it is up to you to identify the message that the client is communicating. In this example, probably no single detail is the most important part of the story. Rather it is the cumulative details that suggest what the client is trying to get across: that she is busy, overworked, under constant demand.

Having observed the key message, the task of the counsellor is to communicate this back to the client. This will largely depend upon the individual counsellor, but the skill involves summarising the message in as succinct a phrase as possible. Using the previous example, the counsellor might say something like the following:

It really was just one thing after another.

It sounds like there can be no end to the demands that you have to fulfil.

So, even your one day away from work is just filled with more work.

Skills: Observing and Communicating Understanding of Experience

As is emphasised by the theories that we have studied in this chapter, understanding the content of the story is only part of the picture. Rather it is important to understand the client's subjective, lived experience of the events that they are describing. As discussed, different people can go through the same thing and have very different experiences. For the client to feel heard, they need you to communicate that you have heard *what it is like for them to live the life they are living*.

As with the content, this involves both observing and communicating. One of the most important elements of lived experience is emotion – the feelings that arise in response to the events of our lives. At times clients will use explicit feeling words, which you can simply communicate back to them to show that you've heard.

Client: When my son talks to me like that, I get really sad.
Counsellor: Sad?
Client: Yeah, upset. After all I've done, he treats me like dirt.

Client: I'm just so mad at my boss. I can't believe what she's done now.
Counsellor: There's a lot of anger there.

Other times, the emotion will be communicated more indirectly, and the counsellor will need to tentatively infer what the experience is like.

> Client: All I asked for was one night of babysitting and Mum couldn't even do that. After all that she does for my brothers, it seems the least I could get.
> *Counsellor: It sounds like this felt really unfair, maybe you're even a bit angry. Would that be right?*

If this reflection is offered in this way, at times the client might be able to clarify their experience, even if the counsellor didn't quite get the exact emotion correct the first time. To continue the previous example:

> Client: All I asked for was one night of babysitting and Mum couldn't even do that. After all that she does for my brothers, it seems the least I could get.
> *Counsellor: It sounds like this felt really unfair, maybe you're even a bit angry. Would that be right?*
> Client: Not angry... more just let down.
> *Counsellor: Yeah, is it more like disappointment than anger?*
> Client: Yeah, yeah. Disappointment is a good word.

Still, the client's subjective experience is not simply limited to the emotions they feel. Other parts of their subjective experience that you need to listen for and observe include things like:

- Values and priorities – What is most important to the client? Is there anything precious to them that is being threatened by these events?
- Causes and explanations – How does the client explain what is happening to them? What is causing their experience?
- Judgements and evaluations – What categories does the client divide the world into (e.g. good/bad, painful/comfortable, etc.)? What criteria does the client use to decide if something is in one category or the other?
- Meaning and significance – Why is this important? What are the implications from the client's point of view?

With these in mind, you will be able to offer more complex reflections of the client's experience. Typically, this includes the client's emotions, but also coupled with a reflection on why they feel they way they feel

from their point of view. Look at the following example of how the counsellor builds a picture of the client's experience throughout the interaction.

Client: Honestly, I still can't believe that Dad's gone. I mean, he was only meant to be getting minor surgery, and so when I got the call to say that he had died... it just felt so unreal.
Counsellor: It was such a shock, wasn't it?
Client: I can't believe he's gone. I know this sounds strange, but I just never considered my dad dying. He's so strong. And healthy. I mean, I can't even remember him being sick. It was like nothing could stop him.
Counsellor: It sounds like it is almost unbelievable – unfathomable – that someone who seemed so unstoppable could be gone so suddenly.
Client: Right. You know, I probably just expected him to grow old. You know, get frail, get sick, that sort of thing. I can picture him as an old man slowly losing his strength, but I'd never thought he'd die at his age.
Counsellor: So part of the shock of all of this was that you had never expected it to happen in this way. It is not the way that things were meant to pan out.

Skills: Observing and Communicating Observations of Process

A final skillset that counsellors use through the joining process is observing and communicating process. As gestalt and existential theory would posit, this means listening to how the client is telling their story, and not just what they are saying. It means paying attention to the here-and-now process occurring in therapy, and (if appropriate) reflecting on what messages this might be communicating.

Some of the things that you might pay attention to in observing process include:

- the client's body language, non-verbal communication, mannerisms, and gestures
- the way the client structures their story, such as what material they prioritise, the sequence in which they put events, and words or expressions that are used more than others
- any discrepancies or omissions, such as an inconsistency between the content of the story and the client's affect, or a reaction or consideration that might be expected but is not present
- how the client interacts interpersonally (this will be covered in more detail in Chapter 6).

At times, the here-and-now process will be able to be observed, but sometimes it might be that the counsellor will want to ask about it directly:

You've been talking a lot today about a very distressing part of your history. I am just wondering what that's been like for you to do this, and how you are feeling here and now having told this story?

There's no doubt that this whole experience has left you very stressed. Can you pinpoint anywhere in your body where you are feeling or sensing that anger right now?

In observing and communicating process, it is important to be clear about what you do know and what you don't know. What you do know is *what you have observed*. What you don't know is what it means. Therefore, in communicating your observation of process, it is best to focus on the observation and allow the client to fill in the interpretation. The most obvious way to do this is to couple the observation with an invitation for the client to explain it; for example:

I notice that you keep looking at your watch. Is there something on your mind that would be useful for me to know about?

[Client goes silent] I'm just wondering what is going on for you at the moment?

Just now, as you've started to talk about the work you do, I've felt your energy lift and seen a smile on your face for the first time this hour. Can you tell me what that's about?

Another way to do this is to make the observation and offer a range of possible explanations, leaving it open for the client to explain this for you.

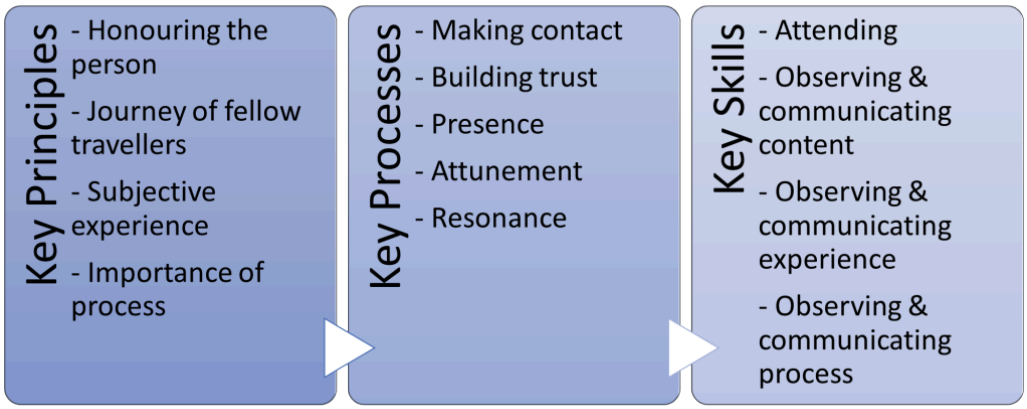
It seems that every time we start to talk about your relationship you start to rub your eyes and your brow. Are you thinking about something, or is this something that is difficult to talk about, or something else?

Conclusion

This chapter has introduced the importance of the first session of counselling. Using the theoretical

foundations of gestalt and existential psychotherapy, this chapter has provided an overview of some of the key principles, processes and skills that are provide a foundational for effective practice in counselling and psychotherapy. These are summarised in the figure below:

Figure 1. *Key Principles, Processes and Skills for Effective Practice in Counselling and Psychotherapy*



An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://uq.pressbooks.pub/practice-counselling-psychotherapy/?p=168#h5p-5

Given the centrality of the first session of counselling, understanding these principles and mastering these processes and skills represent a key priority – perhaps even the highest priority – for new practitioners. The more time you can spend in deliberate practice activities of trying, reflecting, getting feedback and trying again, the better. That said, the mastery of these skills also represents the work of a lifetime.

Questions for Reflection

An interactive H5P element has been excluded from this version of the text. You can view it

online here:
https://uq.pressbooks.pub/practice-counselling-psychotherapy/?p=168#h5p-14

Additional Reading

The following books are some of the most thorough introductions to the foundational skills of counselling and psychotherapy, and are thus a great reference to get in depth information on how to practise the skills:

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6.

PSYCHODYNAMIC THEORY

Denis O'Hara

"The therapist's task is to reach to the heart of loneliness and speak to that." – Robert Hobson

Key Takeaways

This chapter traces key ideas in the development of psychodynamic approaches to therapy.

- Unconscious processes such as defence mechanisms, splitting, and projective identification are explained and their relevance for the therapeutic process identified.
- The importance of therapy being a safe 'holding environment' is briefly explored.
- What is described as a 'relational turn' in psychodynamic theory is highlighted.
- An integrative view of psychodynamic theory is described in brief.
- Understanding the place of communication microskills within a psychodynamic framework is discussed.

Overview

This chapter provides a general introduction to modern psychodynamic theory. There are many contributors to the development of the theory and as such, it is beyond the scope of this chapter to cover the full breadth of contribution. It is true to say that there is no one psychodynamic theory as such, but many theories have a broadly common theoretical foundation and practice focus. Our modest aim is to provide a brief description of the development of the collected theory and to explain commonly held psychodynamic views about psychic structure and the therapy process, what might today be called, an interpersonal psychodynamic approach to counselling and psychotherapy.

Early Developments

Psychodynamic theory owes a great deal to Freud's (1923) psychoanalysis and his key ideas about intrapsychic structure. Concepts such as the unconscious, objects, the impact of anxiety, the idea of psychological development in general, transference and countertransference, splitting, and other concepts form the foundation of psychodynamic theory. There are, however, some major differences between Freud's views and modern psychodynamics. One of the first significant departures from Freudian theory was the shift away from understanding biological drives as the primary explanation for human behaviour. Freud's classical intrapsychic structure of id, ego and super-ego is an essential feature of psychoanalytic theory. While many theorists appreciate the notion that the psyche is divided or organised into different sub-structures or functions, the focus on the influence of libidinal and aggressive drives as formulated by Freud is not generally a view shared by psychodynamic theorists.

Ronald Fairbairn

One of the earliest theorists to move away from the notion of drive theory and set the scene for the development of a psychodynamic view of the person was Scottish psychiatrist Ronald Fairbairn. Fairbairn (1952) proposed that people are not principally driven to relate to other people (i.e., objects) to satisfy pleasure-seeking drives, but are naturally relationship seeking. In Freud's scheme, when an individual has strong Id impulses (e.g., libidinal/sexual) they seek satisfaction or relief of the drive through objects. Contrary to Freud, Fairbairn believed libido is not a pleasure-seeking force but an object seeking-one oriented towards forming and maintaining relationships.

Instead of Freud's intrapsychic structure of id, ego and superego, Fairbairn (1944) proposed what he called an endopsychic structure containing three different features:

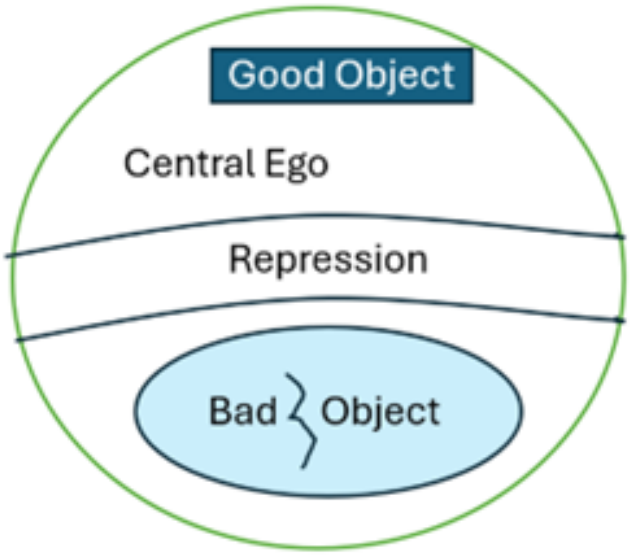
- **Central ego**: The part of the self that engages in realistic and adaptive interactions with the external world.
- **Libidinal ego**: The part of the self that is driven by the desire for gratifying relationships.
- **Antilibidinal ego**: The part of the self that harbors negative feelings and defenses against disappointment and rejection.

From a psychodynamic perspective, we internalise or introject experiences and representations of others into complex cognitive/affective frames of the self and other. Within this model, psychological disturbances arise from problematic internal object relationships rather than unresolved instinctual conflicts.

The notion that the ego can be split into different components is a central idea within psychodynamic theory. Most psychodynamic theorists would agree that through developmental challenges and relational injuries individuals protect themselves, largely unconsciously, by repressing or pushing down into the unconscious aspects of their experiences. While theorists don't always agree on the exact form of this repression and splitting of the self, there is general agreement that splitting as a process exists. Fairbairn was

one of the first to provide a detailed explanation of the process and structure of splitting. He asserted that in the process of relating with primary others we experience both positive and negative interactions. In other words, we can experience the other as good or bad in given moments. As it is difficult to relate to an aspect of another that is experienced as bad in the real world, Fairbairn suggests that we repress the 'bad other' into our unconscious and maintain the 'good other' in our conscious awareness. The notion of a 'bad other' does not necessarily mean that the other person is bad; rather, it is better to think of this as an experience of the other which may range between an uncomfortable aspect of their personality or behaviour and objectively harmful behaviours of the other such as in emotional or sexual abuse. A representation of this psychic structure is seen in Figure 1 below.

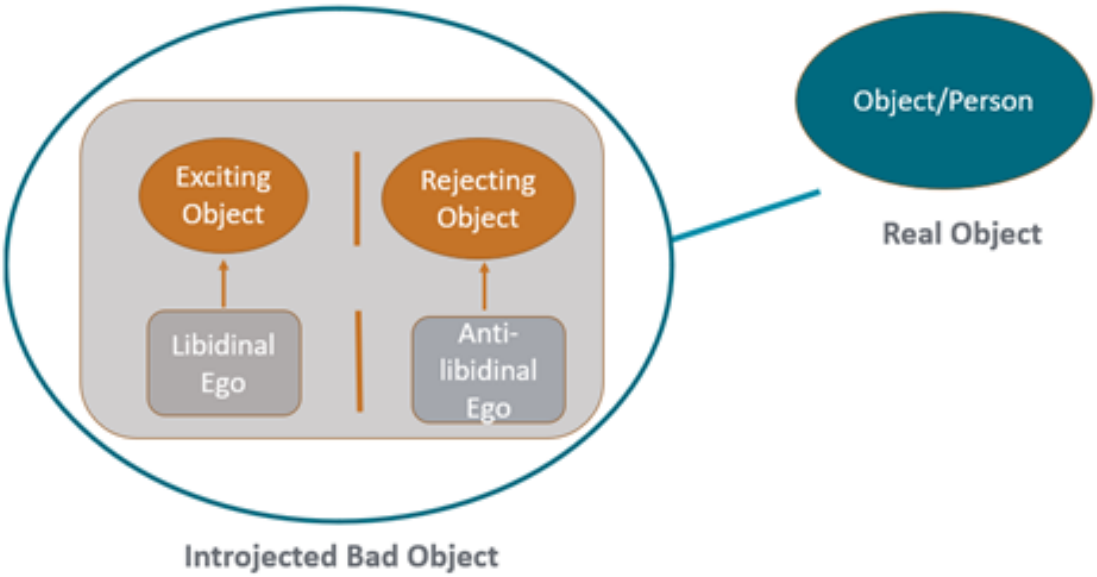
Figure 1. *Fairbairn's Intrapsychic Structure*



"Fairbairn's Intrapsychic Structure" by Dr Denis O'Hara, licensed under a Creative Commons Attribution NonCommercial 4.0 International licence

The difficulty with splitting the perceived bad aspects of the other into the unconscious is that some aspects of what is uncomfortable about the other, and therefore considered bad, may actually be more enticing aspects of the other with which we are not ready to engage. Hence, the fact that the other may be strong and spirited, while somewhat disconcerting for a child, may also be exciting and alluring. At the same time, there may be aspects of the other that are fundamentally experienced as harmful and therefore bad. In recognition of this reality, Fairbairn argued that the object was further split into the exciting object and the rejecting object and that a part of the ego is attached to both. This can be seen in the Figure 2 below.

Figure 2. *Introjected Bad Object*



When the split off 'bad object' is not integrated into a holistic view of the other as in the normal maturation process, the individual is more likely to engage in an unconscious relationship with the perceived bad aspect of the other. In the case of the exciting (bad) object, the unintegrated ego is still desiring attachment to the object, seeking from it the qualities/relationship which the ego perceives has been withheld or missing. This unintegrated position produces a relentless pursuit or expectation of the other that, in reality, the other cannot fulfil.

Figure 3. *Connection between Introjected Ego and Bad Object*

The ego is in effect saying. "Be who I want you to be" "Relate to me the way I want you to relate to me". Underneath the pursuit is a desperation which is fuelled by the unconscious despair that maybe the other does not give the individual what they want because there is something unacceptable or wrong with them. One could say that this repressed confusion is filled with a shame in being. A central action of the maturation process is the progressive disillusionment of this unconscious expectation through growing awareness. The individual has to come to realise that they cannot gain from the other what they are seeking. This realisation leads to a grieving process, a letting go of unrealistic expectations and ultimately to a more integrated self.

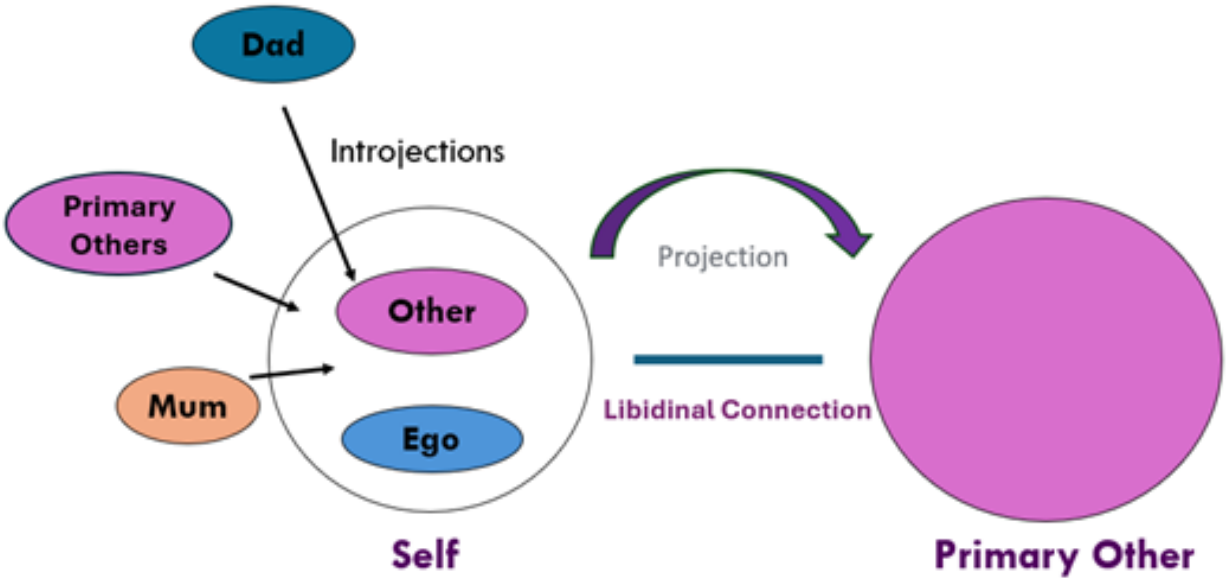
A lot more can be said about the implications of Fairbairn's endopsychic structure but that is beyond our brief in this chapter.

Melanie Klein

Melanie Klein, along with Fairbairn, Donald Winnicott, Anna Freud, and others, collectively contributed to what has been referred to as the British Object Relations School. This is not to say these theorists agreed with each other on all aspects of theory, but they did hold many essential ideas in common as noted above. Klein, Winnicott, and Anna Freud explored the nature of early psychological development. Klein, for example, proposed different stages of intrapsychic development and also noted that splitting was a natural aspect of the human process. Somewhat differently to Fairbairn, Klein (1946) believed that we did not just split the 'bad object' into our unconscious but also the good. Hence, we have introjected aspects of a good and bad self and a good and bad other. Similar to Fairbairn, Klein understood splitting to occur as a way of managing emotionally overwhelming and frustrating experiences.

Klein (1946) asserted that splitting was a normal part of psychological development because it was a primitive (meaning early) way of managing relational stress and anxiety. However, in mature adult development the aim is to reconcile the split aspects of the ego and object/other so as to reach a more integrated view of self and other. This process is more obviously seen in late teenage and early adulthood where the individual begins to realise that one's parents have both strengths and limitations, that they like all people, are a mixture of both appealing and unappealing qualities. You can see in the Figure 4 below how we introject or internalise aspects of primary others and our experience of them into our inner schemata or models of self, other, and the world.

Figure 4. *Introjection and Projection*



An important contribution of psychodynamic theory is an explanation of what happens when the process of maturation or psychological integration does not progress successfully. In reality, no one reaches a perfect level of maturation and hence we are all in the process of development throughout our lives. Freud proposed that we all experience anxiety in living and manage our anxiety through defence mechanisms. Psychodynamic theorists agree that we defend against the experience of anxiety through such mechanisms and as such these mechanisms provide a window into what is occurring in an individual's intrapsychic experience. Freud's list of defence mechanisms is well known and includes:

1. **Repression**: Unconsciously blocking unacceptable thoughts, feelings, and impulses from conscious awareness. For example, a person who has experienced a traumatic event may not remember it because it is repressed.
2. **Denial**: Refusing to accept reality or facts, thereby blocking external events from awareness. For instance, someone who is addicted to alcohol might deny having a drinking problem.
3. **Projection**: Attributing one's own unacceptable thoughts or feelings to someone else. For example, a person who is angry at their boss might accuse their boss of being angry at them.
4. **Displacement**: Redirecting emotions or impulses from a threatening target to a safer one. For example, a person who is frustrated with their boss might go home and take out their frustration on their family.
5. **Regression**: Reverting to behaviours characteristic of an earlier stage of development when faced with stress. For example, an adult might throw a temper tantrum when they don't get their way.
6. **Sublimation**: Channelling unacceptable impulses into socially acceptable activities. For example, someone with aggressive tendencies might take up a sport like boxing to channel their aggression.
7. **Rationalisation**: Justifying behaviours or feelings with seemingly logical reasons, even if these are not the true reasons. For example, a student who fails an exam might blame the difficulty of the questions rather than their lack of preparation.
8. **Reaction formation**: Acting in a way that is opposite to one's unacceptable impulses. For example, a person who feels insecure about their masculinity might act overly macho.
9. **Introjection**: Internalising the beliefs and values of another person. For example, a child might adopt the attitudes of their parents.
10. **Identification with the aggressor**: Adopting the characteristics of someone who is perceived as threatening. For example, a victim of bullying might start to bully others.

Klein (1946) proposed an additional defence mechanism known as **projective identification**. This is regarded as a more primitive form of defence and is the process whereby individuals project unwanted parts of themselves onto others and then interact with those others as if they embody those projected parts. This process goes beyond projection in general where an individual transfers thoughts and feelings onto another. In projective identification an additional step is taken wherein the individual tries to recruit the other person into the beliefs and feelings projected onto them without being aware that these thoughts and feelings are part of themselves. Projective identification occurs when healthy psychological development is in some way blocked or limited and can be highly disruptive in close and intimate relationships.

Donald Winnicott

Donald Winnicott is another significant theorist who contributed to what may be regarded as modern-day psychodynamics. As a contemporary of Fairbairn, Klein and Anna Freud, and as both a paediatrician and psychotherapist, he appreciated the profound impact that developmental experiences have on children in their formation of the self and the movement towards adulthood. Like others from the British Object Relations School, he understood that we all interpret our relational experiences idiosyncratically constructing internal representations of the self, others, and world. Winnicott (1965) believed there is a nascent genuine or true self that experiences life and that this true self, in the process of constructing a mature functioning self, protects itself through various defences which he believed formed a type of false self. This double-self representation is best pictured as a seed kernel of the true self surrounded by a protective husk of the false self. To help us manage difficult emotional experiences Winnicott thought that we present to the world a self that is not always genuine. This false self emerges to protect the true self but in so doing confuses which self is the genuine self. When the individual struggles to connect with their true desires and emotions it results in a sense of disconnection from their authentic or true self. While living authentically out of the true self is a life-long challenge, it is particularly salient in teenage and early adulthood when the task of establishing one's identity is central.

Another seminal contribution of Winnicott is the concept of the 'good enough mother'. This idea might well be widened to refer to the 'good enough parent' or carer, but Winnicott did particularly denote the essential place of the mother's care, especially in the early months of life. Focusing on the importance of nurture and the provision of a safe environment, Winnicott highlighted that if the infant experienced attuned relational care as well as functional care as in appropriate feeding and hygiene, they would experience the world as a warm and inviting place. He referred to this caring provision as the 'holding environment'. Parents and carers are responsible to provide an environment in which both the psychological and physical needs of the child are provided responsively according to the child's developmental stage. Some form of a holding environment is provided by parents until the child transitions into adulthood. In the early months of life, this provision of care and nurture is particularly dependent on eye contact, and on the touch and smell of the mother. Winnicott noted however, that while this was essential for effective nurture, it did not imply that the mother or primary carers had to provide this care perfectly. Hence, as long as care in all its various forms was consistently provided, albeit imperfectly, the child would feel safe and loved. This is the notion of the 'good enough mother'.

It is important to remember that in the period that Winnicott was writing there was still a strong cultural influence on views about psychological health reflective of Freud's more deterministic perspective about the influence of the unconscious. Winnicott was to some degree countering this overemphasis by implying that yes, we are influenced by our experiences, which may be registered in the unconscious, but a 'good enough' nurturing environment was really all that was needed. This view was not only refreshing but also had clear implications for the practice of psychotherapy. A therapist in this view does need to provide a safe 'holding environment' but cannot do so perfectly or provide a faultless response to a client's/patient's needs.

Stephen Mitchell

The progressive development of psychodynamic theory reached a seminal moment in the work of Stephen Mitchell. Building on the work preceding him, Mitchell (1988) highlighted the importance of relationship over drives in what he referred to as the 'relational matrix'. Essential to this is the view that personality and psychopathology are shaped by early formative relationships. Mitchell reasoned that if relationships are fundamental in the formation of the self, then it is relationships that will provide the ground for healing. This view had significant implications for practice and was a departure from the classical approach that viewed the therapist as a neutral observer. Mitchell saw the therapist as an active participant in the therapeutic process, co-creating the therapeutic experience with the client.

This shift towards a much more relational approach encouraged therapists to be more attuned to the relational dynamics within therapy. It involved recognising and addressing the ways in which both the therapist's and client's histories and relational patterns influence the therapeutic process. Mitchell's approach highlighted the importance of authenticity and mutuality in the therapeutic relationship and the need for emotional presence.

Robert Hobson and Russell Meares

Two psychiatrists one from the United Kingdom, Robert Hobson, and one from Australia, Russell Meares, became dissatisfied with the psychanalytic approach dominant at the time they were working together in the 1960s. Much of their work was with highly dysfunctional patients, many of whom today would be diagnosed as having borderline personality disorder. Drawing on a breadth of theory including Freud's psychoanalysis, the self-psychology of Heinz Kohut, the client-centred therapy of Carl Rogers, and Carl Jung's analytic psychology, Hobson highlighted the essential place of the therapeutic relationship and of emotional experience. Hobson initially developed what became known as the 'Conversational Model' also called psychodynamic interpersonal therapy (PIT) by analysing recordings of counselling sessions (Hobson, 1985; Guthrie, 1999). In these recordings he observed that the patient's sense of self could either flourish or deteriorate within the counselling session. He represented these fluctuating experiences by the term 'form of feeling'. Hobson noted that within the micro-moments of a relational interchange, the feeling experience or 'form of feeling' was ever changing and dynamic. He noted that part of this movement was influenced by how responsive the therapist was to the client's experience in the moment. For example, a misaligned response, wherein the therapist communicated inadvertently that they did not understand or appreciate the client's narrative or emotional state, tended to result in a negative shift in the 'form of feeling'.

The 'form of feeling' was also related to what is sometimes referred to as the 'intersubjective field' or 'therapeutic third'. This is the concept of the 'space between' the therapist and client. Each interlocutor brings their own histories and experiences to a meeting, but in the meeting, it is also recognised that there is a third entity: that is the feeling in the room, the energy or space between each person. Hobson highlighted the significance of the interrelationship between each person's 'form of feeling' and its relationship to

the 'therapeutic third'. In recognising this powerful dynamic Hobson coined the term 'aloneness-togetherness'. This dialectic highlights the balance between individuality and relational connectedness. The central idea of the approach is to foster the client's sense of personal being by encouraging a form of conversational relating that allows them to feel seen, accepted, and understood.

The focus of therapy for Meares and Hobson is the experiencing self within the micro-moments of therapy. Priority is placed on the therapeutic relationship for it is the relationship that provides a corrective emotional experience, fostering the development of a more cohesive and resilient self. Meares (2005) highlights the fact that if the self emerges in childhood through an experience of play in a safely attached environment, it is also through play that the adult self is healed. By play he is referring to the freedom to move between inner-world speech of metaphor, dreams, and association, and outer-world social speech focused on communication, allowing the 'felt sense' of one's body and emotions to be encountered in new ways. Meare's book, 'The Metaphor of Play' expresses the profundity of self-discovery especially as it is mediated through somatic and emotional engagement in the presence of an attuned other.

Martha Stark

Martha Stark is an American psychiatrist and psychodynamic psychotherapist who has written extensively on the development of psychodynamic therapy with a view to providing an integrative framework for the various contributions to the field. Stark highlights that each stage of the development of psychodynamic theory has provided a new insight and way of working, enriching the whole field. She identifies three broad stages of this development referring to them as three models of therapeutic action (Stark, 1999).

1. Classical Psychoanalytic Theory
2. Self-Psychology and Deficit Theories
3. Contemporary Relational Theories

Each model, while having much in common, has a different therapeutic focus. Classical psychoanalysis aims is to promote understanding of intrapsychic conflicts and facilitate insight into the working of one's inner world. This is largely brought about by gaining insight into one's inner conflicts. It is not uncommon in this approach for the client and therapist to spend many sessions exploring the client's history and internal struggles, especially as expressed in the form of defence mechanisms, with the therapist providing an interpretation of their meaning. The task of the therapist in this approach is to act as an observer and interpreter or analyser, hence the term analyst, of the client's internal struggles. Stark refers to this approach as a *one-person therapy* as the therapist classically is understood to be a neutral observer.

In what Stark refers to as the deficit models, the focus is on what clients did not gain or achieve in their developmental years and thus are still seeking. For example, a person who did not receive warmth, care and loving attention in their family is likely to still be seeking such relational care and loving support in adulthood. While this, of course, is a natural desire throughout the life span, the relentless drive to gain such care is likely to result in dysfunctional expectations of primary others, negatively affecting relationships. Stark refers to Heinz Kohut's Self Psychology as an exemplar of this approach. Kohut argued

that what the narcissistic client did not receive was empathic and loving recognition in their developmental years and hence in adulthood is still seeking such personal affirmation. The lack of normal developmental recognition and support can result in a narcissistic personality formation wherein the individual develops a grandiose self and tries to manage their need for recognition through controlling and manipulative behaviour. Instead of focusing on analysis and interpretation, Kohut in such cases saw that the primary need was the provision of empathy and understanding so that the person progressively gained what was never received. This is not to say that the only goal of therapy in this view is to fill the void of insufficient developmental care. An important focus in the approach is to provide enough empathy and care so that the person is supported to grieve that which was never gained. In this respect, the focus is on empathic care so that the person is able to move through the grieving process to acceptance. Stark refers to the deficit models as *one-and-a-half-person therapy*. This is because unlike the classical analyst, the therapist is much more relationally involved in the therapeutic process. They allow themselves to feel the client's pains and struggles and offer empathic support. However, the therapist is still in the expert position in which they do not share their own self.

The most recent developments in psychodynamic therapy are the relational theories. The notable turn in this direction came with the work of Stephen Mitchell and is also central to the Conversational Model developed by Hobson and Meares, the mentalization based therapy of Bateman and Fonagy (2016) and other modern dynamic approaches. In this different expression of relational theory, the therapist not only seeks to understand the client's internal world and to provide some measure of repair to client deficits but also participates as a 'real person' who not only presents their expertise but also themselves as a person. This approach, similar to the expression of the therapist self in humanistic therapies, prioritises a genuine encounter between therapist and client. The therapist allows themselves to be 'affected' by the client, to empathically enter the client's world not just for the purpose of appreciation of the other but also for the purpose of a genuine meeting between two people, a *two-person therapy*. According to Stark, the focus of therapy in the relational approach is to work with client enactments with a view to relational detoxification. When a client is presented with a genuine two-person encounter, it is more likely over time that their unresolved inner dynamics will emerge within the relationship. Here we are likely to see such defences as transference and projective identification play out in therapy. Within the dynamics of the relationship, the therapist will be at times the object of projection and therefore be affected by the client's expectations. A skilful therapist will be able to work with the client to relationally process such psychic material enabling a detoxification of unresolved dynamics.

Implications for Practice

A central feature of all psychodynamic approaches is use of the therapist's self, mediated through the therapeutic relationship. There is less focus on interventions as objective strategies like developing a thought record as in CBT or employing two-chair work as in gestalt therapy, for example. Generally, the intervention is the relationship itself. This is not to say that there are not key processes attended to by the therapist. Psychodynamic therapies predominantly share the importance of working with transference and counter-transference, facilitating emerging insights about intrapersonal and interpersonal dynamics,

providing new and corrective emotional experiences via the provision of experiences not previously gained, and through processing enacted interpersonal dynamics (patterns) through a real two-person encounter. Therapists who employ modern interpersonal psychodynamic therapy integrate the three models outlined by Stark to meet the need of the individual client. As Martha Stark (1999) expresses it, "Armed with what she has come to know about the patient by way of listening to her, the therapist will intervene in a manner that involves either (1) enhancement of knowledge, (2) provision of experience, or (3) engagement in relationship as the primary therapeutic modality" (p. 236).

An interpersonal psychodynamic therapist would commonly work with clients by:

- joining with the client in a two-person encounter
- working in the here-and now while being aware of past developmental experiences
- attending to micro-moments especially shifts in emotional and somatic expression and follow these where they may lead
- reflecting these shifts to the client sensitively in a well-timed manner
- acknowledging changes in the relational dynamic in the room (e.g., transferential moments, defences, immediacy)
- encouraging the client's discovery of insights and new meanings in a shared co-discovery.

Thinking About Skills

Given the focus of the therapeutic relationship in psychodynamic therapy it is obvious that active listening is a central capacity required of therapists. Training in communication microskills common to much of counsellor education is less prominent in standard psychodynamic programs. This is not to say that microskills are not valued. Traditionally, the emphasis on listening and interpretation have implied the use of microskills and assumed that such skills were part of the counsellor's repertoire. Listening skills such as paraphrasing and summarising are essential to any deep listening encounter. Obviously other skills such as questioning and focusing are used in psychodynamic therapy as well. A microskill which does have prominence in psychodynamic therapy is 'immediacy' due to the importance placed on the relationship as the principal site of therapeutic action. Immediacy refers, first, to the ability to attend to and become aware of the dynamic in the room and within each person, and secondly, to be able to share this awareness. Immediacy may focus on either positive or negative experiences. For example, a counsellor recognising a sense of stuckness in the counselling process might say, "While we've been working well on key issues over the past weeks, I feel like today we're a bit stuck and somewhat frustrated. I'm wondering if you feel that too?" This type of communication represents a genuine two-person relationship and much less one where the therapist takes an expert position.

The skill commonly referred to as 'reflection of feeling' has an important place in modern interpersonal psychodynamics. In counselling and psychotherapy we distinguish between emotions and feelings. Emotions are understood to be the more comprehensive aspect of human functioning related to somatic states including the chemistry that produces emotion, while feelings tend to refer to that aspect of our emotional and somatic states of which we become aware. Hence, our body, for example, might be in a

state of anger involving such factors as increased muscle tension and cortisol production, the narrowing of peripheral vision, and increased hearing acuity, yet we may be largely unaware of feeling angry. Reflection of feeling and more broadly the reflection of somatic states is an important skill as cognition is always linked to emotion. It would be correct to say that *we think what we feel.* It is often the case that we only become aware of our cognitions and the related meanings we attach to them when we become aware of our feelings. Hence, the ability to attend to emotional and somatic states and to offer well timed reflection of these to clients is a key aspect of the therapeutic process.

Another central skill that is well represented in psychodynamic approaches is the 'reflection of meaning'. A reflection of meaning is a tentative recognition of what new awareness is emerging within the conversation. This is different from providing or asserting a particular explanation of the client's intrapersonal or interpersonal experience (interpretation). Rather, a reflection of meaning is the skill of reflecting back to the client what they are presently discovering. A reflection of meaning offered by the therapist helps the client to ground and clarify that which is already arising in client awareness.

In sum, the ability to apply the full scope of communication microskills is essential to any effective therapy and as such is an important foundation for the psychodynamically informed counsellor.

Questions for Reflection

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://uq.pressbooks.pub/practice-counselling-psychotherapy/?p=90#h5p-6

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7.

MOVING TOWARDS CHANGE

Michael Ellwood

"Life is flux" – Heraclitus
"If nothing changes, nothing changes" – Courtney C. Stevens

Key Takeaways

- An understanding of different levels of motivation or readiness for change, and the importance of matching strategies to these levels is vital in meeting clients 'where they are at' in the change process.
- Building on this understanding means building and communicating an accurate and empathic understanding of clients' reasons for wanting and not wanting change, as well as a clear understanding of the strengths, resources and experiences that clients bring with them to the change process.
- In practice, the integration of these concepts involves assessment of readiness or motivation, understanding and strategic use of language in a way that evokes change talk and opens up possibilities for solutions and action steps.
- An appreciation of the importance of reframing away from ideas of client 'resistance' and into ideas of ambivalence, readiness or wanting different types of change is crucial for giving counsellors the responsibility for creating a context for change, while also leaving responsibility of changing (or not changing) with the clients themselves.

Introduction

In the previous chapter you were introduced to psychodynamic theory and its evolution, including the emphasis on the therapeutic relationship; the use of immediacy; an acknowledgement of the power of transference and counter-transference; and reflections on meaning in here-and-now discussions.

In this chapter, you will build further on these ideas and develop an understanding of processes and

considerations around change. In particular, this chapter will focus on two major theories – solution-focused therapy and motivational interviewing – as well as ideas from the transtheoretical model of change. Some of the key principles and strategies that will be discussed from these frameworks include an understanding of the different levels of readiness for change, approaches to goal setting, and strength-based ways of empowering clients to take hold responsibility for their change processes.

The chapter will explore the theoretical origins of these major approaches, including adaptations over time, and will introduce you to the underlying principles and ways of understanding change processes through lenses such as motivation and therapeutic engagement. You will also be introduced to important practice strategies such as eliciting and exploring change talk, assessing and building motivation, and developing client-driven and manageable change plans including seeking exceptions and creating detailed visions of preferred outcomes.

Theoretical Foundations

Solution-focused Therapy

In the 1970s, the Milwaukee Brief Family Therapy Centre (BFTC) became the starting point for what was later best known as solution-focused brief therapy. Led by therapists and researchers Steve de Shazer, Insoo Kim Berg, Eve Lipchik and colleagues, and directly inspired by the previous work of Milton Erickson, Gregory Bateson, Jay Haley, and the Mental Research Institute (MRI) in Palo Alto (Paul Watzlawick, John Weakland and Richard Fisch), the BFTC resolved to effectively create articulated frameworks of practice for brief therapists based on principles of strategic therapy, systems theory, positive psychology and social constructionism, to be implemented through a collaborative therapeutic relationship and within briefer timeframes (often considered as an average of 6-10 sessions). It is worth noting that the 'brief' in brief therapy was intended to reflect the efficient nature of the therapy rather than reflecting a suggested timeframe. The BFTC model is generally goal-oriented, practical, and focused on the present and future, rather than delving deeply into the past. It often emphasises past successes over the origins of problems and examines how language influences the creation or limitation of options and solutions. This approach suggests that individuals enter therapy with a desire for change, but their main issue often stems from the fact that their previous attempts to solve the problem have either worsened the situation or made them feel more stuck (de Shazer, 1985).

Building on her earlier work with the Brief Family Therapy Centre, Insoo Kim Berg, together with co-author Peter De Jong, went on to further elaborate on the theoretical principles of the BFTC approach, to more explicitly articulate solution-focused therapy as a distinct model. In particular, their writing expanded on the key strategies and practices utilised within a solution-focused framework, including seeking exceptions, exploring future-focused questioning including use of the Miracle Question, and identifying client strengths and resources that might be utilised in pursuit of solutions. Shoham et al. (1995) particularly highlights a distinction between the earlier strategic work of the MRI and the solution-

focused approach – that the former is problem-focused and urges clients to *do* something differently, while the latter is solution-focused and encourages clients to *think* differently.

Branching out from the established solution-focused framework, Bill O'Hanlon devised what he came to refer to as solution-oriented possibility therapy (later simplified to Possibility Therapy), along with Michele Weiner-Davis who had worked with Steve de Shazer and Insoo Kim Berg at the Brief Family Therapy Centre. While O'Hanlon had not worked directly with the group, he received mentoring from Milton Erickson and was similarly inspired by Erickson's approach to therapy along with the strategic ideas of Haley and the MRI. Weiner-Davis went on to incorporate possibility therapy ideas into couple therapy and became well known in the 1980s as the "Divorce Buster". While many of the underlying theoretical principles of possibility therapy overlap with those of solution-focused therapy, two key distinctions can be identified – the stronger acknowledgement of client's *emotions*, as well as a greater acknowledgement of the role of *context* in forming client's perception of problems including – the influence of gender, political and historical factors.

In more recent years, other authors and therapists have built further on the foundations of solution-focused therapy to form their own revised models. Two examples of these are solution-focused brief therapy Diamond (Elliott Connie) and solution-focused cognitive systemic therapy (SFCST), also known as the Bruges model (Luc Isebaert). Connie's Diamond model of solution-focused therapy (Connie & Froerer, 2023) aims to simplify the existing SFT framework as a further evolution of the approach. The Diamond model places greater emphasis on identifying the desired outcome from the outset of counselling, and exploring the history of this outcome (where it may have shown up in the client's life previously), the resources for the outcome (the strengths, qualities and skills the client possesses to help them achieve the outcome) and the future of the outcome (how the outcome will show up in the future). Isebaert's Bruges Model of solution-focused therapy (Isebaert, 2016) takes a different approach, using inspiration from early SFT models such as de Shazer's brief family therapy model and integrating other therapeutic models and ideas including cognitive therapy, existential therapy, systemic ideas, and common factors research.

Transtheoretical Model of Change

In the late 1970s and early 1980s, psychologist and researcher James Prochaska began a task of exploring the nature of change – initially the specific ways in which people change on their own, without therapy – with the view of identifying common elements across the range of available therapeutic models and approaches (Prochaska, 1979). Despite an initial sense of disorganisation and disagreement between approaches, Prochaska subsequently identified specific *processes of change* which could be seen in different forms and iterations across the varying models, including such processes as *consciousness-raising, self re-evaluation,* and *commitment* (Prochaska, 1979; Prochaska et al., 1994, pp. 27-32). Building further on this comparative analysis, Prochaska, together with colleague Carlo DiClemente, set about attempting to explore how often clients used these different change processes when attempting to change on their own. In the process of their research, Prochaska and DiClemente started to identify themes around change occurring through a series of changes, leading the development of their *transtheoretical model of change* (Prochaska & DiClemente, 1982). With the subsequent addition of John Norcross to the research team, the group began

a series of studies and papers exploring the application and viability of the model, particularly in relation to identified areas of desired behaviour change such as smoking and alcohol/substance use, further solidifying their model.

In brief, the transtheoretical model of change suggests that people progress through specific stages of change, each requiring different change processes and with different levels of ease or challenge. While stages are generally not skipped, some stages may be worked through quickly, while others may create a sense of 'stuckness'. The stages of change are identified as: *Pre-contemplation; Contemplation; Preparation; Action; Maintenance; Termination* (Prochaska, 1979; DiClemente & Prochaska, 1982; Prochaska & DiClemente, 1982; Prochaska et al, 1994). In particular, the model highlights the importance of matching processes to the relevant stage of change, as well as the vital need to match therapeutic treatments to the stage of change that the client is currently in – indeed, early models were 93% predictive of clients that would drop out of therapy due to such mismatching (Prochaska et al., 1994, p. 58). Additionally, as an identified transtheoretical model, the approach encourages integration and diversity of therapeutic strategies from across different theories, rather than attempting to propose a new orthodoxy and self-contained approach in and of itself (Prochaska & DiClemente, 1982).

Motivational Interviewing

Motivational interviewing is often thought of as 'client-centred therapy with a twist'. Developed by William Miller and Stephen Rollnick in the 1980s, motivational interviewing has clear links to Carl Rogers' person-centred therapy, with overlapping principles around understanding the client's perspective on their life and their presenting concern, and the ever-present acknowledgement of the role of accurate empathy and unconditional positive regard in providing the appropriate circumstances and conditions for change and growth to occur. In particular, the approach was developed as a method for "enhancing intrinsic motivation to change by exploring and resolving ambivalence" (Miller & Rollnick, 2002, p. 25). In this sense, motivational interviewing shares some overlap with Prochaska and DiClemente's ideas of the stages of change, such as the acknowledgement that people approach change with different degrees of readiness, and that reasons for not changing are regarded as valid and normalised as a stage of change.

Motivational interviewing was particularly developed with behaviour change in mind, again with similar areas of focus as the transtheoretical model of change such as alcohol and substance use. It takes the position that clients generally enter therapy with a degree of ambivalence about change, as well as acknowledging a normal 'ebb and flow' of motivation across therapeutic work. Using language such as 'motivation' as opposed to 'resistance' allows for a more respectful stance with clients, as well as more open acknowledgement of the different ways in which people do change. As a point of differentiation from the stages of change model, motivational interviewing can be seen as a stand-alone approach in and of itself, while also holding potential to be integrated with other approaches such as cognitive-behavioural therapy, or to be used as a pre-treatment approach such as working with substance abuse programs. Indeed, meta-analyses of the use of motivational interviewing as a pre-treatment approach as opposed to a stand-alone approach have demonstrated larger effect sizes and longer-lasting results (Burke et al., 2003; Hettema et al., 2005).

Key Principles

Solution-focused Therapy

Strength-based Work

At the heart of solution-focused therapy is the perspective that clients bring strengths and resources with them to counselling, and that rather than being seen as 'broken' clients are viewed as 'stuck' – stuck within a problem-saturated focus, stuck within a sense of powerlessness in bringing about change, or stuck within previous attempts to solve a problem that have brought about further challenges. This belief in clients as possessing strengths and resources also links to the idea that the responsibility for change lies with clients, in respecting client autonomy and expert knowledge of their life and circumstances. Through exploring ideal futures and past exceptions, possibilities for change are opened up via the lens of past or recent successes and concrete actionable goals and steps towards these.

Pragmatic Perspectives

It is not uncommon to hear solution-focused counsellors refer to the 'solution-focused triad' (Berg & Miller, 1992, p. 17):

1. "If it ain't broke, don't fix it;
2. Once you know what works, do more of it;
3. If it doesn't work then don't do it again, do something different".

This triad of principles highlights the inherently pragmatic perspectives of solution-focused counselling – that the counselling work should be simple (the term 'brief therapy' speaks not only to a shorter timeframe for the therapeutic work, but also to the expected simplicity of the counselling approach); that the counselling approach should emphasise what can and does work rather than becoming more stuck in what does not work; and that a key element of the approach should be the encouragement of the client in taking proactive steps towards change.

Alongside this pragmatic approach to change is the perspective that, generally speaking, a thorough understanding of the history of the client and the presenting problem is less helpful aside from an exploration of past exceptions and successes. While some more recent solution-focused models place stronger acknowledgement on the role of context in understanding presenting concerns, the underlying principle behind this perspective links back to the focus on exploring *solution* or *possibility* thinking rather than *problem* thinking.

Goal Setting

The solution-focused approach places great emphasis on the importance of setting clear and concrete goals from early in the counselling process. This is particularly encouraged to be framed through a positive lens

("What will be happening instead?" as opposed to "What won't be happening anymore?"), defined in such a way as to be concrete, behavioural and measurable as well as realistic (De Jong & Berg, 1998), and often explored in relational terms ("Who will notice something different? What would they observe?"). In line with the earlier principle of "doing something different", another consideration within goal setting is to begin with small achievable changes on the path to broader goals of change – that change can 'beget change', and that taking small steps towards doing something different creates movement out of 'stuckness' and problem-focused thinking. It is important to note that the responsibility for setting goals remains with the client, as the solution-focused approach emphasises the importance of client autonomy and responsibility for change (indeed a common misunderstanding of solution-focused therapy – is thinking that the counsellor is responsible for coming up with and suggesting 'solutions').

Readiness for Change

In his 1988 work "Clues," de Shazer introduced three distinct types of client-practitioner relationships that emerge from the start of therapeutic work: visitor, complainant, and customer. These terms were intended to characterize the nature of the relationship between client and practitioner, rather than to describe motivation or 'readiness' for therapy. However, some have critiqued the choice of language for focusing on the individual rather than the relationship itself (Ziegler, 2010; Isebaert, 2016). In a more recent review of these concepts, Ziegler (2010) suggested alternative terms — 'visitor/host, complainant/sympathizer, and customer/consultant' — to better capture the interactive nature of these relationships. Nonetheless, for the purposes of this discussion, the original terms will be used to accurately reflect the ideas of the original authors. These levels of therapeutic engagement can be understood as follows (Ellwood, 2024):

- **Visitor relationship** – has the client identified a concern or requested help? Often seen where counselling has been mandated or coerced.
- **Complainant relationship** – has the client indicated a desire to make changes within themselves or is the problem viewed as external to themselves or outside of their control? Often seen where the client directly or indirectly implies that responsibility for change lies with someone or something outside of themselves, or with the counsellor.
- **Customer relationship** – has the client identified a clear and workable concern as well as a desire to take active steps towards resolving this? Often viewed as the point where real therapy begins.

Transtheoretical Model of Change

Doing the Right Thing at the Right Time

A fundamental principle of the transtheoretical model of change is that 'stuckness' in change is more likely to be the result of attempting to utilise change processes that do not match the current stage of change. This reflects the earlier studies conducted by Prochaska and DiClemente exploring what self-changers were doing and not doing in order to successfully create change on their own, particularly in hearing what

change processes they naturally adopted during different stages of their change journey. An example of this is clients attempting to apply early stage processes, such as self-re-evaluation or consciousness raising, while moving into action stages of change – or the opposite, in attempting to apply action processes without first having developed awareness and readiness. This then indicates an importance of first assessing current level of change – and clearly matching processes to this. The transtheoretical model of change also acknowledges that movement through the different levels may not always occur in a linear fashion, but rather move back and forth at different times within the context of the client's circumstances.

Motivational Interviewing

Four Basic Principles

Miller and Rollnick (2002) suggest four basic principles that underlie the motivational interviewing approach, which then clearly translate into clinical and practical strategies with clients. These are also at times referred to as "engaging, focusing, evoking and planning" (Miller & Rollnick, 2023).

1. Express Empathy

Empathy involves the ability to understand the world from the perspective of another, without judgement or criticism. While empathy does not mean agreement or disagreement with beliefs, feelings or behaviours, it does allow for greater comprehension as to what sits behind these for clients. Only through developing an empathic understanding of clients' worldviews and perspectives that are linked to their concerns can we start to distinguish between reasons for wanting change and not wanting change.

2. Develop Discrepancy

Motivational interviewing suggests that discrepancies between a client's behaviours and their underlying values are what contribute to motivation. Once awareness of these discrepancies becomes more explicit, there is greater opportunity for an increase in motivation to occur. In motivational interviewing, the counsellor is actively listening for explicit and implicit identification of reasons for not changing and reasons for changing, particularly through identification of important underlying values that may conflict with present behaviours.

3. Roll with Resistance

With the view that "resistance" to change can be better translated as "ambivalence", as well as being a normal part of a change process, this ambivalence can be used as a window into the hopes, fears, desires and concerns of the client. Meeting such ambivalence with empathy, understanding and validation allows for a more open discussion of potential outcomes of change (those viewed as both positive and negative) and greater autonomy for the client in coming to their own conscious decisions around change, rather than

the counsellor attempting to 'force' this upon the client (think about the 'unstoppable force meeting the immovable object' analogy!).

4. Support Self-efficacy

As a vital over-arching principle and belief of motivational interviewing, the counsellor views that the client is ultimately capable of making changes once they have desired to do so, including that they possess the strength, knowledge and resources to take these steps. The role of the counsellor particularly comes into play when there is uncertainty about the decision to change (or not change), in which the counsellor acts as a guide or consultant to the client, still viewing the client as ultimately capable and responsible within themselves.

Implications for Practice

Solution-focused Therapy

Seeking Exceptions

Clients usually present to counselling with explanations of the presenting problem in considerable detail, such as when, where and how the problem is experienced, how long it has been occurring for, who else is involved (or sometimes perceived to be at fault), and the experience of the problem including resulting feelings. Exceptions can be defined as the past experiences in which the problem might have been reasonable expected to occur but has not (de Shazer, 1985). Exceptions may be absolute (the problem has not occurred) or they may be a matter of degrees (the problem has occurred but to a lesser extent). The solution-focused perspective would suggest that while initial descriptions of the problem are useful in both describing the preliminary perspective on what is or is not happening from the client's perspective, as well as allowing an opportunity for the client to express and vent their feelings and struggles in relation to the problem – generally such descriptions would be seen as less helpful in building solutions (De Jong & Berg, 1998). As with many solution-focused questions, exceptions can be sought in a number of different ways. This can include where exceptions are located in time (recent exceptions, historic exceptions, and what the context around these have been), whether exceptions occurred randomly or as a result of deliberate attempts or action, and as noted earlier whether exceptions are experienced as absolutes or in degrees of difference. Another distinction between some solution-focused counsellors (such as more traditional solution-focused practitioners versus solution-oriented possibility counselling described earlier) is the difference in how exception questions are posed – while some may ask "Has there been a time when X has not occurred", a solution-oriented possibility approach may instead ask "Tell me about a time when X has not occurred", inferring that the possibility of such an exception is not an *if* but a assumed certainty.

Seeking exceptions can be seen as a fundamental building block for generating solutions, as a shift away from problem-saturated thinking and into generating possibilities for change, as well as opportunities for

developing hope and identifying existing strengths and resources that the client possesses. Exceptions also highlight current and past successes in relation to the client's goals (De Jong & Miller, 1995).

Miracle Question

> *"Imagine going home tonight, doing your usual evening routines – brushing your teeth, putting on your pyjamas, going to bed. Then imagine that, while you are asleep, some miracle occurs – as a result of this miracle, the concern that you are currently experiencing has disappeared. Now, because you are asleep, you aren't aware that a miracle has taken place. When you wake up in the morning, what would be the first indication to you that a miracle has occurred? What would you first notice is different? What would others around you notice is different?"*

One of the more well-known solution-focused strategies is that of the Miracle Question (De Jong & Berg, 1998). Often use as an early exploration, the question is intended to help guide clients towards new possibilities and away from a problem-saturated description of their world. With guidance from the counsellor, the client is assisted to describe in positive terms what a 'preferred future' might look like (George et al., 1999). This description can then lead into more concrete goal setting, including exploration of any changes that might be more immediately actionable by the client, including 'acting as if' elements of the desired future were already true. While the precise wording of the scenario and question can vary according to counsellor preference, the question is best posed slowly and deliberately, allowing the client to purposefully imagine and think about the possibilities.

Scaling

Scaling questions are often used within solution-focused work to assist with making complex and subjective aspects of clients' experiences more concrete and measurable, such as change before the session, feelings about their problem, desire to make changes and evaluation of progress (Berg, 1994). An important distinction from other psychological assessment tools is that scaling questions within a solution-focused perspective are intended as discussion points rather than formal tools – while scaling questions and responses would still be concrete and measurable [for example, 3 out of 10] – these are explored through conversation rather than formal paper-based tools. In particular, scaling questions are valuable as opening forays into designing more concrete goals and avenues for change, similar to the Miracle Question. For example:

Being here today, how anxious are you feeling compared to how you were feeling when you first made the appointment? {6 now as compared to 9 originally} What is different feeling at a 6 as compared to feeling at a 9? What do you think has made a difference in that time between making the appointment and coming here today? What have you been doing, perhaps, that has made a difference there?

As with many solution-focused questions and areas of discussion, the intention is to build on initial responses and explore more deeply and concretely, searching for initial steps, exceptions to the problem, and hidden or forgotten client resources and strengths.

Transtheoretical Model of Change

Change Processes

The transtheoretical model – by its very nature as a transtheoretical approach – considers strategies and processes from different therapeutic models as being relevant and appropriate at different stages of the change process. It particularly highlights ten change processes that have been identified through early change research (Prochaska & DiClemente, 1982; Prochaska et al., 1988) as being of significance, which can be separated into *cognitive* processes and *behavioural* processes.

Cognitive processes include: consciousness-raising; dramatic relief; environmental re-evaluation; social liberation; and self-re-evaluation.

Behaviour processes include: self-liberation; counter-conditioning; stimulus control; reinforcement management; and helping relationships.

The different change processes are seen to be linked to the stage of change themselves, as identified earlier, with cognitive processes being seen as more helpful and more utilised within the earlier stages of change (pre-contemplation, contemplation and preparation), and behaviour processes being more useful within later stages of change (action and maintenance).

Motivational Interviewing

Accurate Empathy

Many of the practical skills involved with motivational interviewing can be seen as directly drawn from Rogers' person-centred therapy, including the use of open-ended questions, reflecting and summarising, affirming, and communicating accurate empathy. Miller and Rollnick suggest that reflective listening is perhaps the most crucial skill of motivational interviewing, in order to gain a more accurate sense of the clients truly mean. They also suggest differing levels of reflecting that may help access progressively deeper

levels of empathic understanding, starting with simply repeating some element of what the speaker has said, rephrasing with minor synonyms or additions, paraphrasing to attempt an inference at a deeper meaning or theme to what the speaker has stated, and reflecting feelings through an empathic understanding of what the client may be experiencing. The development and communication of accurate empathy is not intended as specific stand-alone strategies, but rather the crucial underpinning micro-skills across all stages of working with clients, from initial conversations around ambivalence around change to eliciting and affirming change talk to development action readiness and planning.

Eliciting Change Talk

Building further on the person-centred ideas of developing and communicating accurate empathy, motivational interviewing specifically aims to then target client language that centres around change. Rather than potentially becoming stuck in an endless loop of reflecting and validating, the counsellor aims to ask open questions particularly targeted at exploring themes such as desire to change (*"I wish I could ...", "I want to ...")*, perceived ability (*"I think I could ...", "I am able to ..."*), reasons for change (*"If I don't ... then I'll never be able to ...", "I'd be able to ... if I did"*) and need for change (*"I have to ...", "I really must ..."*). These types of change talk are often referred to as *preparatory* change talk. It is important to note that this is not asking the counsellor to become a proponent of change, but rather helping the client begin to develop their own change talk through skilful questioning.

Additionally, through these conversations the counsellor will likely also be attuning to language that highlights reasons not to change, often referred to as 'sustain talk'. It is seen as normal, particularly within feelings of ambivalence, for the client to be expressing both *change* and *sustain* talk simultaneously. At other times, *change* talk might be seen as sitting just below the surface of *sustain* talk. This requires a level of double listening on the part of the counsellor – being aware of what is being said but also what is not quite being said. Once there is a sense that the language being used by the client is becoming more concrete in communicating a motivation towards change, the focus of the discussion would likely then shift onto talk centred around commitment and action steps (also referred to as *mobilising* change talk).

Commitment and Action

The phase of motivational interviewing focusing on commitment and action involves building upon the more explicitly identified motivation to change towards creating a change plan and further strengthening the commitment and readiness for change. It is important to note that even in this later stage of motivational interviewing, it is normal for the client to still experience a sense of oscillation between motivation and ambivalence, and earlier strategies should not be neglected during later parts of the therapy. It is also noted that clients may experience discrepancy between a motivation to change the overall problem versus the motivation to engage in action towards accomplishing this change.

Reflecting the underlying principle of self-efficacy, it is important to explore a change plan that primarily comes from the client, rather than offered by the counsellor. This often involves conversation and questions such as "How do you think you might make that happen? What might be some steps that are actionable towards this goal?". In the same vein as exploring *preparatory* change talk, the counsellor would be listening

for and evoking *commitment* language (*"I will ..."*) or *activation* language (*"I am willing to ...", "I am considering ..."*) that is not quite concrete commitment but a clear leaning towards action nonetheless. There may also be language identified that signifies steps already taken towards change (*"I have made several phone calls", "I started doing X yesterday"*). Sometimes during the action planning stage the client may express uncertainty or confusion around appropriate steps to take. At this point the counsellor may offer tentative suggestions in the role of a consultant or guide, such as suggestions of what other clients have found useful or the offer of some particular steps or options from other therapeutic approaches. The key here is that the choice for taking these up or not remains with the client – the counsellor is communicating a respect and a belief that the client is able to choose what they need while also being ready and able to provide appropriate guidance to facilitate that choice.

Resistance to Change

Is there even such a thing as resistance? In 1984, Steve de Shazer (after 5 years of rejections) published his seminal paper 'The Death of Resistance', in which he argued that the prevailing idea of resistance as being located within the client or family is an unhelpful, even clinically dangerous, conceptualisation. Instead, he argued, this idea of 'resistance to change' would be better understood as a therapist-client dynamic – one that exists within the system of client/family and therapist collectively – and that an alternate frame of clients using 'a unique way of attempting to cooperate' allows the therapist to be responsible for this relationship, rather than responsibility being placed onto the client/family solely. This distinction is a crucial one for us to consider – where does the responsibility for change lie?

One frame through which this responsibility can be viewed is common across post-modern approaches to counselling such as solution-focused work and narrative therapy. With underlying principles of co-authoring, recognising client strengths/resources and subjective experience, counsellors in this space might often consider themselves more as consultants. This allows clients to be seen as experts within their own lives and experiences, while responsibility for therapeutic processes still sits with the counsellors. As such, clients are responsible for their own change, while counsellors are responsible for creating the *context* in which change might occur. This also means that counsellors are responsible for maintaining the therapeutic relationship, including responding to difficulties in moving towards change or addressing ruptures in the relationship with the client.

In a similar vein to solution-focused approaches, both the transtheoretical model of change and motivational interviewing suggest a reframing of the idea of 'resistance' into an acknowledgement of 'ambivalence' about change or holding a different level of motivation for change. More than simple semantics, this re-wording allows for a more empathic and acknowledging approach to clients, particularly in placing responsibility back onto the counsellor to more accurately determine and respond to the level of motivation and readiness the client is at, as well as opening up further possibilities around pathways and opportunities for increasing motivation and preparing for change in different ways. Motivational interviewing particularly acknowledges this through the (unfortunately named) idea of 'rolling with resistance', inviting the counsellor to sit together with the client in a space of ambivalence and acknowledge choice of direction, including recognising more openly any concerns about the potential negative

implications of moving towards change. Similar to the aforementioned concept of the counsellor creating a context for change while allowing the actual responsibility for change to sit with the client, 'rolling with resistance' also allows for a more transparent conversation around reasons for changing and reasons for not changing and leaves the decision sitting with the client about which direction they ultimately wish to choose.

Reflection Questions

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://uq.pressbooks.pub/practice-counselling-psychotherapy/?p=92#h5p-7

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8.

SYSTEMIC PERSPECTIVES

Michael Ellwood

"Every person's map of the world is as unique as their thumbprint" – Milton H. Erickson
"Without context words and actions have no meaning at all" – Gregory Bateson (1979, p. 15)

Key Takeaways

- The evolution of systems thinking opened new lines of therapeutic thought and intervention beyond individual and intrapsychic perspectives on problems and wellbeing, and has significant implications for counsellors working not just with families but with individuals and other groups.
- Key ideas in systems thinking includes an awareness of circular and mutual causality as opposed to simpler linear causality; the importance of context when understanding clients' worlds; and the ability to explore and understand the multitude of systems that clients exist within.
- Practical applications of understanding systemic perspectives include grasping the key distinction between first-order and second-order change; shifting from a focus weighted on 'content' and into an understanding of and attention to 'process', both in clients' stories as well as in the here-and-now in the counselling room; and the application of circular questioning as a means to introduce new information into systems.
- Context is key! Understanding broader context, regarding clients' presenting concerns and worldviews as well as regarding the counselling engagement itself, allows for a more holistic and accurate understanding of what clients are struggling with as well as developing the most appropriate therapeutic fit.

Introduction

So far in this text you have encountered concepts and processes with a particular focus on individual

counselling. This chapter will expand this focus to explore broader systemic perspectives and concepts that hold further valuable understanding to your work with clients, regardless of whether you are working with individuals, couples, families or even groups. In particular this chapter will explore the underpinnings of some of these perspectives, namely systems theory and cybernetics, and the varying ways in which these principles have been adapted into therapeutic practice over time. From there you will develop an understanding of systemic practices and skills that can be utilised more generally, regardless of which specific counselling approach or modality you may be working from. Reflections at the end of the chapter will also encourage you to consider how shifts from individual to systemic paradigms may change the ways in which you conceptualise client struggles, as well as how you may find ways of working more holistically and incorporating the varying systems within which clients exist.

Cybernetics

The term cybernetics is derived from the Greek word 'kybernetes', meaning 'steersman', and was coined by Norbert Weiner (1948) as a means to describe systems that regulate themselves through feedback loops. While this study of systems was originally conducted by a multidisciplinary group of researchers including mathematicians, physicians, economists, psychologists, engineers and sociologists, its concepts were later introduced more directly into the therapeutic realm by Gregory Bateson (as discussed shortly). This original research, tied quite closely to the events and context of the Second World War, explored not only system organisation and processes but also patterns of communication, and was curious about comparisons between inorganic (material) and living systems, particularly in attempting to better understand complex systems.

General Systems Theory

Around the same time as Weiner and colleagues were exploring the workings of complex systems, Ludwig von Bertalanffy, a biologist in Vienna, was exploring a better understanding of organic systems and their ability to thrive (or not) based on their connections to their environment (1934, 1969). von Bertalanffy's described his later work as *general systems theory* (1969), in an attempt to develop a universal theory for all living systems. This research particularly focused on organic systems as *open systems* – systems that relate with the environment around them, including the ability to adapt to environmental changes, as well as containing more complex interactions between parts of the system itself as well as conditions outside of the system. These concepts were later applied more directly to human relationships – particularly families – as following the same set of systemic principles as other organic systems.

Introduction into Therapy

The link between the broader systems theory world and the therapeutic world was first made in 1946 by Gregory Bateson, an anthropologist and ethnologist, who was more broadly interested in epistemology

(the study of the grounds of knowledge). First coming across the influential works of Weiner, along with other cybernetics colleagues Rosenblueth and Bigelow, at the 1942 Macy Conference, as well as being formally introduced to the ideas of Milton Erickson, Bateson later returned to the 1946 Macy Conference to present the first of what turned out to be many presentations and papers attempting to articulate a more adequate framework for social sciences, and further bridging the gap between the physical and behavioural sciences. During this time, Bateson joined Juergen Ruesch as a research associate in the Department of Psychiatry at the University of California Medical School, and over the next several years began to further clarify his ideas into a theory of human communication (Heims, 1977). Interestingly, it can be noted that the term *cybernetics* was more commonly used within European circles, while in the United States language around *systems theory* was more broadly used (Bateson & Mead, 1976). Bateson again proved to be a crucial figure in bringing together these varied streams of thought (along with others such as Von Neumann and Craik) into a more coherent and unified theoretical framework exploring communication problems along with "the problem of what sort of a thing is an organized system" (Bateson, 1972, pp. 474-475).

In 1953, Bateson was joined by colleagues Jay Haley, John Weakland and William Fry as part of a research project exploring the role of paradoxes of abstraction in communication. The team was joined by Don Jackson, a psychiatrist, in 1954 as part of a new research project exploring schizophrenic communication, and it was this project in particular that led to the famed "double bind hypothesis" (Bateson et al., 1956) – hypothesizing a shift in thinking around understanding schizophrenia as an interpersonal, relational phenomena rather than purely an intrapsychic disorder of the individual. While later argued to be incomplete if not inaccurate, the theory proved to be a milestone in developing broader systemic understanding of what had previously held to be individualistic perspectives on mental health, families and communication. Indeed, members of this original research team went on to form the Mental Research Institute (MRI) in Palo Alto, along with others such as Virginia Satir, Richard Fisch and Paul Watzlawick. Don Jackson, argued to be one of the most prolific authors within family therapy (Foley, 1974), joined along with Nathan Ackerman in 1962 to establish one of the most recognised and prestigious journals in the field, Family Process. During this time, the field of family therapy began to flourish in multiple theoretical directions, with therapists and researchers such as Salvador Minuchin, Nathan Ackerman, Virginia Satir, Jay Haley and Murray Bowen beginning to articulate their own understandings and theories of families and systemic processes in more concrete ways.

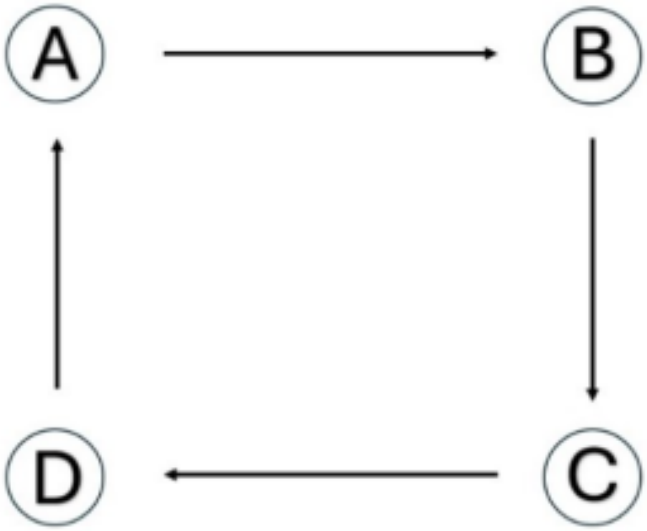
Key Principles

Circular Causality

One of the fundamental shifts in thinking within systems theory is a movement away from ideas of linear causality (A causes B causes C; Figure 1) and into ideas of circular causality (A influences B which influences C which influences D, which in turn influences A; Figure 2).

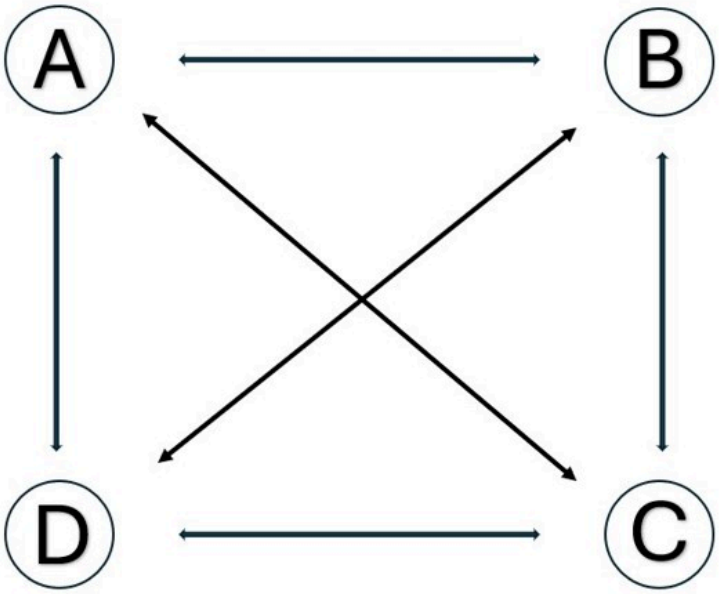
Figure 1. *Linear Causality*

Figure 2. *Circular Causality*



In more specific nuances, one can also view all elements as influencing each other rather than a more simplistic circular demonstration (see Figure 3).

Figure 3. *Mutual Causality*



"Mutual causality" by Michael Ellwood, licensed under a Creative Commons Attribution NonCommercial 4.0 International licence

Becvar and Becvar (2014) discuss the linear causality perspective as a traditional Lockean, scientific view of the world, where one can trace particular events back to a singular cause, while a cybernetics or systems view of circular causality instead focuses on reciprocity and shared responsibility, showing less interest in why something happened and greater interest in what is going on (p. 10). While not without its own implicit limitations (later criticisms highlight the justifiable concerns around suggesting equal or shared responsibility within a family system within contexts such as family violence or abuse), this paradigm shift is still an important shift away from earlier intrapsychic and individualistic views of problem formation, and into a more open conceptualisation of interconnectivity and relational influences.

Context

A simple definition of context is a set of facts or circumstances that surrounds a situation and helps understand it. This brief explanation, however, does not do justice to the profound importance of the idea of context within the field of counselling and psychotherapy – indeed, as the popular maxim goes, "Context is king!" This notion becomes considerably more relevant when exploring the paradigm shift from individual perspectives to systemic and relational lenses. Bradford Keeney (1988) states that "the shock of family therapy involved its proposal that individuals be seen as principally organized by their social contexts" (p. 101), reflecting the change from viewing individual psychopathology as purely intrapsychic to a phenomenon marked by social and relational influences and cues. While the first identification of the role of context within counselling and psychotherapy is more difficult to determine, it was perhaps Watzlawick et al. (1967) who first discussed the role and importance of environment and relationship in their text Pragmatics of Human Communication, through reflecting:

> *... a phenomenon remains unexplainable as long as the range of observation is not wide enough to include the context in which the phenomenon occurs. ... If a person exhibiting disturbed behaviour (psychopathology) is studied in isolation then the inquiry must be concerned with the nature of the condition and, in a wider sense, with the nature of the human mind. If the limits of the inquiry are extended to include the effects of this behaviour on others, their reactions to it, and the context in which all of this takes place, the focus shifts from the artificially isolated monad to the relationship between the parts of a wider system. The observer of human behaviour then turns from an inferential study of the mind to the study of the observable manifestations of relationship* (p. 21).

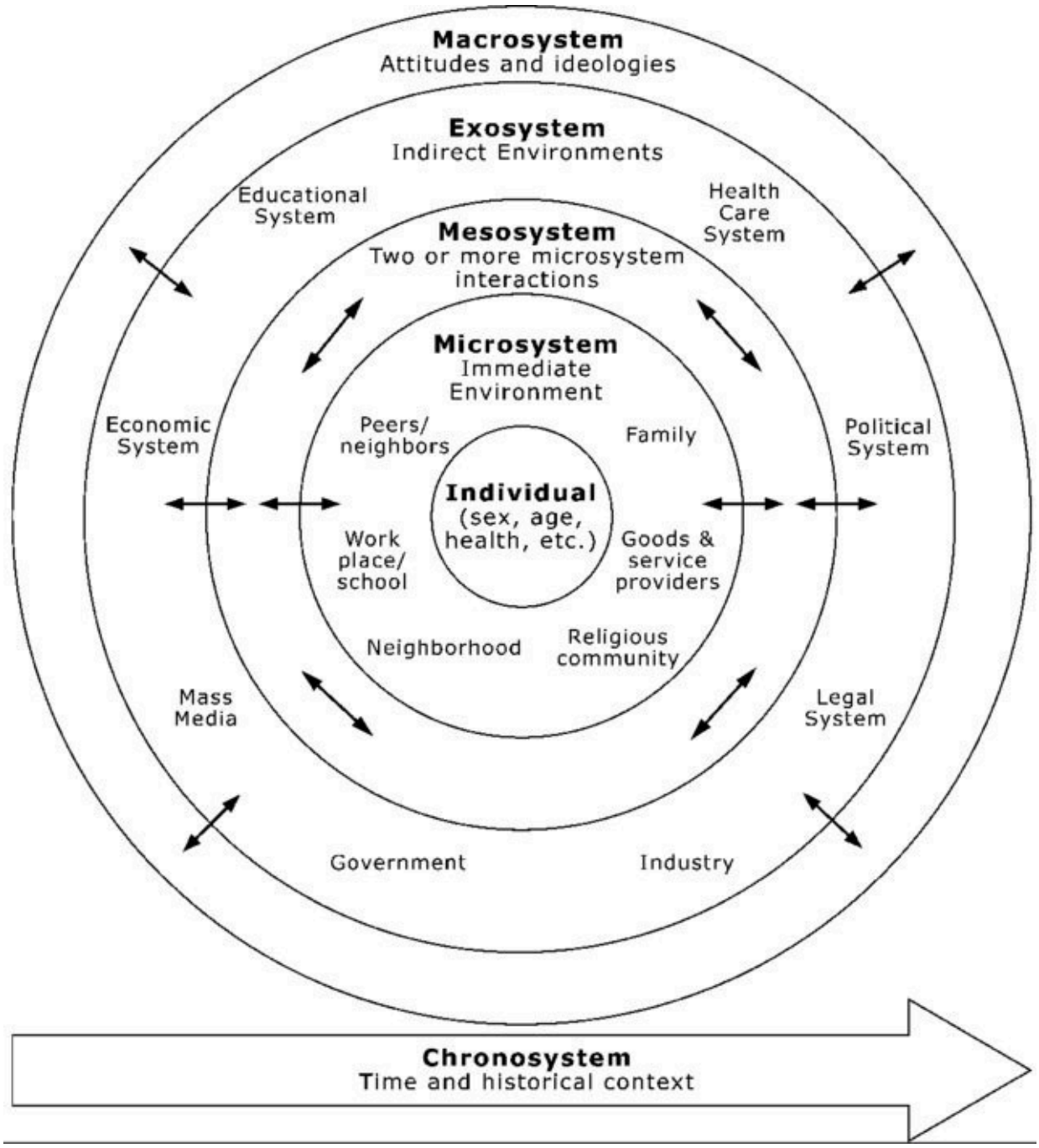
Gregory Bateson (1991) offered a broader set of ideas about context in identifying that "no message or message element – no event or object – has meaning or significance of any kind when totally and inconceivable stripped of context" (p. 143). O'Hanlon and Wilk (1987) furthered this perspective in arguing that reality is always necessarily contextual (p. 183), and that what a thing 'is' always depends on the context in which it is found (p. 183).

In summing up these notions, we can therefore logically infer that it is important to consider the surrounding circumstances, environment, and relationships to better understand the unique nature and meaning of a phenomenon or experience for the individual involved. Context is, indeed, king.

Ecological Systems Theory

Originally proposed as a theory of child development, Urie Bronfenbrenner's ecological systems theory (1977; later revised to a bioecological model by Bronfenbrenner in 1994) was an early example of a shift from an individual and intrapsychic understanding of child development, into a broader systemic understanding of the different environmental and systemic influences on individual development. While originally suggested specifically as a model of child development, the model has broader applications when considering systemic influences on both individuals and broader relational systems. The model suggests five nested systems – the microsystem, mesosystem, exosystem, macrosystem and chronosystem – that extend out in order of impact, and are interrelated and mutually influence each other.

Figure 4. *Ecological Systems Theory*



"Ecological systems theory" by Denis O'Hara, Jim Schirmer, Kate Witteveen and Michael Ellwood, licensed under a Creative Commons Attribution-Share-Alike 4.0 licence, is adapted from "Bronfenbrenner's ecological theory of development" by Hchokr, licensed under a Creative Commons Attribution-Share Alike 3.0 Unported licence via Wikimedia Commons.

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The microsystem involves the most immediate relationships and systems surrounding the individual, such as family, peers, work or school, religious community, and the like. These relationships are also seen to be bi-directional with the individual, mutually influencing each other.

The mesosystem is viewed as the interactions between two or more microsystems at the first layer, thus making up a mesosystem – examples may include family systems that are also actively involved with school systems.

Exosystems can be seen as broader social structures that do not necessarily interact directly with the individual but can be seen as influencing the microsystems – these involve larger systems such as government, educational systems, legal or political systems.

The macrosystem reflects less concrete structures than the earlier layers, but rather the broader social conditions surrounding the other systemic levels. This can also be seen as a layer that is less specific to one individual, but rather sitting across multiple individuals within a particular society and culture. This layer involves aspects such as social norms, cultural values and attitudes, and beliefs and ideas regarding elements such as gender roles, family structure and social issues.

Sometimes seen as a broader nested level and other times depicted as a separate layer (as depicted in Figure 4), the chronosystem depicts the shifts and transitions over time, recognising distinctions between predicted or unpredicted changes across time, as well as the ways in which other systemic layers change or are influenced over time.

Taken as a whole, the ecological systems model demonstrates a broader systemic understanding of the various influences on the individual client, while this can also be extended to consider the different levels of context surrounding couples, families, communities and beyond. As discussed later in this chapter, this also lends itself to the different considerations about how we can best explore the different contexts in which our client exists and that may relate to their presenting concerns, rather than conceptualising clients as individuals in isolation.

Change – First-order and Second-order

Acknowledging that taking a systemic perspective involves shifting beyond individual paradigms and into broader relational and contextual view of the world, this paradigm shift also extends to different understandings of change itself. This can be defined as a distinction between first-order and second-order change (Watzlawick et al., 1974). The concept of first-order change, such as exploring individual behaviour change within any particular system or context, makes sense from a perspective of linear causality – if we can trace a problem back to some origin or cause and create change at this point, the problem therefore becomes eliminated. Often being a more superficial change, such as changing the timing of an event, the success of this level of change depends on context. If this involves shifting the timing of a meal due to a change in schedule, then this can be an appropriate level of change within a family or relationship system. Postponing an argument until a later time, however, provides less relief for the system. It is at this point that second-order change becomes relevant.

If first-order change is considered to be change within a system, such as changing individual behaviour or creating a superficial change, then second-order change can be considered as a change to the system itself.

Again, depending on context this can take different forms. Using the examples above, while shifting the time of a meal due to a change in family members' schedules may be effective in and of itself, a second-order level of change might involve changing who prepares meals, or even a change to the expectation of everyone sitting down for meals at the same time. In a more significant example, while we can clearly identify that shifting the time of an argument provides a less effective solution to the argument itself, a second-order change might involve addressing the pattern of arguments themselves, such a sitting down with a counsellor or therapist, or at least having a different type of conversation about the recurrence of conflict.

In this sense, second-order change is often also referred to as meta-change, or a "change of change" (Watzlawick et al., 1974, p. 11). This can mean changing the rules of a system, redefining the structure or hierarchy of a family, or having conversations about conversations (talking about the way we talk). As we will explore in the following section, this also signifies an important shift in the therapeutic focus from content and into process.

Implications for Practice

Content vs Process

One way in which the shift from linear to circular causality applies more concretely in practice is a change to a lesser focus on content and a greater focus on process. This can present in different ways depending on the context and nature of the counselling setup. (See also the earlier exploration of similar ideas in chapter 5).

Individuals may commonly present with the 'facts' of their problem or concern, including a history of how this has developed, possibly ideas about the cause or origin, and/or a view of how they would like problem resolution to look like. Large parts of this might be viewed under the banner of content – the facts, the details, the cause, and the desired outcome. While this is still highly relevant to the counselling process, a systemically-minded counsellor will also be curious about processes underlying this content – when this problem was occurring, what was the context in which it was occurring? What were you doing or not doing? How did this impact you during and after? Were others influenced by or influencing this situation? As you are telling this story now, what do you notice as you tell it? How are you experiencing the re-telling in the present moment? Within this desired future or outcome, how will you notice that things are different? What will you be thinking or doing differently? These questions – and other variations on the theme – might be asked explicitly, or they may be more internal curiosities on the part of the counsellor while exploring the story.

In family or relationship settings, along with the aforementioned ways of thinking, the counsellor is also intensely interested in the here-and-now dynamics of the clients in the room. As one client is speaking, how are others reacting to these discussions? What physical or non-verbal dynamics are playing out in the room? As clients speak with each other, how are they speaking with each other? Are there patterns or themes to their way of communicating? Along with what is being said, what is not being said (the absent but

implicit)? As potentially new information or perspectives are shared by different members of the family or relationship, does this lead to shifts in thinking or feeling within other family members (news of a difference that makes a difference)? This extends to a curiosity about the clients' experiences of the concern outside of the counselling room as well – rather than simply what was said within conflict, how was it said? What led up to the experience, and what occurred afterwards? What was each client's experience of that event? Who did what to whom and in what way?

A practical example of this content-process distinction lies within the standard couple therapy assessment process in the Gottman couple therapy method (Gottman & Gottman, 2015). During the initial interview with the couple, the counsellor explores milestones and experiences across the couple's relationship history. As these experiences are discussed, the counsellor is paying attention not only to the content of these experiences, but also to the ways in which the couple experiences the re-telling together, as potential indicators of dynamics in their relationship – do they smile fondly at each other and laugh at enjoyably memories? Do they challenge or contradict each other in the details of their stories? Are they closed off and non-responsive to each other as each partner shares their experiences? These observations of process provide a greater depth of insight into the couple's relationship as they experience it in the moment.

Exploring Context

Building on the ideas posed earlier regarding broader systemic understanding of the client's world and environment, several practice considerations can be explored here. Firstly, the importance of exploring and understanding the wider contexts in which the client and their concern exists cannot be overstated. Apart from allowing a deeper and more empathic understanding of the client's experiences and current circumstances, an exploration of the wider contexts, such as that suggested by Bronfenbrenner earlier in this chapter, can also create a difference in the way a concern is conceptualised. A simple example here involves a child client who has been referred with concerns around concentration and behavioural challenges at school. An individual and intrapsychic exploration alone may lead to hypotheses and assessments around neurodivergence and possibilities such as ADHD or ASD diagnoses. Zooming out and exploring the broader contexts around the child may reveal greater difficulties in the home environment such as domestic and family violence, high conflict separation, significant physical or mental health concerns for another family member, or abuse or neglect of the child themselves. Taken in this context, the difficulties at school now may be viewed differently, potentially as a symptom of larger systemic or relational challenges in the child's life rather than problems isolated within the child themselves.

We can also view this contextual understanding over time, such as differences in perception of the current situation by the client as compared to historic contexts. An example of this may be a client who presents with concerns about her relationship with her husband who she feels can be overly rigid in his approach to structure, routine and behaviours within the relationship. While some counsellors may quickly jump to questions around the sustainability of the relationship for the immediate client, an exploration of the client's history may reveal early family and relationship experiences marked by significant violence, unpredictability, and a lack of affection or warmth. In comparison to these past experiences, the client may feel this current relationship to be markedly more reliable and safer, despite the concerns

around rigidity and rules, and may find that the prospect of ending this relationship generates fears of returning to a lack of warmth and care and an increase in unpredictability in their world. While this does not eliminate the need to still explore the present concerns, an understanding of the contrast between current and historic contexts generates a greater understanding of the client's dilemma at this point in time.

This leads neatly into an acknowledgement of exploring context as a way of better understanding our client's unique worldview and perspective on their concerns. This includes a clear understanding of the client's intended or desired focus of the counselling work itself. While not the first to explore such ideas, Erickson (1980) proposed the use of what he called utilization – "exploring a patient's individuality to ascertain what life learnings, experiences and mental skills are available to deal with the problem ... [and] then utilizing these uniquely personal internal responses to achieve therapeutic goals" (Erickson & Rossi, 1979, p. 1). This concept was further built upon by the Mental Research Institute (MRI) in exploring the idea of position – the client's worldview and beliefs that influence both the presenting problem itself as well as the client's engagement in therapy (Watzlawick et al., 1974). In more recent decades this has evolved in conversations and acknowledgement of what Duncan et al. (2004) refer to as the client's theory of change – seeing the client worldview as the determining theory for therapy (Duncan et al., 1997). This exploration and acknowledgement of how clients perceive and make sense of their lives and their presenting concerns creates opportunities for the building of a strong alliance, clearer and more meaningful goal-setting in line with the client's identified desired direction and outcomes, and a strong alignment of strategy and intervention with the client's systemic contexts as well as their unique understanding of their lives and the world around them.

The last important consideration is an understanding of context when it comes to the counselling work itself. Far from being irrelevant, the environment and systems within which counselling takes place can have far-reaching implications for the nature and focus of the work itself. Consider the contextual distinctions between clients attending counselling within an organisational disciplinary process, a mandated therapeutic engagement within a correctional facility or context, a school setting as a result of behavioural concerns in a classroom, and a minimally funded organisation offering short-term counselling support around a limited range of presenting concerns. Simply put, in settings other than privately funded counselling practices, the potential is much higher for different agendas to be in play other than the immediate wellbeing of the client or their own desired focus for therapeutic work. Thus, this context needs to be acknowledged and incorporated at least in some ways into the goals and focus of the therapeutic work – ignoring these broader contextual requirements and agendas can threaten the viability of maintaining support for the client and risk broader relationships; while ignoring the presenting needs as identified by the client themselves risks a rupture to the therapeutic relationship and an ignoring of the client's own worldview and desired outcomes.

This understanding of the broader contexts and agendas for the therapeutic work also extends to the way in which the client perceives these contexts; Do they align with these larger agendas and goals or does this pose a dilemma or tension around the focus of the work? Does the client view this therapeutic offering as being helpful and desired, or is there a sense of coercion or mandating of the engagement? Are there concerns about how the client may be perceived by others as a result of attending counselling? Within

the current social and political environment for counselling practice, these are vital considerations that counsellors must keep in mind when considering the larger context of their therapeutic work.

Circular Questioning

Originating in Italy in the 1970s, the Milan Associates (Mara Selvini Palazzoli, Luigi Boscolo, Gianfranco Cecchin and Guiliana Prata) developed a model of systemic family therapy inspired by the strategic work of the Mental Research Institute along with the systems theory and communication ideas of Gregory Bateson, with a particular focus on paradox/counter-paradox and circularity. The Milan Associates particularly viewed families as presenting to therapy with an inherent paradox, with an underlying message of "We have this (problematic member who must change) ... but as a family we are fine ... (and intend to remain unchanged)" (Tomm, 1984a, p. 115), implying an impasse of seeking both change and stability. Inherent to their approach was a focus in attention towards patterns of interaction rather than intrapsychic problems, viewing families as caught up in recursive and holistic patterns, and including perceiving therapists as being a part of the pattern they are observing. A key therapeutic practice emerging out of this systemic understanding was the use of circular questioning (Selvini Palazzoli et al., 1980; Penn, 1982; Tomm, 1987). This style of questioning draws back to the circular ideas of patterns within family relationships, as well as arguing that inviting other family members to share their perceptions of relationships between particular family members allows for a breaking of a rule that they believe operates in dysfunctional families: that family members should not comment on the relationship of other family members in their presence (Selvini Palazzoli et al., 1980).

The concept of circular questioning, therefore, invites new perspectives into the family almost as a soft reframe, rather than directly suggesting "Think about your family/family member in this particular way", through the addition of potentially new information about how family relationships and behavioural patterns are experienced and perceived by others in the family. A key consideration when engaging in circular questioning is not to ask questions that we believe we (or the family) know the answer to – rather, the intention is to explore new information and perspectives for the family, keeping in mind the often-quoted proposition by Bateson that a bit or piece of information is "news of a difference that makes a difference" (Bateson, 1972, pp. 271-272). Selvini Palazzoli et al. similarly suggest that "1. Information is a difference. 2. Difference is a relationship (or a change in the relationship" (1980, p. 8). The precise types of circular questioning are quite varied in style and focus and have been articulated in different formats by various authors over time.

The Milan Associates (Selvini Palazzoli et al., 1980) originally suggested questions that focus on behavioural sequences and different family members' interpretation of behaviours, such as ranking each other on specific behaviours ("On a scale of 1 to 10, how bad do you think the fighting was this week?") or exploring hypothetical questions ("If you were to separate, which parent would the children want to live with?"). Penn (1982) suggested difference questions such as changes over time or between verbal and analogic information. Tomm (1984b; 1988) originally explored questions highlighting the spatial and temporal differences, and ultimately proposed four major types of questions linked to the theoretical assumptions and intention of the therapist: Lineal (problem definition/explanation); Circular (difference

questions); Strategic (leading and confrontational); and Reflexive (hypothetical or observer perspective). As the types and styles of circular questioning can feel confusing and difficult to understand to novice counsellors, Brown (1997) suggests an initial focus on creating distinctions and connections through circular-type questions as a simpler starting point, with more complex approaches to questioning developing over time and with experience.

Reflective Questions

An interactive H5P element has been excluded from this version of the text. You can view it online here:
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9.

APPLIED CASE FORMULATION

Jim Schirmer

"Integration in psychotherapy is about increasingly honoring human complexity in the pursuit to address the diversity of patients' needs and to affirm patients' strengths so as to provide pertinent, relevant, and comprehensive services, be those clinical or preventative." (Fernández-Álvarez et al., 2016, p. 822)

Key Takeaways

- Aspiring to practise psychotherapy in a way that is adaptive, responsive, personalised and tailored to the individual client presents a distinctive challenge for new counsellors and psychotherapists.
- Developing case formulation skills involves fostering the three core processes: description, organisation and double description.
- Understand how the Power-Threat-Meaning Framework can be used to guide steps to create a one-page formulation and working hypothesis.

'Now What?'

In this book, you have learnt some of the essential ideas, processes and skills that undergird the practice of counselling and psychotherapy. As you practise these skills in classes and role-plays, you would be beginning to develop the basic competencies of seeing a client, connecting with them, and hearing their story. By learning these essentials, you are preparing to be able to do client work.

Let us imagine, then, that you are ready to see your first client. Your client is Emily, a 39-year-old primary teacher who has self-referred to come to see you. You have very limited information on the referral, so you gently ask Emily what brings her to counselling and what she is hoping to get out of it. She initially responds that she "wants to get some clarity" and that lately there has been "kind of a lot" going on.

She explains that six months ago she has remarried. Her new husband, Sai, has two primary-school-aged children. This was initially exciting for Emily, as she had always wanted a family, but does not have any

children of her own. Due to this, when they first got married, Emily cut back on her work to spend more time with the children. However, Emily explains to you that the children have reacted very differently to what she expected:

> So basically when it's just me and them, they won't come to the table. They won't eat their dinner a lot of the time. I've had food thrown at me. They really resist going to bed. They won't do their homework. I can't get them to go to school in the morning. I'm getting calls from the school. I don't know what to do anymore … I am so tired, and I don't know what to do.
>
> By the time she finishes saying this, Emily is in tears. You can feel the weight of the demoralisation and exhaustion in the room. Emily says that she has been living with this ever since the wedding; in other words, she has been in this state for over six months. You ask Emily to share with you what this time has been like for her, and she says the following:
>
> It's been lonely. And, like, disappointing as well. I'm not disappointed in them. I get disappointed in myself. I just feel like they're failing in all these areas, and it's because of me. Like, I hear all these things about parenthood and have all these expectations of all these perfect moments. But it's not like that. I'm trying really hard, and I just get … hate. Failure. Letting people down.

Again, Emily cries, physically expressing the loneliness, disappointment, guilt, hurt and fear that she has expressed verbally. Together you talk about life for her being like a "struggle" or a series of "battles". At one point, she offers the following image:

> It's like I'm living in a cloud that's like blocking everything in. This big, dark, heavy, foggy cloud. I feel mentally clouded. I feel suffocated. It's not just from the physical family, but from everything. I'm just so confused… what to do? It's created this fog. There's no room to move. There's just so many things, I don't have time to think properly about how to make this work.

At the end of such a session, it is perfectly normal for new counsellors to then ask a question like "Now what?" While you have an understanding of the theories, processes and skills of therapy, it is not always obvious how to apply these to the stories you hear in practice. For example, what would therapy look like

for Emily? We will return to this question by the end of this chapter, but first we will discuss the importance of case formulation in the process of therapy.

What is 'Case Formulation' and Why Do We Need It?

In one of his well-known aphorisms, Irvin Yalom (2003) encourages therapists to "strive to create a new therapy for each patient". This idea is not particular to Yalom. Rather, throughout the history of psychotherapy it has been widely held that practitioners of counselling and psychotherapy must tailor their approach to the individuality of the client (Norcross & Wampold, 2011). While Yalom's phrase is uniquely evocative, the principle of 'creating a new therapy for each client' has been known by many names:

> "The process of creating the optimal match in psychotherapy has been accorded multiple names over the years [including]: aptitude by treatment interaction (a research design), attunement, customizing, differential therapeutics, fitting, individualizing, matchmaking, personalizing, prescriptionism, responsiveness, specificity factor, tailoring, therapy fit, treatment adaptation, and treatment selection. In the professional literature, *treatment adaptation* and *responsiveness* tend to prevail... [while] in clinical work, patients tend to prefer the terms *individualizing* and *personalizing*". (Norcross & Wampold, 2018, p. 1891, original emphasis)

As the above quote indicates, the desire for a tailored approach is not limited to practitioners. Rather, clients of counselling and psychotherapy regularly express preference for a personalised approach, and report discomfort when they feel like they are being made to fit the therapy rather than the other way around (Li et al., 2024).

Further Reading

For a moving first-person account of a person struggling through being made to fit the modality of the therapist, read Morris' (2015) chapter on his experience of therapy for war-related PTSD.

Still, aspiring to practise this adaptive, responsive and personalised form of psychotherapy presents a distinctive challenge for new counsellors and psychotherapists. Gibney (2013) likens this challenge as the process of learning an improvised art. In this way, new practitioners must learn the theories and skills (such as those contained in this book) in the same way that artists must learn and practise the techniques of their medium or instrument. However, improvised artists – and therapists – must then deploy these skills in response to unexpected stimulus to produce a bespoke performance of their skills. Therefore, a common (yet often unexpected) challenge for new practitioners is dealing with the uncertainty that is inherent with every client and every session.

So, how do we go about creating a personalised therapeutic experience for the individuality of each

client? An essential mechanism for this process is case formulation. Sometimes also called a case conceptualisation, a case formulation is a condensed summary of the client's story, along with a set of hypotheses about things such as the nature of the client's problems, underlying factors causing and maintaining the problem, and the factors that might support or impede progress. Often these hypotheses then form the basis of a plan of the therapeutic strategies that might resolve the issue.

There are three key features of a case formulation that make it an effective tool for guiding practitioners in creating a tailored course of therapy for clients:

1. Formulations are *personalised* to the client. There is no such thing as a generic formulation. Rather, the starting point for each formulation is the client's story. The resulting hypotheses will be bespoke for that person.
2. Formulations are *informed* by theory and research. While the formulation starts with the client's story, the counselling practitioner brings their professional knowledge of theory and research to help illuminate the story in new ways. By viewing the client's story through those lenses, the therapist has the potential to notice previously unseen causes of problems or to reveal new avenues for change.
3. Formulations are *evolving* representations. Formulations generate hypotheses, not conclusions. They are always tentative and always subject to revision with new information. This stance helps the therapy to remain tailored to the person. Conversely, a practitioner who holds onto their formulation too tightly (disregarding all evidence to the contrary) is at risk of trying to make the client fit the therapy rather than the other way around!

The capacity to formulate is a core competency for practicing therapists (Kendjelic & Eells, 2007). As such, developing skills in case formulation has several benefits for your practice of counselling and psychotherapy (Johnstone & Dallos, 2013), including:

- bridging the gap between abstract, generalisable psychological theory and the specificity of the client's situation;
- helping the therapist maintain intentionality and focus;
- giving the client an orderly understanding of what might have previously been a chaotic or confusing reality; and
- providing a road map for the work being done throughout the process of the therapeutic relationship.

As valuable and as important as case formulation is, it is also a task that new counsellors find hard to develop. The process is cognitively demanding, requiring the practitioner to synthesise complex (and sometimes contradictory) information, to discern factors such as causality, significance and implications of various elements of the story, and to inductively posit best-fit explanations on what is often a non-linear and inconclusive set of data. Given this, the remainder of this chapter will introduce you to key processes and skills to guide you in formulation.

Process: Description, Organisation and Double Description

Developing a case formulation is an example of a 'black box process'. A black box process is a term used to describe what happens when you have an observable input or stimulus, and then an observable output or response, but an unseen or unobservable process in between the input and the output. We encounter black box processes every day. For example, when you type a query into a search engine, you provide the search engine with an input. The search engine then provides you with an output: a response to your query. But what happens in between to produce that result is a mystery to you. It is like it happens within a black box.

When applied to counselling, the input is the client's communication of their story, and the output is the counsellor's response or (in this case) their case formulation. What happens in between these two things can seem mysterious. However, an action research process showed that there were three major things that happened inside the black box to process the client's story (input) and produce the formulation (output) (Schirmer, 2023). These processes are:

- Description
- Organisation
- Double Description.

This section will introduce these three processes, as well as the outcome of the processes in the form of a 'working hypothesis'.

Description

In case formulation, the function of the process of description is to summarise – as accurately and as succinctly as possible – the major features and themes of the client's story. As noted above, the client's story is the starting point for all formulation. Therefore, before we can commence any reflection or interpretation of that story, we need to ensure that we understand it as completely and as accurately as much as it has been told to us.

In practice, therapists use the process of description to summarise the essential elements and themes of the client's story that they have heard from them. For instance, as a client is talking, practitioners might make brief notes or mentally store the key features of the story. At the end of the session, practitioners might make a list of dot points that summarise the topics of the session. If this list covers all the topics, it is an effective description in that it is a reduced, workable summary of the major elements of the story.

It is important at this stage to make sure that the language is only describing rather than interpreting. For example, in this step, we would not talk about the client's "avoidant attachment to her caregivers" but rather that the client said that she "didn't feel close to her parents". It is the task of subsequent steps to begin to layer hypotheses about this material. For now, it is sufficient to stay close to the client's language and to summarise rather than interpret.

Organisation

In the case formulation process, the role of organisation is to take the key features of the client's story and to categorise them into some sort of systematic framework. Think of this as a bit like starting a 1000-piece jigsaw puzzle. While the first step might be to turn over every piece so that you can see all of the individual units that will make up the whole picture, the second step would be to start to sort the pieces into meaningful groups (e.g. by shapes such as edge pieces, or by colour, etc.). This grouping moves you forward in the puzzle as it helps you see what might go where. Similarly, where the process of description shows you what elements you are working with, the process of organisation will help you to start to see where these elements fit in relationship to one another.

There are many different frameworks that practitioners use to organise a client's story for formulation. Some of these frameworks are *theory-specific models* of organisation. These models use the categories of major theories (e.g., psychodynamic, CBT, narrative), and organise the client's story into these categories.

Example of Theory-specific Organisation

Leiper (2013) outlines a psychodynamic approach to formulation. In this approach, there are four major categories that are built on psychodynamic perspectives:

(a) the Dynamic (unconscious drivers of emotions and behaviours)

(b) the Developmental (past events that have significance in understanding the present)

(c) the Structural (the way the individual's mental life is organised)

(d) the Adaptive (the individual's approach to solving conflicts and problems).

A practitioner using this structure would organise the client's story into these categories. For example, key past relationships and life events would be categorised as 'developmental' , whereas the person's degree of ego strength or their reflexive mental defences might be categorised as 'structural'.

Other approaches to organisation are i*ssue-specific models*. These types of organising models of formulation start with the client's issue (e.g. addiction, trauma, relationship conflict), and outline common considerations that are consistent with that issue.

Example of Issue-specific Organisation

Murray's (2015) integrative model of loss and grief is a good example of an issue specific model related to the many types of loss that people can face. When hearing a story of loss, practitioners can organise the various parts of the story into five major categories to understand:

(a) the client's world 'That Was' (before the loss)

(b) their world 'That Is' (now, after the loss)

(c) the person's subjective experience of the loss

(d) the potential roads to healing

(e) the complications or blocks to healing.

Murray (2015) summarises that in a thorough formulation of loss, the practitioner should be able to answer at least the following ten questions:

1. What has been lost?
2. What was the position/role/importance of that loss in the life of the person?
3. What are the major symptoms of grief that this person is experiencing? Are there any causing particular distress?
4. How far along the journey of mourning has the person progressed?
5. What is the world of the person like?
6. How is the person trying to deal with the transition from the world 'that was' to the world 'that is'?
7. What strengths does the person bring to his or her loss?
8. What hindrances are there to the progress of mourning?
9. Is there any indication that mourning has become complicated?
10. Are there particular characteristics of the person that are going to challenge my care of him or her?

A final approach to organisation could be termed *generic* or *transtheoretical models of formulation*. These models use some major categories that could apply to any issue, no matter what theoretical framework the counsellor is using. The best know examples are the Biopsychosocial model (which organises the story into biological, psychological and social factors impacting the client), and the 5-Ps model (which organises the story into the presenting problem and its corresponding predisposing, precipitating, perpetuating and protective factors).

Further Reading

To see how the Biopsychosocial and 5-P models can be used in practice (and in conjunction with each other), two excellent examples can be found in the articles by Weerasekera (1993) and Selzer and Ellen (2014).

Another example of a transtheoretical model is the Power-Threat-Meaning Framework (Johnstone & Boyle, 2018a), which will be discussed and demonstrated in detail in the next section.

Double Description

Along with describing and organising the client's story, the process of case formulation also starts to experiment with viewing the story through various lenses in an attempt to identify resonant hypotheses. This process could be called double description, a term first coined by Gregory Bateson (1985) to describe how the mind develops, organises, and uses knowledge. In Bateson's framework, double description is the capacity for a person to describe something in more than one way in order to represent an object or phenomenon more precisely. For example, while one can accurately describe a crab as a crustacean, using a double description of a crustacean that *also* walks sideways is more precise, and thus distinguishes it from other crustaceans. Of course, with each extra descriptor the description becomes even more precise.

In case formulation the idea of double description applies to the practitioner's use of theory and research as a language to re-describe our clients' stories to see what these descriptions might reveal about causes and solutions to client problems (Gibney, 2003). In practice, both during and after a session of counselling, an experienced counsellor will likely be referring to theory as they think about the client's story.

Example: Double Description

Consider a client who reports that he has shouted at his boss and, shaking his head in disbelief, tells his counsellor, "I can't believe I did that – that is not like me at all!" Using double description, a person-centred therapist might think of this as a statement of incongruence and wonder about the conditions that led the client to behave so inauthentically. A more psychoanalytic therapist might think about the emotional drive that was expressed (Id), the internalised social standard the client has transgressed (Super-ego), and the features of the client's boss that might have evoked this out-of-character reaction (transference). Other therapists might examine the nature of his beliefs (CBT), the stories he

tells about 'who he is' (narrative therapy), the socio-political influences (feminist therapy) or the parts of himself he was in contact with at that moment (gestalt therapy).

As can be seen in this example, any lens of theory has the potential (though not a guarantee) to illuminate previously unseen elements of the story. Consequently, if a practitioner can look from a multiple theoretical or even integrated theoretical point of view, it adds potential for the complexity of the formulation. In short, the human experience is so irreducibly complex that no single theory can adequately capture it. Consequently, being able to formulate using more than one perspective increases the chances of a helpful formulation to guide therapy. Appendix A contains a list of some basic hypothesis-generating questions from major theories of psychotherapy.

Outcome: The 'Working Hypothesis'

As stated earlier, case formulation is an ever-evolving process. The processes of description, organisation and double description are not 'steps' that you do once and then are finished. Rather, they are more like movements in a cycle that you continually work through while in conversation with the client. Still, as the cycle repeats, you will increasingly return to particular hypotheses that are more informative and influential for the therapy.

Early on in a therapeutic relationship, you might have a relatively long list of possible hypotheses and potential purposes. As therapists we try to stay as open as possible for as long as possible, in order that we do not prematurely rule out potentially significant conceptualisations. Still, with the repeated iterations of the process of therapy, you are able to both hear more of the client's material and also test your hypotheses with the client.

This repeated cycle should enable you to hone your hypotheses significantly. Some hypotheses will have more power than others in being able to explain the experiences of the client. It is possible that you will even develop a single-sentence statement of your primary hypothesis and priority plan for work with this client. At this stage, we would say that you have developed a 'working hypothesis': a hypothesis that is robust enough to use as a basis for your therapeutic intervention with the client.

It is important to clarify two things about this working hypothesis. Firstly, it is not the case that you have to get this 100% correct. It is likely that this hypothesis will continue to be refined or even changed as you get more information from the client (including how they might respond to any therapeutic processes you use). It is better to think of your hypothesis in terms of its usefulness or its consistency with the client's story, rather than evaluate its perfection.

Secondly, your working hypothesis does not have to come from a single theory. While there may be one singular theoretical interpretation that makes sense of a particular client's story, the working hypothesis may just as easily need to draw on two or more theories to provide an adequate conceptualisation for the story. The working hypothesis in the case study in the next section gives an example of exactly this.

Skills: Steps to Creating a One-page Formulation

This section will introduce you to one way of preparing a case formulation. The skill you are learning in this section is preparing a 'one-page formulation'. The ability to be able to do this enables you to demonstrate all the key processes that are involved in being able to formulate competently.

The organising framework for this example is the Power-Threat-Meaning (PTM) Framework (Johnstone & Boyle, 2018b). The PTM Framework was launched as an alternative paradigm for understanding the lived experience of life and distress that was more comprehensive, holistic and contextually sensitive than traditional medical or diagnostic model

At its heart, the PTM replaces the diagnostic model's core question of "What is wrong with you?" with the more holistic question of "What is your story?" More specifically, it proposes that it is helpful to organise the experience of psychological distress along three key axes: power, threat and meaning.

- **Power**: What has happened to you? How is this power operating in your life? What power do you have access to?
- **Threat**: What kind of threats did this pose? How did you respond to these threats in order to survive?
- **Meaning**: What sense did you make of these situations and experiences?

When integrated with the processes described in the previous section, the PTM give a six-step structure to preparing a one-page formulation. These are outlined in the following table:

Table 1. *Processes and Steps in Case Formulation*

Process	**Description**
Description	Step 1: What is the story?
Organisation	Step 2: What has power? Step 3: What threats do these powers pose?
Double description	Step 4: What are your hypotheses from theory? Step 5: What sense does the client make of it? Step 6: What are your working hypotheses and plan?

This section will introduce each of these steps, using the example of the case of Emily that was introduced at the beginning of the chapter.

Step 1: What is Your Story?

The first step of therapy is always to 'hear the story'. We cannot conceptualise a story until we have heard it. Consistent with the PTM Framework, we actually start with the client's story, rather than with a particular theory or model.

This step fulfils the 'description' process of case formulation. Thus, the focus is to summarise the elements and themes of the client's story that you have heard. Again, remember that it is important at this stage to make sure you are only describing rather than interpreting.

As you gain experience as a counsellor, you will begin to naturally track and compile the important elements of the client's story at the same time that you are listening to it, but in early stages of your career it can be a helpful process to write down a list of the key components of the client's story. In some ways, the process of writing your case notes can achieve this step as it forces you to record the essential elements of the story in a descriptive way. The key elements of Emily's story are summarised in the first example box, below.

Example: The Case of Emily – What is the Story?

The following is a summary of the major topics that our client 'Emily' brings to her first session:

- **New marriage**. Married 6 months ago to her new husband (Sai). Met Sai 18 months ago. Both in second marriage; Sai's first wife died of cancer. Emily reports a positive relationship with her husband and that she finds him supportive.
- **Previous marriage**. Emily's first marriage ended in divorce. The couple were not able to have children due to fertility issues; stress and disagreements about this was part of the reason for the separation.
- **Step-parent role**. Sai has two children (aged 7 and 5) from previous marriage. Due to her desire to be a parent, Emily chose to reduce her work commitments (as a teacher) to be the primary caregiver for the children. However, the children's reaction has been very distressing to Emily, as they react to her with difficult behaviours such as refusal to eat, throwing food, difficulties going to bed, and not completing homework. Describes feeling completely 'stuck' in not knowing what to do. Also describes feeling very little happiness across her life, and feeling exhausted (as if from constant struggle)
- **Sense of failure**. Emily reports that she has felt a deep disappointment with herself in not being able to manage the children. Describes a feeling of not just letting herself down, but also the children, Sai and his extended family.
- Emily describes that part of her distress is that she expected parenthood and family to be very different, partly due to social and media messages about parenthood, but also the happy experience she had as the eldest child of a large family. Feels guilty that she should be enjoying this but is not.
- Emily describes feeling loneliness on a number of levels. Feels rejected by the children. Has difficulty talking with other friends who have children given that their families seem

more 'perfect'. Feels disapproval and pressure from her husband's extended family.

Step 2: What has Power?

The second step in the case formulation process is to begin to organise the client's story. The first category of the PTM Framework is the category of Power: those things that influence the client in their life, and those strengths and resources that they have access to. The aim is to create a rich narrative that traces the role that power has operated in a person's life through considering questions like:

- What has happened to you? How has this power been operating in your life?
- What are your strengths? What access to power and resources do you have?

The PTM Framework encourages practitioners to think about power comprehensively. That is, think of anything that is influencing the client in any aspect of their experience: physical, personal/psychological, social and existential/spiritual. Power operates in many forms including biological/bodily; coercive/forceful; legal; economic/material; social/cultural; interpersonal; and ideological.

Example: The Case of Emily – What has Power?

The following is a summary of the major things that have power in Emily's life:

- Feeling very little happiness in her role in the family, but rather that family life is an exhausting struggle
- Shattering of beliefs about what parenting should be like (e.g. social/media message of 'easy' or natural'; family of origin expectation of 'perfect')
- Belief of not meeting social and personal expectations (e.g. "I am letting everyone down"; "I should be enjoying this but I am not")
- Feeling stuck and not knowing what to do
- Loneliness, rejection and low levels of social support (e.g. disapproval and pressure from her husband's extended family; difficulty talking with other friends due to their families seeming more 'perfect')
- Disappointment in self due to sense of failure in a meaningful life role

Further to this, the interview shows that there are a number of things that could be considered to be power that Emily has access to:

- Ability to be connected to and express emotions
- Self-reflective and insightful
- Positive relationship with her husband
- Sense of self as being able to cope with other adverse life events.

Step 3: What Threats do These Powers Pose?

The third step in the case conceptualisation process is to consider the influence of power in the client's life, particular in the impact that it has had on major needs. This corresponds to the questions relating to Threat from the PTM Framework:

- How did it affect you? What kinds of threats did this power pose?
- What did you have to do to survive? What kind of threat response are you using?

Again, it is important to think of this comprehensively. One way of doing this is to think of threat operating across the range of a person's major needs such as safety and survival, attachment, control, pleasure achievement and pain avoidance, and self-esteem.

Another important consideration at this step is that a person's 'symptoms' (i.e. the emotions, thoughts or behaviours that are causing distress or that are seen as problems) are reframed as a form of threat response, rather than as just a pathological, diagnostic category. While these symptoms are still seen as undesirable and changeable, this perspective also considers them as understandable given the context of power and threat that the person is facing.

Example: The Case of Emily – What Threats to These Powers Pose?

The recent events and their affects pose a threat to a number of Emily's fundamental needs:

- **Need for safety and pleasure**: Emily currently finds it difficult to feel a sense of joy in her life. Rather than the happiness she expected, she reports exhaustion.
- **Need for control**: Emily experiences a loss of control in that her experiences do

not fit previous beliefs and expectations, and that attempted strategies to solve the problem are not causing desired change.

- **Need for attachment**: Emily's need for attachment is threatened through feelings of rejection and inferiority, coupled with a lack of adequate support in the midst of this interpersonal crisis.
- **Need for self-esteem**: Emily's sense of self and meaning built around being a 'mother' is threatened by the dominance of a story of failure in this area, which is reinforced socially.

Step 4: What are Your Hypotheses From Theory?

At this step, the formulation moves out of an 'organisation' process and into a 'double description' process. It is here that the established theories of counselling and psychotherapy offer insights that can help us to generate hypotheses about what has power in our client's life as well as what impact this power has had (i.e. threat). As the counsellor is listening, they are filtering the story through the prism of theory in order to see the different colours that make up the client's experience. The counsellor at this stage is staying open, so these hypotheses are framed as, "I wonder if..." Below is a non-exhaustive list of examples from some of the major theories, as they might apply to parts of Emily's story.

Example: – The Case of Emily – Possible Hypotheses

Theory	Power/Threat	Hyptotheses from theory
Psychoanalysis	• Desire to have children/family, yet unhappiness in current role • Childhood experience of 'perfect family' and eldest child responsibilities	• Internal conflict – Id (drive to be a parent); Ego (Unhappy/conflicted) • Developmental experience of 'perfect family'
Gestalt	• Feelings of exhaustion and struggle with current role, compared to how she imagined it to be	• Unfinished business focus of Emily's attention • Defensive living impacting her ability to feel authentic
CBT	• Sense of not meeting expectations • Feeling exhausted of options	• Presence of unhelpful beliefs around self and others (e.g. "letting everyone down"; "should be enjoying this") • Stuck in behavioural cycle; need for variety of skills
Solution-focused therapy	• Feeling stuck and unsure of how to solve issues	• Problem focused orientation toward her situation • Need to break out of repeated strategies
Person-centred therapy	• Disappointment in self • Feelings of loneliness, rejection and low social support	• Incongruence with ideal self • Conditions of worth from major social figures
Feminist therapy	• Not meeting social expectations and experience of judgement from friends and family	• Internalisation of socialised identities • Constraining discourses and expectations around roles
Narrative therapy	• Shattering of beliefs of what parenting should be like • Sense of failure in personal expectations of a valued life goal	• The internalisation of constraining discourses about parenting • Strong personal intensions that had been obscured by problem-saturated narratives
Existential therapy	• Unsure of value of her efforts in this situation or if she will be able to resolve the situation	• Crisis of meaning of the current suffering, and how to integrate this experience into her sense of identity

Step 5: What Sense Does the Client Make of It?

The next step in the double description stage aims to return the client's voice into the case formulation process. This is the 'meaning' aspect of the Power-Threat-Meaning Framework. The PTM Framework sees meaning as the mediating factor that determines how individuals and groups experience, express and respond to the power and threats in their life. A nearly universal premise in all psychotherapies is that human beings are not just passive recipients of experiences, but rather actively order, construe, organise and construct the phenomena we experience, both to make sense of it and to provide a framework for their action within it.

In this way, the PTM questions relating to meaning are:

- What sense did you make of it? What is the meaning of these situations and experiences to you?

The attention to the questions of meaning helps us to recalibrate our attention back to the client's priorities and lived experience. By hearing how the client makes meaning of their experience, we get a glimpse of the 'big picture' into which the various pieces of the jigsaw puzzle fit. It focuses our energy on the most pertinent hypotheses and guides us towards which interventions would best fit the client's motivation and theory of change. In short, we are meaning-making creatures. We take what we experience and draw conclusions on the causality, significance and implications of those experiences.

A skilled counsellor finds the client's meaning of the experience by listening carefully to the narrative form of the client's story. This involves not just listening to the content of the narrative, but also (and often more so) to the process of how the client tells their story. Listening in this way will often show you a number of ways that someone makes meaning of their life:

  - **Values and priorities** – What is most important (precious, urgent, etc.) to the client? What do they talk about first? What do they talk about most? What is at stake for them?
  - **Intentions and visions** – What is the dominant image that the client has for their life and for the world? What do they see their life as being about?
  - **Symbols and metaphors** – What metaphors or analogies does the client use? What does that suggest about the way they understand their experience?
  - **Judgements and evaluations** – What categories does the client divide the world into (e.g. good/bad, painful/comfortable, etc.)? What criteria does the client use to decide if something is in one category or the other?
  - **Worldviews and culture** – What socially learned stories does the client use to make sense of their life and their difficulties?

The following example outlines how Emily made sense and meaning of her experience:

Example: The Case of Emily – What Sense Does She Make of This?

Emily herself makes meaning of this through the metaphor of a dense, grey fog made up of the many people and things that have a suffocating effect on her life. This fog leaves her feeling emotionally blocked, unable to express herself, and mentally clouded (no space to "think properly" to break patterns). She finds herself becoming more insular, and unable to get a clear view on what is most important to her (i.e. children's needs). Nevertheless, partly due to her positive upbringing, she maintains her belief that there is something beyond the fog, and is confident of the future, especially if her need of feeling valued is able to be met more satisfactorily.

This description gives some indications of Emily's motivation, theory of change and what theoretical explanations and strategies might be most congruent with her. These include the following:

- Hope for the future and confidence in herself – may suggest that positive interventions that are centred on client capacities might be appropriate
- The clouding effect of the 'fog' and the desire to find space to thinking clearly, break patterns and make plans – might suggest counselling goals and methods that focus on generating clarity and choice could be appropriate
- Motivation and value for supporting the children – counselling needs to be sure that this value is able to be maximised
- An expressed need for feeling valued – counselling needs to foster this as the context in which change can happen for Emily
- Need for self-esteem: Emily's sense of self and meaning built around being a 'mother' is threatened by the dominance of a story of failure in this area, which is reinforced socially.

Step 6: Working Hypothesis, Purpose and Plan

At this point, you will have a succinct, organised version of the client's story, a set of hypotheses of what is happening, and an awareness of how the client personally makes sense of it. Given all these points of information, it should be possible to begin to condense a working hypothesis – a succinct statement that summarises the conceptualisation on which you might base your intervention. This working hypothesis should aim to provide as much explanation of the client and the story as is possible with the information you have at this time. As noted in the previous section, it is open to change, and it can draw on more than one theory.

New counsellors often wonder how to articulate a working hypothesis given the range of information provided. However, if you are asking this question, it shows you are on the right track. It shows you are taking in the complexity of the client story and not settling for a simplistic response. Two questions might help you in this process:

- **What makes the most sense for this person?** This question helps us to find the right hypothesis for the client. It is about taking seriously the individuality of the client. This story is uniquely their own and their experience of it is uniquely their own. Nobody else could have had either the same series of events or indeed had the same lived experience, interpretations or goals.
- **What makes most sense of the story?** This question helps us to find the right hypothesis for the story. In other words, it helps us to look for the hypothesis that has the most explanatory power. In asking this question, it helps us to examine whether there are any aspects to the story that remain unaccounted for by your working hypothesis; if there are such aspects, the hypothesis needs to be developed or deepened.

From this working hypothesis, you can begin to consider options for your therapeutic work with the client. But before jumping to specific techniques or strategies, it is important to consider the broader purpose or objective of the therapy. While there seems to be hundreds of distinctive methods of psychotherapy, it has long been acknowledged that in actual fact all these therapies work according to a small, finite number of common mechanisms (Prochaska & Norcross, 2018). Given your working hypothesis, what is the best overall use of counselling for this person? For example, is it:

- creating an experience whereby the client can become aware of, express, accept and regulate their emotional material?
- increasing options available to the client to respond to their situation, either through new ways of thinking or new ways of acting?
- establishing safe, reliable and responsive relationships with the therapist, others or with broader systems?
- connecting with and integrating narratives that provide a sense of meaning, value or worth for the client?

From this broader goal, it is then possible to consider best-fit strategies for the client that would lead toward this purpose. Working from an integrated perspective, you can draw on the range of theoretical interventions to find strategies that help work towards this goal.

Example: The Case of Emily – Working Hypothesis, Purpose and Plan

Given the information we have so far, the working hypothesis is that Emily is overwhelmed with the number and intensity of adjustments and demands that have occurred as a result of the changes she has recently experienced, resulting in a devalued sense of self and a reduced capacity to find meaningful solutions. This is likely exacerbated by beliefs and narratives that have developed through previous significant relationships. The therapeutic relationship should be marked by the support and validation that Emily has said has already resulted in her feeling calmer and with a plan to talk to her husband. Granting this, due to the immediate concern of breaking through the 'fog', in the short term it is proposed to focus counselling on solution-focused processes. The aim of this is to open up a variety of best-fit practical options, such as self-care, increased support, or reviewing interactions with children (or others). In the long-term there is scope for restructuring cognitions or re-authoring narratives to challenge unhelpful thinking and/or reconnect with a more enriched sense of self.

Bringing it Together: The One-page Formulation

One image for case formulation is that it is like putting light through a prism. When the client shares their story, it comes as one integrated, unified whole: like white light. When we put this story through the prism of case formulation, we become able to see the spectrum of colours that make up this story. An important step in this process, though, is being able to pull together these various elements back into a unified whole.

This is where you can do this through writing a one-page formulation. This comprises a succinct summary of the client's story and your working hypotheses for work going forward. In the framework we are using, the one-page formulation would include the following elements:

1. A brief orientating statement of the client's story, the reason they are seeking counselling, and any information on their motivation and theory of change
2. A summary of the various factors that have power in their life
3. A summary of how these powers may have threatened various needs
4. A statement of how the client is making meaning of their experience
5. A list of possible hypotheses that are refined into a working hypothesis
6. (As the process develops) A statement of the potential purpose of therapy for this client.

An example of the one-page formulation for Emily is included as Appendix B to this chapter.

Conclusion: The Intellectual Work of Counselling

In reading through this chapter, hopefully you will be left without a doubt that the art of counselling and psychotherapy is many things, including an inherently intellectual practice. This is evident in the research on master therapists that has indicated that, along with expert emotional and relational characteristics, the masters also commonly hold expert cognitive characteristics (Skovholt & Jennings, 2017). These characteristics include an embrace of cognitive complexity, the ability to be guided by accumulated wisdom, an insatiable curiosity and appetite for learning, and a profound depth of understanding of the human condition. This is commonly reflected in the complexity of thinking that expert therapists are able to apply to their case formulations (Eells et al., 2011; Mozdzierz et al., 2013).

Does this seem a long way off for you right now? Doubtless, mastery is a very high bar to set. Nevertheless, something that every novice should always remember is that every expert or master once was at your stage of development. Your development as a person and as a helper is a lifelong process. Encouragingly, there is evidence that – just like other skills – case formulation skills can improve with training, deliberate practice and feedback (Kendjelic & Eells, 2007).

When this type of development happens, it means that the counsellor has effectively metabolised the knowledge and theory that is part of the tradition of psychotherapy. At this moment, the theory stops being an abstract set of ink-on-paper ideas, and suddenly becomes living, breathing and potentially transformative ideas embodied in the person of the therapist. Therefore, theory was never designed to be 'studied', just a recipe was never designed to be studied. Both are meant to be used to create something new. Thus, as you start to metabolise theory, you will find that it will nourish you in your day-to-day work in a way that you probably never thought possible.

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10.

COUNSELLING AND PSYCHOTHERAPY INTEGRATION

Denis O'Hara

"Psychotherapy integration is about finding what works, for whom, and under what circumstances." – John C. Norcross

Key Takeaways

This chapter explores how counsellors and psychotherapists approach the dynamic task of integrating different theories of psychotherapy. The chapter covers several key features of integration as listed below:

- The emergence of psychotherapy integration from research on common factors of therapeutic change is explained.
- It is asserted that integration is based on the recognition that no one theory provides all the available knowledge, skills, and processes to facilitate change.
- Different established approaches to psychotherapy integration are described.
- The place and contribution of *theory* within the context of counselling and psychotherapy is explored.
- The notion that therapists apply therapy in their own idiosyncratic fashion is highlighted.
- The place of Practice Frameworks is examined, and examples of several Practice Frameworks are described and discussed.

Introduction

In Chapter 2, we introduced the common factors involved in any psychological change process. Research has identified several common factors with the formulation by Lambert (1992) the best known. This early arrangement identified four broad categories of *extra therapeutic or client factors, the therapeutic*

relationship, theory, hope and expectancy. Each of these factors contains within it a further set of more specific sub-factors (Grencavage, & Norcross, 1990; Leibert, 2011). As change research progresses, we know more and more about the finer aspects of change. For example, we now know that the category of client factors involves such elements as client personality, coping style, and problem type. Similarly, we know that relationship factors involve empathy, congruence, goal consensus, and attachment style, to name a few (Norcross, 2019). The recognition of the place of common factors in counselling and psychotherapy has deepened our appreciation of the breadth of ideas and processes involved in psychological change.

While theory is listed as one of the common factors, it is not regarded as the singular explanation for how and why psychological change occurs. This is not to say that theory is not highly significant. We noted in Chapter 2 that there exist specific factors of change. This is the notion that while there are common factors that are always in operation, in certain situations and with specific presenting conditions, some interventions or approaches tend to produce better results (Cuijpers et al., 2014; Zilcha-Mano et al., 2019). Hence, we should always appreciate the fact that psychological change is a complex process and that we need to maintain an open mind about what are the best ways of working with individuals struggling with a wide range of challenging issues.

The recognition that many factors contribute to change shifted the counselling field away from a concern about which theory/therapy is the most effective to an awareness that any bona fide therapy must, at least, be facilitating some dimension of the common factors of change, as well as potentially contributing a unique or specific change factor. This awareness gave rise to what is more generally known as the psychotherapy integration movement (Norcross & Newman, 1992).

Psychotherapy integration begins from the premise that all good theories add something valuable to our understanding of change. Integration was also spurred on by research which found that most counsellors and psychotherapists draw on a wider range of theory than their espoused theories of practice (Boswell et al., 2009). Hence, while a practitioner might assert, for example, that they are a CBT therapist or narrative therapist, each tends to borrow ideas from other approaches when the need arises. The fact that therapists draw on a range of theories raised the question, "How do therapists integrate different theories into their practice?" What guides therapists' practice is important for several reasons. Firstly, in seeking to be scientist-practitioners as well as reflective-practitioners, therapists want to be able to establish the discipline's academic credentials and be able to measure and prove what works and what does not work. Of course, this is a laudable aim but one not so easily achieved in a field where the concern and focus is not principally on organic disease but on less tangible inner human dynamics. Secondly, if we can identify how therapists integrate and facilitate psychological change, then it may be possible to replicate the process. Thirdly, if integration is researched, then it may be possible to identify the most effective form of integration.

As the field progressively realised the importance of integration, new journals and professional associations were established to provide sites for professional dialogue. As early as 1983, the *Society for the Exploration of Psychotherapy Integration* (SEPI) was established eventually sponsoring the creation of the *Journal of Psychotherapy Integration* in 1991. These have been important vehicles for research and dissemination of ideas about integration. One of the outcomes of these dialogues was the identification of

several different approaches to psychotherapy integration. Apart from a recognition of the place that the common factors play, three other major forms of integration were proposed.

Technical Eclecticism

Early considerations of integration were focused on eclecticism. Eclecticism is based on the idea that a therapist can select strategies and interventions from a breadth of therapies as they see fit. The fact that it had been demonstrated that therapists do draw on many therapeutic approaches supported the viability of eclecticism (Norcross, & Goldfried, 2005). A more specific form of eclecticism made famous by Arnold Lazarus (1981) is known as technical eclecticism. Lazarus argued that a general eclecticism is not a sound foundation for the practice of counselling and psychotherapy as it has no firm rationale for the selection of strategies from different approaches. Instead, Lazarus argued that strategies should be selected based on evidence of their respective efficacy. In other words, if an intervention from a particular therapeutic approach had been demonstrated in research to be effective, especially if it was demonstrated to be more effective than other strategies, then that is a firm rationale for its selection. An illustrative example often used is the effectiveness of exposure therapy for anxiety disorders, especially social anxiety (Parker et al., 2018).

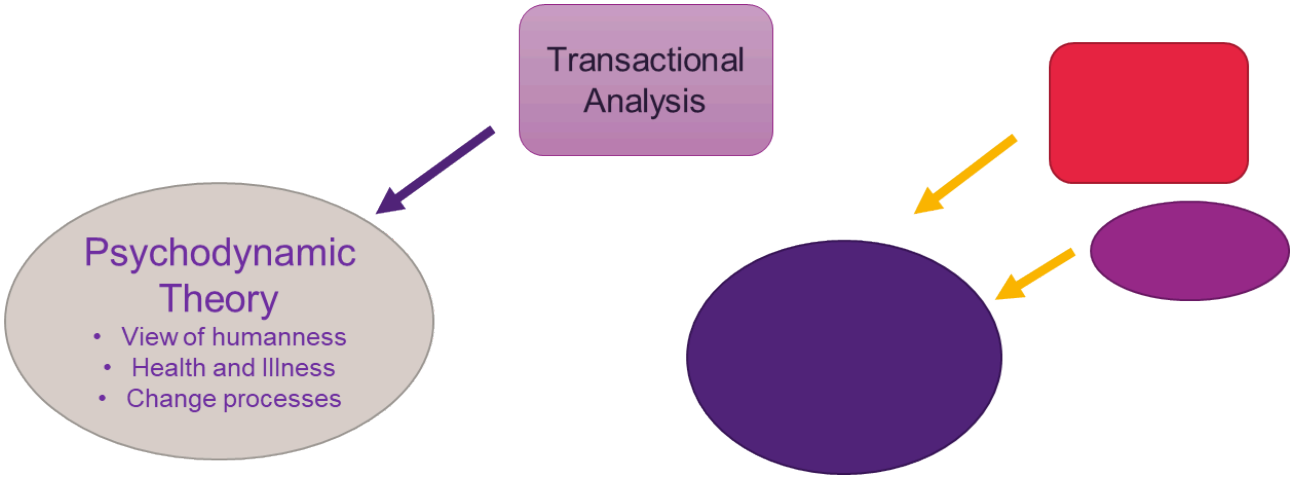
While technical eclecticism has much to recommend it, one of the more subtle issues inherent in the approach concerns its assumptions about what constitutes research evidence. The general assumption is based on a strictly empirical approach highly reliant on randomised controlled trials (RCTs). While RCTs contribute significantly to our knowledge base, it can also be argued that there is much valid evidence that is provided by other quantitative and qualitative methodologies. In this respect, how one delimits what is regarded as evidence also limits the range of interventions that meet the benchmark of 'technical'. It is important to realise that how one views evidence is circumscribed by one's worldview or metatheoretical assumptions.

Assimilative Integration

Another approach to psychotherapy integration is known as a*ssimilative integration*. This approach proposed by Stanley Messer (1992; 2001) suggests that therapists naturally have preferred metatheoretical assumptions whether they are clearly aware of them or not and, as such, naturally are drawn to theories of counselling and psychotherapy that are consistent with these assumptions. This being the case, Messer argues that a counsellor will have a dominant theory that informs their practice. However, as all theories are limited, singular theories are unlikely to have the necessary framework to explain all human problems. Hence, while psychodynamic theory, for example, may be very good at providing an understanding of a client's history and unconscious processes, it may not be as effective in explaining the impact of biochemical rewards active in drug addiction. With this realisation, Messer argued that therapists are predominantly informed by their dominant theoretical approach but draw into their respective base

approach strategies, interventions, and ideas from other theories that meet specific needs of the individual client. This is illustrated in Figure 1 below.

Figure 1. *Assimilative Integration*



A therapist's base theory provides the main category or frame of understanding of such key notions as:

- What it is to be human.
- How human health and illness is understood
- How therapeutic change occurs

Answers to these questions provides the main foundation upon which individual therapists operate. The secondary theory or theories are understood to be inculcated into the base theory. However, Messer acknowledges that in assimilating ideas from an approach that has different worldview assumptions, the base theory is adjusted or changed. While the dominant or base theory remains, it is reorganised to accommodate the ideas and strategies of the assimilated theory. It is often thought that assimilative integration is one of the most common approaches to integration as it provides a coherent worldview or metatheoretical foundation but also allows for ideas and practices from other theories to be incorporated making a therapist more adaptive to the needs of clients.

Theoretical Integration

Theoretical integration approaches the task of integration by drawing on key ideas from existing approaches to form a new comprehensive theory. As in assimilative integration, adherents of theoretical integration recognise the need to have some central or integrating frame, idea or device. In its purest form, the approach seeks to draw together the breadth of counselling theories into an overarching theory or metatheory. As theories are based on quite different assumptions, integrating such diversity requires going beyond the level of individual theories and identifying higher order conceptualisations of the human

condition and of change approaches. This necessitates a keen awareness of metatheoretical assumptions as a way of accounting for change mechanisms. The perfect form of theoretical integration might almost be a theory about everything, but as this is not possible, a more modest expression of the approach is to construct theory based on some focusing device such as skills, procedures, categories or combinations of existing theories. Often such approaches are referred to as transtheoretical approaches.

One of the best known of such approaches is the 'transtheoretical approach' proposed by Prochaska and DiClemente (1983). The authors organise their model by identifying three main categories through which therapists filter their thoughts about clients and their presenting problems. The categories are:

- processes of change
- stages of change
- levels of change.

The details of these categories are listed below:

Processes of change

- Consciousness raising
- Counterconditioning
- Dramatic relief
- Environmental re-evaluation
- Helping relationships
- Reinforcement management
- Self-liberation
- Self-re-evaluation
- Social-liberation
- Stimulus control

Stages of change

- Pre-contemplative
- Contemplative
- Preparation
- Action
- Maintenance

Levels of change

- Symptom/situational problems
- Current maladaptive cognitions

- Current interpersonal conflicts
- Family/systems conflicts
- Long-term intrapersonal conflicts

In the processes of change, the therapist asks themselves and possibly the client what type of change is being sought or required. As several different types of change may be engaged, it is important for the therapist to know what to focus on in any given moment of therapy.

A seminal contribution and probably the most famous aspect of the transtheoretical model is the idea that change goes through stages. Associated with this idea is that the type of change sought, and the degree or level of change required, must match the stage of change an individual is ready to embrace. For example, the first stage of change is where a person is not clear about what change they are seeking but has some vague sense that some change is needed. This emerging awareness is usually one of the factors that draws a person to therapy as they have some perception that something is wrong and needs to be addressed. The next stage is where the nature of the change sought is pondered and gradually becomes clear. Later stages involve preparing for change, then acting to effect change, and finally maintaining the change achieved.

The final category in the model is the level of change. This refers to how deep or comprehensive the change sought might be. The first level of change focuses on symptom relief and situation changes. This level of change is regarded as much less challenging than the last level which refers to long-term relational change. Overall, the Transtheoretical Model of Change provides a very helpful way of thinking about the change process while at the same time allowing practitioners to draw on a breadth of counselling theories.

Pluralism

In more recent years, another approach proposed by Mick Cooper and John McLeod (2011) exemplifies a particular form of pluralism. All forms of pluralism are similar in that they encourage selection from the breadth of established therapies. This is consistent with the common factors view that any well-established therapy, when applied well, is likely to activate change processes. McLeod and Cooper agree while also drawing on ideas of the philosopher Rescher (1993) and others (McLellan, 1995; Derrida, 1974) who hold that any significant question can be answered in a variety of ways and that the diversity of nature cannot be reduced to a single principle. Drawing on these notions, McLeod and Cooper affirm that any established therapy could be used to address the needs of the client. What they suggest though is that the choice of therapy used in any given session of therapy has more to do with the client's choice than the therapist's choice. This is not to say that the therapist is not involved in the approach undertaken but it does highlight the very important common factor of the client and what they bring to the therapy process. Of course, counselling and psychotherapy are principally about the client and their concerns and intentions and not those of the therapist.

Cooper and McLeod (2011) set out a particular form of pluralism which, in its most basic design, has three stages or phases:

1. Goals

2. Tasks
3. Methods

Given that the client is the focus of therapy, it is first important to establish what is the client's goal for therapy. Why did they come and what would they like to achieve? While this might seem obvious, it is not presumed that clients are always crystal clear about what they want from therapy. Sometimes a client's search is more intuitive than objectively clear. However, part of the therapy process is to help the client clarify their goal or goals.

Once the client's goals for therapy are established, the next stage is to find agreement between the client and counsellor about the tasks that need to be undertaken to achieve the stated goals. Some examples of common tasks of therapy include:

- making meaning of problematic issues
- problem-solving
- changing behaviour
- negotiating life transitions
- dealing with difficult feelings and emotions
- dealing with difficult and painful relationships (Cooper & McLeod, 2011; Holtforth, & Grawe, 2002).

Having identified the tasks required to achieve the goals of therapy, the next stage is to agree on the theoretical approach or method employed. This is where the pluralist therapist is free to choose from an array of theories and approaches in cooperation with the client. McLeod and Cooper hold the view that the 'way of working' informed by a theoretical approach must be a way the client is in agreement with or at least can appreciate. In this respect, therapy is a co-creation between the therapist and client. If the client, for example, is more comfortable working in a cognitive way than in an affective or somatic manner then the therapist will draw on cognitive approaches to meet the client's concerns.

One criticism of this form of pluralism is that it is not really a form of integration but a particular form of eclecticism. There is no real attempt in the pluralism described above to draw together different theories. However, allowing this, it is an important way of addressing the issue of "What is the most effective approach to counselling?"

Personal Approaches to Psychotherapy Integration

Another way of thinking about how practitioners approach psychotherapy integration apart from these meta-approaches is to acknowledge that almost everyone approaches integration in their own idiosyncratic way (O'Hara & Schofield, 2008). Unless one is a mono-theorist dedicated to only one theory, which we would argue is much harder to do than one might think, then most of us are either eclectic or integrative in our approach to therapy. Now this does not mean that we are fully aware of our approach. Practitioners

probably range between those who freely choose or integrate by simply doing what feels right in the moment to those who integrate via quite sophisticated philosophical and structural approaches.

One of the curious things about counselling theories is that they are usually wonderful at helping us to think about the nature of humanness, assessment, diagnosis, and change principles but often not as strong at providing a detailed map of therapy. One of the obvious reasons for this is that each client and each presenting problem are unique making it impossible to simply provide a 'generic fix'. The sheer complexity of human beings and of the therapeutic process requires us to constantly adjust to client needs often within the minute moments of the therapeutic encounter. However, having said this does not mean it is impossible to provide a general map or practice framework that helps therapists focus on what is important.

It is an interesting fact that as therapists we are naturally drawn to prefer different theoretical approaches over others. While we may change our mind over the course of our career, we will always have our preferred approaches. This is an interesting reality and less common in other professions, especially in the hard sciences. Even with an enormous volume of research in psychotherapy, we still cannot say, "It is proven that this is the very best approach". So, while we know that certain strategies are highly effective, there is room for choice. The fact that we have preferred approaches begs the question, "On what basis do you choose?"

The answer to this question has many elements, some of which include, personality, past life experience, past therapy experience, cultural influences, client context, and more. As we are focusing on theory, it would be fair to say that it is something about the respective theory to which we are drawn that answers certain questions. Several of these questions were listed earlier in this chapter. Theory addresses at least three major concerns:

- What it is to be human.
- How human health and illness are understood.
- How therapeutic change occurs

The first of these concerns has been the topic of philosophy, theology, and anthropology for centuries. Whether you are aware of it or not you have firm views on the question of human nature or at least nascent (tentative or emerging) views. To help us think about this question, how would you answer the following questions?

Activity

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https://uq.pressbooks.pub/practice-counselling-psychotherapy/?p=206#h5p-10

If you think about your preferred theory or theories, you may notice that inherent in these theories is a preference for certain of these dichotic pairs. While this may be a somewhat simplistic approach to deep philosophical questions, it is true that we cannot escape having to respond to these questions in some way.

If we turn to the second of the concerns listed above, we are confronted by the issue of how human health and illness are understood. Again, this is a complex issue and has many elements. We know that some health conditions are principally genetic in origin while others have more to do with lifestyle. We might also add that lifestyle has both a personal and a sociocultural dimension. For example, our attitude to work has both personal and cultural features. Some people are workaholics due to their own predilection, and others are forced to work hard due to social and cultural imperatives. Related to this is the question of whether an illness is *intrinsic* to the person or *extrinsic*. A classic example here is depression. Is a person's depression due to their inherited genes or to their sense of self, personal experiences, and lifestyle choices?

Our views about health and illness influence not just our choice of therapy but how we approach our clients. We will generally tend towards one end of the continuum below.

Of course, this will vary depending somewhat on the nature of the problem being addressed. The issue is further highlighted when we consider diagnosis. If we think a presenting problem is largely due to *genetics*, we are likely to understand the problem in terms of a diagnostic category. If, on the other hand, we see the

problem as being due to the client's *sense of self, lifestyle*, or *social conditions* then we will be less inclined to categorise in a diagnostic fashion. We could say that to a significant degree, the nature of a client's problem is largely determined by the eye of the beholder.

The third concern regards our view of how therapeutic change occurs. This is very much influenced by our perspective on the first two concerns. It will also be influenced by our own experiences, personality, and training. Some of us will naturally default to a view of change as principally based on cognitions. For others it will be more about emotions and feeling states, and for others it will be about somatic or bodily states. Obviously, in realty, change is influenced by all these factors as well as by transpersonal issues such our understanding of the transcendent.

With all the above in mind, our assertion is that each counsellor brings to therapy their collective and embodied perspective on all these issues. We choose theories, whether intuitively or consciously, that best represent our views on these matters. Interestingly, even though we have our preferred approaches, when working with our clients we typically do not follow a purely prescribed theoretical approach. Instead, we draw on theory but adjust it to the needs of the client in the moments of therapy. We suggest that while this is a good thing, it presents us with a problem. If we do not follow our preferred theory to the letter, then what directs our approach to therapy? The short answer is all the things we have discussed in this chapter and more. While this is true it leaves us with the need for direction. What are the steps that guide us?

Implications for Practice

Practice Framework

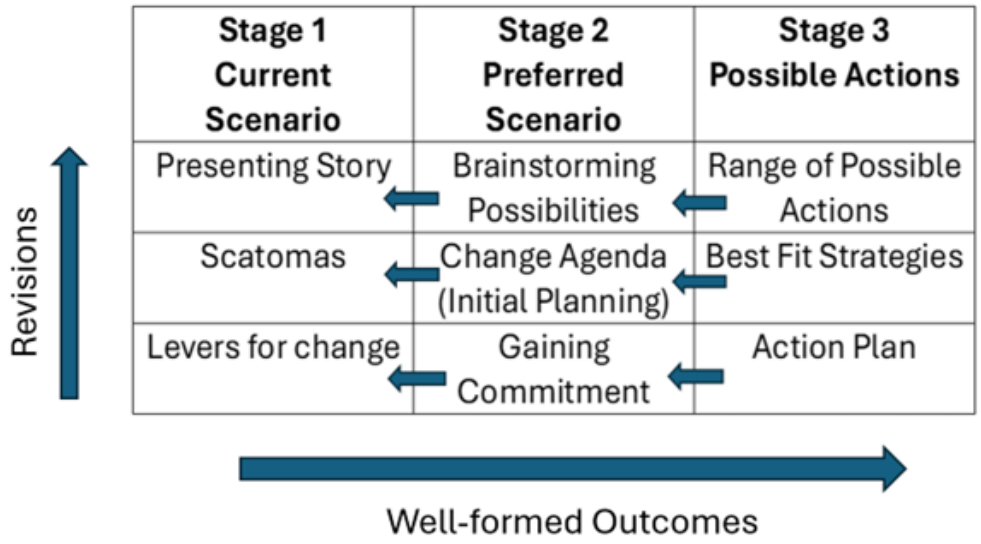
One way to address this question of direction is a practice framework. A practice framework is essentially an overview map of the steps and stages of therapy. It is influenced by theory but is broader in scope, allowing for adjustments as required. Practice Frameworks come in varying degrees of specificity; some are quite minimalist and others very detailed. An example of a minimalist framework is that provided by Ivey and others (Ivey, et al., 2016) in what they refer to as the Five Stages of the Counselling Session:

1. Empathic relationship or rapport building
2. Story and strengths
3. Goals
4. Re-story
5. Action.

As you can see the authors recommend that therapists be guided by these therapy stages. However, the approach is general enough that therapists are at liberty to incorporate strategies from their preferred theories.

Another Practice Framework by Egan is more detailed. His model can be seen in Figure 2 below.

Figure 2. *Egan's Model*



Adapted from "The Model" in T H R E S A G M O D L The skilled helper Gerard Egan (1975)" by Dwight Mitchell, which was adapted from "The skilled helper: A problem-management and opportunity-development approach to helping" by Gerald Egan (2013).

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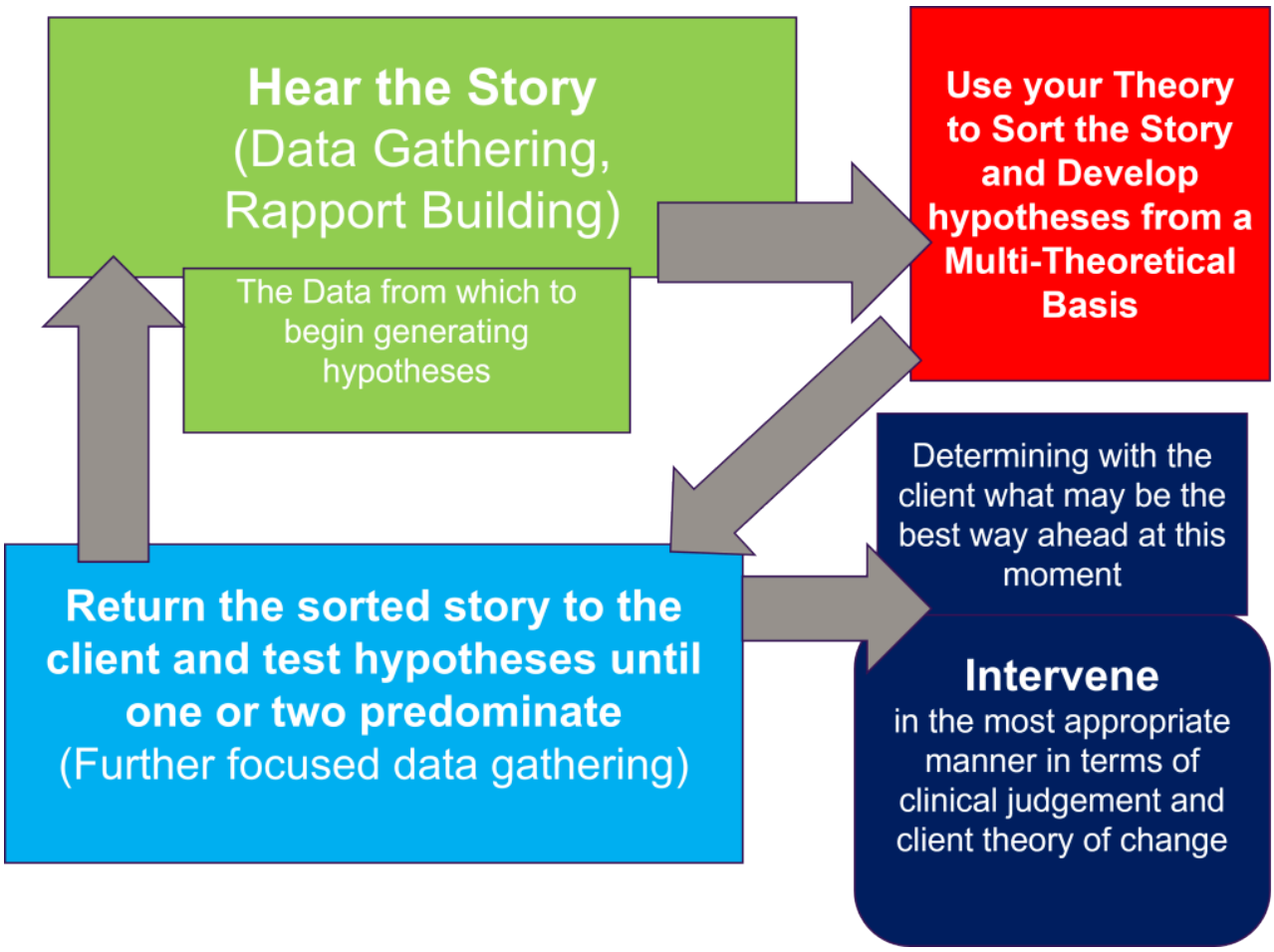
Egan envisions therapy moving across three broad stages each involving three sub-components which are dynamic and can be returned to or adjusted as the therapy progresses. This model is often called a problem-solving approach and like all frameworks has its own theoretical assumptions and preferences.

One of the Practice Frameworks used at The University of Queensland in the education of counsellors and psychologists can be seen in Figure 3 below.

Figure 3. *UQ Practice Framework*



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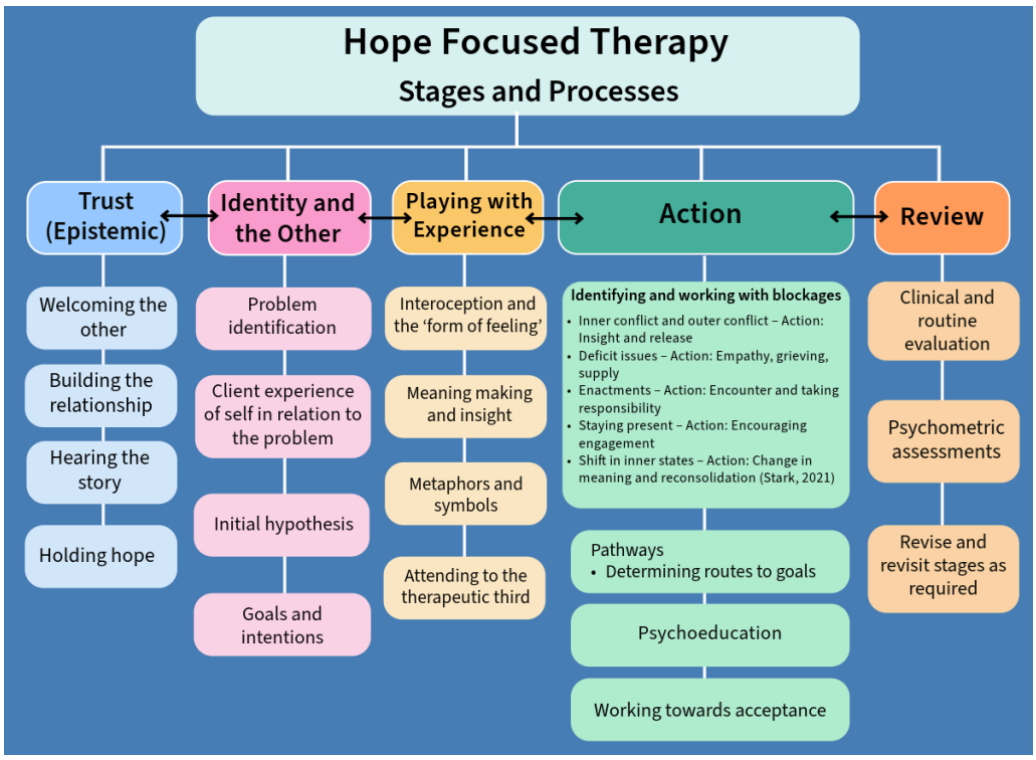
This framework provides a helpful guide or map to the main stages or steps within the therapeutic process. You can see that the process is dynamic in that the next step depends on achieving the preceding step and, if necessary, returning to it until clarification is reached. A central emphasis is placed on deeply listening and hearing the client's story and then cocreating a hypothesis about the nature of the problem.

Another practice framework comes from hope focused therapy (O'Hara, 2013; O'Hara & O'Hara, 2020) which while an integrative approach is strongly influenced by interpersonal psychodynamic and humanistic theories and the important place that facilitating hope plays within the therapeutic process. A basic outline of the Practice Framework is provided in Figure 4 below.

Figure 4. *Hope Focused Therapy Practice Framework*



"Hope Focused Therapy Practice Framework" by Dr Denis O'Hara, licensed under a Creative Commons Attribution-NonCommerical 4.0 licence.

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The mnemonic TIPAR is an easy way to remember the stages of therapy, Trust, Identity, Play, Action and Review. The establishment of trust and the therapeutic relationship is an essential foundation for hearing the client's story. As the problem story is told the therapist must apply deep listening while holding hope for the client especially when the client is struggling to maintain hope amid the problem. As we discussed in Chapter 1, therapy is about 'the self' of the client. It is the self that is experiencing challenges and this experience of self or 'sense of self' impacts who the client is in the world – their identity. It is important for the therapist to attend to the client's 'sense of self' and self-definition especially as it relates to the problem. From this the therapist can construct an initial hypothesis of the problem issue. As we value collaboration, the initial hypothesis is shared with the client and jointly constructed. From this understanding the client can solidify their goals for therapy. Following hypothesis generation and goal clarification, the task is to work on what the client is experiencing in more detail and what has led to and is perpetuating the problem. We use the term 'play' here to capture the multifaceted challenge of staying connected to the problem experience, of imagining new possibilities and gaining deeper insight (O'Hara, 2016). There is not enough space to really develop the significance of play in therapy, but we recommend the text by Russell Meares (2005) entitled the 'Metaphor of Play' as a wonderful exploration of what play means in the context of therapy. As insight and understanding are gained, further actions are likely required to address the problem

issues. There are many possible actions that may be necessary to meet the problem. Areas common to working with life challenges are identified including different types of blockages, identifying pathways towards resolution, psychoeducation and acceptance. Assuming that good progress has now been made, the last stage is to review progress.

To fully appreciate each of the Practice Frameworks listed above we would need to explore in greater depth what informs them and what each stage entails in more detail. The aim here is to provide examples of different approaches. Each therapist has some form of personal framework for therapy whether they are fully conscious of it or not. The more you practise therapy and reflect on your professional experiences you will develop and adjust and hopefully become highly conscious of how you practise.

In this chapter we have sought to show how therapists integrate into their practice a wealth of knowledge about the human condition and about psychological theories of change. Some of the approaches discussed are more formalised, as in the transtheoretical approach, while others are more idiosyncratic. We have highlighted that even when we know our preferred theories we still need to consider our map of therapy or practice framework. Just as human beings are complex, therapy is a complex and dynamic process. As you learn more and practise the art and science of therapy you will continually adjust your approach.

Activity

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11.

PROFESSIONAL PRACTICE

Jim Schirmer and Kate Witteveen

"Counselor professional identity is the integration of professional training with personal attributes in the context of a professional community." (Gibson et al., 2010, p. 21)

"Counselors' identities differ from identities formed in many other professions because. in addition to forming attitudes about their professional selves. counselors develop a "therapeutic self that consists of a unique personal blend of the developed professional and personal selves" (Skovholt & Ronnestad, 1992. p. 507)." (Auxier et al., 2003, p. 25)

Key Takeaways

- An understanding of the professional demands of practising counselling and psychotherapy in a real-world context
- The importance of self-awareness as a counsellor, and the essential areas for self-reflection
- The attitudes, awareness, skills and actions needed to create cultural safety for clients
- The common standards and requirements that are set out by the counselling and psychotherapy profession

Introduction

The previous chapters of this book have covered some of the essential elements of practice, including:

- The underlying philosophy, research and neurobiology of therapeutic change;
- The enduring ideas of major theories of psychotherapy that inform the practice of counselling;
- The essential therapeutic processes that take place within the counselling relationship; and
- The foundational skills that counsellors need to apply in practice.

As authors, we take the position that these are essential features of practice. That is, any practitioner in this field needs to have these foundations in place in order to safely and effectively offer psychotherapy to clients.

It is on the basis of this foundational knowledge and skillset that counsellors step out into the world as professionals. This usually first happens in training during an internship or practicum experience, but soon enough it will happen as a fully qualified graduate. It is at this point that new practitioners of counselling realise that professional practice is more than just having certain theories and practical competencies; rather, it also involves fulfilling your responsibility to certain expectations and standards.

Pellegrino (2002) explains it in this way:

> Profession means, in its etymological roots, to declare aloud, to proclaim something publicly. On this view professionals make a "profession" of a specific kind of activity and conduct to which they commit themselves and to which they can be expected to conform. The essence of a profession then is this act of "profession" – of promise, commitment and dedication to an ideal. (p. 379)

Thus, when you go into the world and profess that you are a counsellor or a therapist, and ask someone, 'How can I be of help to you?', you are making a promise and a commitment to that person and to the community. As such, you then have a responsibility to honour the trust that is being placed in you by fulfilling the commitment that you have made.

> This "act of profession" is an act of implicit promise making that establishes a covenant of trust at the [practitioner's] voluntary instigation. This self-imposed trust covenant imposes obligations on the professional from the moment it is made. (Pellegrino, 1995, p. 267)

Two conclusions can be drawn from this aspect of professionalism. Firstly, to be a professional is inescapably and invariably an activity that must consider the role of ethics. As the previous paragraphs have demonstrated, being a professional involves a spectrum of ethical considerations: promises, commitments, trust, obligations and responsibilities. It is not that ethics is something that gets added to professional practice, but rather that it is something that that is inseparably interwoven into the very fabric of what it means to declare yourself as a professional. As such, becoming a professional requires you to reflect on yourself as an ethical being.

Secondly, to be a professional is to put your knowledge into practice in a context. This is the difference between being a student of counselling and a practitioner of counselling. A practitioner does not just learn their field, but also applies it. Therefore, a practitioner must choose a place to apply their skills: a real-life setting in which to put their knowledge and skills to work. Consistent with ecological theories of systems (e.g. Bronfenbrenner, 1977), your work as a counsellor is nested within relationships (e.g. colleagues and workplaces), communities, policies and laws, economics, media, social attitudes and norms, and historical events.

As such, along with knowledge and skills, the 'practice of counselling and psychotherapy' also requires you to *fulfil your professional commitments within the context in which you practise therapy*. The fulfilment of this professional commitment exists in the intersection of three different (and sometimes competing) sets of values and standards:

1. Your own personal values
2. The worldview and expectations of your client
3. The standards set out by the workplace and the profession.

Figure 1. *Intersecting Values and Standards*

As a result, the practice of psychotherapy frequently requires reflecting on and adapting to the interaction between these three sets of expectations. There will quite often be a strong (or at least very close) synergy between these three areas, meaning that your practice can congruently express your values, meet your client's expectations, and fall within the professional standards, all at the same time. However, it is possible that, at times, the realities of the context may create difficulties and dilemmas in the form of a dissonance between these three sets of expectations.

The purpose of this chapter is to briefly introduce you to some major considerations of each of these three areas of professional expectations. The treatment of this topic is not meant to be exhaustive, as you will likely gain a deeper knowledge of this through other aspects of training, further reading, and experience in the field. Rather this chapter is designed to have you reflect on three initial questions to prepare you for professional practice in context:

1. What are my guiding values and principles as a professional?
2. How might I need to adapt to the worldviews, expectations and cultures of my clients?
3. What professional standards do I need to be aware of in practice?

Personal Values and Standards

A cornerstone of professional practice as a counsellor is self-awareness. Self-awareness is valued by all

approaches to psychotherapy and is an integral part of all training programs (McLeod, 2019). There are several reasons why self-awareness is often seen as an indispensable quality for counsellors to possess:

- Because counselling is fundamentally a relationship, it is crucial that counsellors have a deep understanding of their interpersonal patterns, needs, issues and defences, as these will turn up in therapy and have the potential to interfere with the client's process.
- Due to the often sensitive, complex and potentially distressing subjects that are the focus of counselling, counsellors need to be aware of their own vulnerabilities, blind spots, emotions and unresolved issues in order to maintain their own health and wellbeing.
- As therapy is meant to be a safe and non-judgemental space, counsellors need to gain awareness of attitudes, assumptions and biases that might leave the client feeling judged or unsafe.
- Finally, because the person of the counsellor is an influence on the outcome of counselling, greater self-knowledge broadens the capacity for the counsellor's 'use of self' in helping others.

So, what is self-awareness, and how do counsellors go about increasing it? Pieterse et al. (2013) define self-awareness as:

> "...therapist's knowledge and understanding of [self] in relation to values, beliefs, life experiences and worldview ... [It is] a state of being conscious of one's thoughts, feelings, beliefs, behaviours and attitudes, and knowing how these factors are shaped by important aspects of one's developmental and social history" (pp. 190-191).

This definition highlights a few key areas that counsellors should reflect on to gain greater self-awareness. The first could be referred to as the *influence of their history and experiences*. Like anyone, a counsellor's life experiences will have shaped the person they have developed into. One particularly important aspect of this is the counsellor's social history, which will have shaped their relational patterns and needs. Another key area to be aware of is any lived experience of issues that the client is presenting with, both for the counsellor's own wellbeing, and also for the potential influence that this may have on the therapeutic process.

A second area for awareness could be termed the counsellor's *psychological and moral schema*. This includes a wide range of things such as the beliefs, attitudes, worldview, values and motivations. The value of gaining awareness of these aspects of self is that many of these operate below our conscious awareness. In other words, they act more like assumptions that we bring to the world. Nonetheless, they are highly influential, such as in the following example.

Example

Consider the topic of motivation. Many counsellors would describe their professional motivation as wanting to 'help others'. While this of course has its merits, there might also be some unexpected undercurrents that a counsellor should explore.

For example, wanting to help another is rarely purely altruistic. Rather, it feels good to be an important person in another person's life. If we are not aware of how this feeling of importance is motivating us, then we may be tempted to make ourselves indispensable to the other person. That is, if our reward is feeling important, then this may then subtly influence the counselling relationship, such as maintaining the client's need for us, or feeling disappointed if someone doesn't need us anymore.

Another side of helping is feeling influential. If we have influence in another person's life, it can leave us with a feeling of power. If we are working from this motivation, and someone doesn't accept our help, or is passive-aggressive, we might suddenly find ourselves frustrated. There might be a sudden instinct or urge to try to get our way. As such, an unchecked motivation can have strong influences on the relationship and the client.

A third area for counsellor self-awareness is the awareness of the *moment-to-moment thoughts, feelings and behaviours*. This is sometimes termed the skill of immediacy: being able to pay attention to what is going on for you, here and now. Another word for this is interoception, which is the capacity to perceive physical and emotional states. This first involves recognising how the counselling session might be influenced by things like the counsellor's physical state (e.g. hunger; tiredness), their emotional reactions (e.g. offence, frustration, affection, pity), or cognitions (e.g. interpretations). This then also involves how the counsellor understands, regulates and possibly uses these reactions.

Given the value and the content of self-awareness, it is worth briefly mentioning some of the common ways that therapists develop self-awareness. Broadly, this process could be called reflection, i.e. that self-reflection is the means to gain self-awareness. Due to the interpersonal nature of counselling, many practitioners do this reflection in an interpersonal environment, such as their personal therapy or as part of a personal development group. However, counsellors might also have personal processes of reflection, such as journalling, art, or contemplative practices. Of course, life experience and work experience provide stimuli for reflection, with the latter often processed in supervision or among peers. Whatever the method, the important thing is that you have a regular, sustained practice of reflection on yourself as a person and a professional.

Client Culture and Worldview

A second dynamic to professional practice is recognising and adapting to the individuality of the client and their worldview, culture and expectations. While the principles of recognising and adapting to the individuality of the client undergird practically all the skills and processes in this book, the emphasis in this section is on the ethical requirement of the professional counsellor to create a *safe environment* for their clients.

The basis of this principle is the reality of diversity. Just as one might express a paradox such as 'the only constant is change', so too it might be accurate to say that in counselling the only true universal is difference. Even veterans of this practice can be surprised by the sheer spectrum of ways that people view, experience and act within the world. So, how, as a professional, do we go about fulfilling our promise and responsibility in the context of client diversity?

A substantial proposition of the answer to this question could be summarised under the term 'cultural safety'. Creating a safe therapeutic environment is a foundational professional responsibility. Some authors (Eckermann et al., 1994, as cited in Williams, 1999) have described this culturally safe environment in the following way:

> "an environment which is safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening" (p.213).

Implicit in this definition are two elements. Firstly, a culturally safe environment can be defined by what is not there, namely an absence of prejudice, judgment, coercion, paternalism or any other factor that dehumanises, devalues or demeans the person and their experience. Secondly, and more substantively, a safe environment is marked by the presence of respect and dignity in which the worldview, knowledge, experience and culture are actively acknowledged, heard and incorporated into the therapeutic environment.

Of course, the range of possible areas of diversity is wide. Any individual client will represent a unique constellation of factors such as (but not limited to) culture, ethnicity, gender, sexuality, religion, socio-economic status, and level of education. So, what does it take to make safe professional environments for our clients? The American Counselling Association (Ratts et al., 2016) summarises the competencies needed for multicultural counselling under four headings:

1. Attitudes and beliefs
2. Knowledge (or awareness)
3. Skills
4. Action.

This section will briefly introduce some of the major features of professional practice in each of these four areas.

Attitudes and Beliefs

A recurring theme in most accounts of culturally safe professional practice is that creating safety is not just a matter of knowing about other cultures or saying the right words. Rather, it also involves some inner work of examining our attitudes and beliefs in order to consider the effects these have on clients. Thus, many contemporary approaches to diversity do not just mention 'competency', but also attitudes of humility, sensitivity, empathy and wisdom (Sullivan, 2008).

At one level, this reflection on attitudes and beliefs is about fostering awareness of pre-existing attitudes and beliefs that might benefit or inhibit client safety. Our life experiences, upbringing and own cultural discourses leave us all with presuppositions, assumptions and cognitive scripts, many of which are below our awareness. Even so, they have an influence in how we act and communicate with others. Compassionately and honestly reflecting on these has the potential to avoid inadvertently creating an unsafe environment for our clients.

Example

In one of Irvin Yalom's (2012) stories of psychotherapy – titled "Fat Lady" – the author offers a raw and sometimes uncomfortable reflection on his attitudes towards weight and how these impacted upon a client, even without his awareness. While some have criticised the content and the impunity with which he shared his judgements (e.g. Fuller, 2017), the essay still stands as an example of a therapist wrestling with their own inherited attitudes and biases.

If you were honest with yourself, are there any attitudes or beliefs that you need to reflect on in terms of how they might impact client safety?

Along with becoming aware of our pre-existing assumptions and beliefs, cultural safety is also about cultivating the kind of attitude that enables one to adopt an open, sensitive and respectful presence in counselling. A major term that has been used to describe this type of attitude is 'cultural humility' (Mosher et al., 2017). Cultural humility has many aspects, including:

- being aware of our limitations, leading to a willingness and openness to learn new cultural information;
- a respect for the knowledge and expertise of the other person, leading to a stance of listening, learning and not making assumptions; and
- a willingness to divest power, leading to a more mutual partnership of knowledge.

As such, an attitude of humility has the potential to create a safe environment for the client, their culture and their worldview.

Knowledge: Awareness for Empathy

A second feature of creating a culturally safe therapeutic space for clients involves the counsellor developing a growing awareness of the worldviews and lived experiences of their clients. As mentioned earlier, each person you see will have their own combination of social groups and identities that have shaped their life and their experience. It is not reasonable to think that any counsellor will be an expert in all possible cultures and experiences; furthermore, it is also questionable whether 'expertise' is even desirable, given that it is a stance that operates against the humility discussed in the previous section.

In contrast, the 'knowledge' needed to create culturally safe environments is perhaps better categorised as an ongoing attitude of openness, sensitivity and awareness. Chung and Bernak (2002, pp. 157-158) list some prominent areas that counsellors need to develop awareness in, leading to questions like:

1. What are the social contexts of my client (e.g. family, community, culture)? What norms, values and worldviews exist within these groups? How do these influence my client?
2. What are the help-seeking and healing practices that are common in my client's culture? How does this culture understand 'mental health', the nature and cause of 'symptoms', and the steps in 'treatment'?
3. What is the historical and sociopolitical background of the social groups to which my client belongs? How does this background influence the client in the present?
4. What psychological or social adjustments might the client need to make in navigating various roles and contexts? What adjustments might the client be feeling they need to make to 'fit in' to therapy?
5. Where in their life might the client experience inequality, discrimination, prejudice or oppression because of a social group or identity? How have dynamics of privilege and marginalisation been experienced by the client?

An awareness of these types of issues has the potential to shape the course of therapy in several ways. Firstly, this awareness helps the counsellor to remain sensitive and flexible in the formation of the therapeutic relationship. By attending to the client's experience in these areas – and, conversely, by not basing the therapy on the assumption that the client's experience is the same as the counsellor's – the counsellor increases the chance that they will show the empathy needed for the client to feel heard and understood. Furthermore, by understanding the norms of roles and communication that the client is bringing to therapy, the counsellor may be able to adjust their interpersonal style to facilitate a more comfortable interaction for the client. It is also important for the counsellor to be sensitive to potential power dynamics that may leave the client feeling unsafe.

Moreover, by understanding what the client might be expecting from the encounter, the counsellor can help to form the therapeutic alliance by adjusting their approach or (where needed) negotiating the basis on which they and the client might work together. In this way, an awareness of the client's social background

helps to shape therapy by accounting for their worldview in all aspects of the therapeutic process, including case formulation and the selection and implementation of interventions. By understanding the way in which the client might understand their problems and their resolution, the counsellor is more likely to be able to shape the goals and tasks of therapy in way that will be acceptable and safe for the client.

Skills for Promoting Safety

While awareness of ourselves and our clients is a necessary foundation for culturally safe practice, it is rarely sufficient. Rather, cultural safety also requires counsellors to develop the skills needed to practise in a sensitive and flexible way. If the client is to experience a therapeutic environment free from judgement and discrimination, which has limited barriers to receiving care and honours their perspective and self-determination, what types of skills would a counsellor need to possess?

Sue et al. (2012) summarise the skill component of culturally safe practice as the capacity to be responsive, flexible and adaptable in your approach to helping others:

> "The multicultural skills component of cultural competence requires that counselors effectively apply a variety of helping skills when forming a therapeutic alliance... [I]t is important to individualize the choice of helping skills and avoid a blind application of techniques to all situations and all populations... It is important to individualize relationship skills and to consistently evaluate the effectiveness of our verbal and nonverbal responses to the client" (p. 351).

From this definition, it is possible to draw out two major capacities that counsellors need in this area. Firstly, flexible and adaptable counsellors need to have a capacity for higher-order thinking skills. That is, they do not just have the ability to understand, recall and apply, but also to analyse, evaluate and create. In other words, rather than just applying their known therapeutic theories and techniques, culturally responsive counsellors can think critically about the appropriateness for the client, and creatively adapt their practice to match the client's needs. In this way, the purpose of processes like rapport-building, assessment, formulation and intervention can still be achieved, but in ways that are individualised to the client.

The second area of capacity for counsellors is the breadth of skills in communicating with and relating to others. These communication skills include both listening and responding, as the safe therapeutic environment needs both understanding and responsiveness. Again, the key here is adaptability. A culturally safe counsellor will have the interpersonal agility to adapt elements of their communication style; for example, their formality and directness, the language, images and metaphors used, the volume of their content, and their rhetoric. This applies to all parts of the counselling process including relationship-building, formulation and intervention.

Exercise

Consider how you might adapt your communication in the following circumstances:

- Building rapport with a client who comes from a culture that values formality and hierarchy, and therefore expects the counsellor to be the expert and to lead the session.
- Talking with a client who is displaying symptoms of depression but who is from a generation where mental illness was considered 'madness' or 'insanity' and therefore carries a lot of stigma.
- Discussing how to respond as a parent to a child who has come out as gay when a client has religious beliefs that are strongly heteronormative in their approach to sexuality.

Action: Safety Through Justice

A final area of practice for counsellors wanting to create culturally safe therapeutic environments for clients is the capacity for action on issues of injustice or oppression. In this area of practice, counsellors are asked to consider how they might exercise their agency to take proactive action in the direction of greater social equality and justice.

While this perspective is not new in therapeutic theory – it was particularly championed through the perspectives of feminist therapy – it has recently experienced a renewed emphasis in the forms of concepts such as decolonisation, solidarity and liberation (Torres Rivera, 2020). In these perspectives, a more critical approach is taken to reorient counselling practice to consider socio-political aetiologies of human suffering, the impact of dominant discourses and ideologies that oppress or marginalise various people and groups, the power dynamics that are present in professions, and the need for praxis in producing change.

From these principles, other competencies emerge for counsellors who are seeking to create safety through solidarity, liberation and justice (Constantine et al., 2007), including the following:

1. Be aware of ways that oppression and inequality might be manifested and experienced by individuals and communities, including a critical reflection on how issues of oppression, power and privilege operate in your own life.
2. Maintain an awareness of how dynamics of power or privilege operate within your professional role (including processes of assessment and intervention), and be willing to question and challenge practices that might be marginalising, inappropriate or harmful.
3. Be active in collaboratively evaluating and exploring programs and interventions that better address

the needs of marginalised populations, including traditional healing practices.

4. Work at a systematic level to collaborate, learn and advocate for social change processes.

Importantly, these types of action need to be considered across a range of ecological levels, from the immediacy of intrapersonal and interpersonal, through to action in institutions, communities, public policy, and even the international level.

Reflection Activity

The Cultural Responsiveness Assessment Measure (CRAM; Smith et al., 2023) is a self-reflection tool for mental health practitioners working with First Nations people. This tool is intended to guide practitioners and students to reflect upon their own practice, and enhance self-awareness and capacity to work in a culturally responsive way. This tool includes items pertaining to the following themes:

- Awareness
- Knowledge
- Inclusive relationships
- Cultural respect
- Cultural safety
- Social justice
- Cultural humility
- Cultural competencies (p. 195).

From these themes, it is evident that culturally responsive practice includes a synthesis of knowledge, skills and competencies, about self and about others.

Take a few moments to complete the CRAM (Smith et al., 2023).

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://uq.pressbooks.pub/practice-counselling-psychotherapy/?p=153#h5p-3

Understanding and Maintaining Professional Standards

Being a professional does not just involve mediating between personal values and client expectations. Rather this interaction takes place within a wider social context. As a professional, you not only need to consider your own and your clients' expectations, but also the expectations of the workplace, your professional bodies, the community and the political and legal system in which you operate. All of these are stakeholders in the work you do, and influence your interactions through both written standards (e.g. laws, policies, codes) and unwritten expectations (e.g. norms, worldviews, cultures).

A major aspect of this is being part of a professional association, the association or body that represents the specialised knowledge and skills of the profession. Professional associations act as the public face of the profession through fulfilling numerous functions. These associations accredit training and have standards for the admittance to the profession. In this way, they help to ensure that all practitioners meet a recognised set of standards. They also have codes of conduct and ethics, which effectively provide accountability for professionals' behaviour. In this way, if practitioners do not maintain certain standards (both in terms of their practice and their behaviour), they can lose their status as a professional. As such, professional associations provide benefits for all stakeholders. For the professional, they provide credibility. For the public, they provide protection through accountability.

Some major standards that a professional counsellor needs to maintain are (a) ethics, (b) scope of practice and ongoing development, and (c) participation in supervision.

Ethics – Codes and Decision Making

One source of professional standards is a code of ethics. This includes features such as the guiding values and principles of the profession, namely: autonomy, justice, beneficence, nonmaleficence and fidelity (Kitchener & Anderson, 2011), and also particular standards of behaviour related to major aspects of practice. These standards range from what is mandatory (i.e. you must do), to what is permitted (i.e. what you can do), to what is proscribed (i.e. what you cannot do) as a professional.

Exercise

Look up a code of ethics from a major counselling and psychotherapy association (e.g. the Australian Counselling Association, the Psychotherapy and Counselling Federation of Australia).

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://uq.pressbooks.pub/practice-counselling-psychotherapy/?p=153#h5p-4

These principles provide the foundation for ethical practice and are helpful in ensuring the safety of clients. However, they may not provide sufficient guidance and clarity in situations in which you encounter complex ethical dilemmas.

In the event of an ethical dilemma, ethical decision-making frameworks provide professionals with a means of systematically evaluating the options available to them and developing a plan of action that is based on a transparent and good-faith application of ethical principles. Many ethical decision-making models have been proposed (see, for example, Johnson et al., 2022 for a review), and you are encouraged to explore these models to see which ones align best with your personal and professional context. Although derived from different theoretical and practice-based frameworks, common elements across ethical decision-making models include the following factors: consultation; considering culture and/or context; making professional and personal judgements; and engaging in ethical and legal considerations (Heller Levitt, 2013, p. 215).

Ethical Decision-making Model Example

The practice-based model proposed by Corey et al. (2024) provides an example of an ethical decision-making model that incorporates these elements into an 8-step model, as follows:

1. **Identify the problem** – This includes conceptualising the nature and type of the problem, e.g. is it an ethical, legal, moral, values problem – or some combination of these?
2. **Identify the potential issues involved** – Consider: What are the competing perspectives and/or concerns? You may like to ask yourself: "Why is this problem a problem?" In this step, it is relevant to consider the context (including culture) in which this problem is being experienced.
3. **Review the relevant ethical codes** – Refer to your professional body's code of ethics. It is possible that the situation you are navigating is less complex than you first thought

and may be specifically accounted for in the code of ethics. Alternatively, the code of ethics will serve as a helpful reminder of the "non-negotiables" that you will need to consider in your decision.

4. **Know the applicable laws and regulations** – As professionals it is our obligation to be familiar with the relevant laws and regulations that govern our practice. It is important to note that some laws that may be relevant to counsellors (such as mandatory reporting legislation) differ across jurisdictions, so you need to ensure you are up to date with those that apply to your work.
5. **Obtain consultation** – It can be a tremendous relief to remember that we are not expected to make complex ethical decisions in isolation. It is appropriate and recommended to seek support from supervisors and/or other experienced professionals as part of your ethical decision-making process.
6. **Consider possible and probable courses of action** – Brainstorm all of the options you can identify, taking into account the unique circumstances of your dilemma.
7. **Enumerate the consequences of various decisions** – Evaluate each of your options from Step 6 through the lens of the ethical (including the ethical principles and the specific ethical guidelines of the code of ethics you consulted) and legal obligations you must consider.
8. **Decide on what appears to be the best course of action** – Taking into account all of the information you have gathered throughout this process, identify the most appropriate option. It is possible that you may need to revisit some of the earlier steps in the model to refine your decision.

Ultimately, the specifics of the ethical decision-making model you choose to implement are less important than the process of careful consideration and reflection that you engage in when you encounter situations that are ethically complex. Like many facets of the counselling process, there are many possible approaches to ethical decision-making, and the usefulness of individual models may vary across counsellors, clients and contexts (Sheperis et al., 2016). It is up to you, as a professional counsellor, to familiarise yourself with ethical decision-making models that are applicable to your practice, and engage with these models, as appropriate, when navigating difficult ethical situations.

Scope of Practice and Professional Development

Another important aspect of maintaining professional standards is holding a 'scope of practice'. A scope of practice defines the activities a practitioner is permitted to undertake in their professional role, and (by extension) shows the limits to their practice (often referred to as those activities 'beyond the scope of practice'). In layperson's terms, a scope of practice defines what you can and cannot do in your role as a counsellor or psychotherapist. As a professional it is important to:

- know the limits of your scope of practice
- make sure that every service you offer is based on adequate knowledge, training and skills
- refrain from making false claims about your qualifications or competence, and do not allow others to do so either.

Some aspects of a counsellor's scope of practice are static. For example, counsellors virtually never have the scope to provide a conclusive mental health diagnosis, nor can they prescribe medication. Other aspects are more dynamic. That is, your scope of practice may expand across your career, such as working with particular populations (e.g. children), presenting issues (e.g. psychosis), interventions (e.g. Eye Movement Desensitisation and Reprocessing, i.e. EMDR), or modalities (e.g. couples and families), as you undertake additional training and/or gain specific experience.

A major professional standard relating to competence and scope of practice is *continuing professional development*. That is, after your initial qualification in counselling, it is important that you keep up to date with emerging knowledge in the field and that you continue to expand your knowledge and skills. This expectation is so important that most professional associations require practitioners to meet minimum requirements (e.g. 25 hours per year) of professional development in order to maintain their membership as a professional. This professional development often takes the form of a training event (e.g. workshop, conference, course or online training), but professional bodies often also recognise some activities such as professional reading, imparting knowledge (e.g. writing and presenting), or participation in peer learning groups.

Supervision

A final essential standard for professional counsellors and psychotherapists is participation in ongoing supervision. Supervision has been described as a:

> "...mechanism for registered counsellors and psychotherapists to review caseloads with an experienced practitioner and to develop the best therapeutic outcomes for the client, to discuss any concerns or ethical issues that may arise, and to reflect on the impact of the client work on the counsellor in an effort to improve self-care" (Schirmer & Thompson, 2021b, p. 10)

Given that the aim of supervision is to provide some support, guidance and review of the work of the counsellor, the practice of supervision is an essential system for both the professional development of counsellors and the quality assurance of the care provided to practitioners and the public. In this way, it is highly valued and widely used in human service professions such as counselling, psychotherapy, psychology, psychiatry, social work and mental health nursing (Barletta, 2017).

There are many different models for supervision, and much of what you learn about supervision will be through your experience as a supervisee in practice. Still, most supervision fulfils at least three basic functions, which have been termed the *formative*, *restorative* and *normative functions* (Proctor, 1988). Firstly, as a formative practice, supervision is educational, in that you engage in learning through a mentoring-like relationship where you reflect on cases, themes and questions from your work. Secondly,

as a *restorative practice*, supervision is supportive in that it is meant to monitor impact of the work, mitigate stress and promote growth in the counsellor. Finally, supervision has a normative or managerial function in that it also provides quality control through accountability to the ethos and standards of the profession, creating a common standard across the profession. These three functions each present unique contributions to the practice of counsellors, and research has shown that an overwhelming proportion of practising counsellors both value and receive benefit from supervision (Schirmer & Thompson, 2021a).

Conclusion: On the Value of Wisdom to Practice

This chapter has explored some of the major dynamics of stepping out as a counsellor into the real-world context of practice. In doing so, we often have to mediate between our own personal values, the worldview and expectations of our clients, and the standards set out by the workplace and the profession. The reality of mediating between these various perspectives cannot be reduced to knowing and following rules. Rather, it is a process of constant reflection, awareness and judgement, which is perhaps best summarised in the word wisdom.

In their attempt to define "wisdom", Zhang et al. (2023) identified more than twenty definitions in the literature, none of which were universally recognised. In synthesising these definitions, two common elements were recognised, namely:

1. A cognitive and affective component (i.e. intrapersonal knowledge and emotional mastery)
2. Concern for the welfare of humanity (i.e. interpersonal awareness and altruistic intention).

From these elements, we can determine that wisdom involves the capacity to integrate knowledge acquired through learning to new and different situations ("wit") and the discernment, motivation and ability to apply that knowledge in an ethical way ("virtue").

By this conceptualisation, it is apparent that the acquisition of wisdom is a process that occurs throughout your professional journey. It is not something you collect upon your graduation along with your degree. Rather, as you engage in your professional practice by applying your knowledge, skills, ethical decision-making processes and continuous self-reflection, you will enhance your capacity to understand "what is" (wit) and "what to do" (virtue) (Zhang et al., 2023).

For counsellors, wisdom in practice can be understood as a progression from needing to know "the single best thing to do", to recognising that, in many cases, the "best thing to do" depends on many factors that need to be considered on a case-by-case basis. Wisdom in practice requires the recognition and integration of a constellation of intrapersonal, interpersonal and sociocultural factors, as well as the elements of the therapeutic process we have explored in this book.

In this chapter, we have considered the intersection of personal values and standards, clients' culture and worldview, and ethical and professional standards, which influence our identity and practice as counsellors. It is apparent that "being" a professional is not something we attain upon meeting a certain training threshold. Rather, it involves a process of continuously "becoming", as we strive to integrate our knowledge

and experiences in ways that enhance our wisdom. In so doing, we are able to achieve our purpose of being professionally and ethically competent counsellors which, ultimately, means we help our clients.

Additional Reading

The following books provide some practical guidance and exercise on undertaking self-reflection as a trainee counsellor.

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12.

APPENDIX A - HYPOTHESIS GENERATING QUESTIONS FROM MAJOR THEORIES OF PSYCHOTHERAPY

Jim Schirmer

Hypothesis Generating Questions From Major Theories of Psychotherapy

Theory	Hypothesis generating questions
Psychoanalysis	• What unconscious drives might be influencing the client's behaviour? • How might the client's childhood experiences be influencing them now? • Does the client feel discomfort from tension between various parts of the self? • Are there learned defence mechanisms that are now causing pain for the client?
Gestalt	• Does the client have unfinished business and/or a desire to maintain certainty which is leaving them out of contact with themselves, their environment or their relationships? • Has the client lost contact with the here-and-now experience? • Has this loss of contact created an inauthentic and unsatisfying way of living?
Cognative-behavioural	• What are the client's learned scripts of behaviour and how are they serving them right now? • What are the client's automatic cognitions in response to their situation? • What patterns of beliefs and schemas does the client hold regarding their experience? • Is the client's learned pattern of behaviour ineffective for the current problems being faced? • Are there patterns of beliefs and cognitions that are leading to undesired emotions or behaviours? • Does the client have sufficient skills for managing their current challenges?
Solution-focused	• What is the client's goal? • What strategy is the client using to try to reach this goal? • How well is that strategy serving them? • Has the client's talk become saturated with the problem? • Has the problem-saturation led the client to feel stuck or hopeless about change?
Person-centred	• What is the client's view of their true or ideal self? • What feedback are they receiving about themselves from the key relationships in their life? • Does the client feel their worth is conditional on doing things or being a certain way? • Is the client feeling an incongruence between their ideal self and the self they have to be for others?
Feminist	• What social messages has the client received and internalised relating to roles and identities? • Is the client feeling constrained by unhelpful discourses about self and role? • Has the client internalised these discourses into their identity?

Narrative	• What values does the client want to build their life story around? • What social discourses might have been internalised by the client? • Has the problem become the main character in the client's life story? • Has the problem obscured or constrained the client's intentions and preferred narrative for their life?
Existential	• How does the way the way they tell their story influence their experience of it? • What inescapable parts of living is the client confronting? What frameworks of meaning does the client use to make sense of and give significance to their life? • Is the client feeling angst in the face of the realities of existence? • Has the client lost a sense of meaning and authenticity in living in the face of these challenges?

13.

APPENDIX B – ONE-PAGE FORMULATION FOR THE CASE OF EMILY

Jim Schirmer

Emily presented to counselling wanting to gain clarity on what she said was "a lot going on" in her life. In particular, she named significant changes that have happened as a result to her marriage, 6 months ago, to her new husband (Sai). Emily and Sai met 18 months ago and moved in together when they were married. Sai has two children (aged 7 and 5) from a previous marriage who are also living with them. Emily reported feeling very excited about the chance to be part of a family with children, given that she had always wanted to have children, but had not been able to due to fertility difficulties with her first husband. Consequently, Emily chose to reduce her work commitments so that she can be the primary caregiver for the children.

Given her excitement about this role, the reaction of the children has been very distressing. Emily reports that the children's behaviour toward her has been very difficult to manage, such as refusal to eat, throwing food, difficulties going to bed, and not completing homework. As a result of this, Emily describes experiencing:

- little happiness in her role in the family, and that family life is an exhausting struggle
- shattering of beliefs about what parenting should be like
- belief of not meeting social and personal expectations
- feeling stuck and not knowing what to do
- loneliness, rejection and low levels of social support
- disappointment in self, due to sense of failure in a central life role.

In contrast, Emily also reports a positive relationship with her husband, shows evidence of self-reflection, ability to express emotions, and ability to cope through other adverse life events.

Nevertheless, these recent events and their effects pose a threat to a number of her fundamental needs. She reports finding it difficult to feel a sense of joy in her life, which is compounded by the expectations of this time of life being one of happiness. There is a sense of a loss of control due to experiences not fitting previous beliefs and expectations, and due to attempted strategies to solve the problem not causing desired change. Her need for attachment is threatened through feelings of rejection and inferiority, coupled with a lack of adequate support in the midst of this interpersonal crisis. Finally, her sense of self and meaning built around being a 'mother' is threatened by the dominance of a social story of failure.

Emily herself makes meaning of this through the metaphor of a dense, grey fog that is made up of the very many people and things she has to consider in everyday life. This fog leaves her feeling emotionally

blocked, as well as so mentally clouded that she does not have the space to "think properly". She finds it difficult to get a clear view on what is most important to her, namely the children's needs. Nevertheless, she maintains her belief that there is something beyond the fog, even though she is not sure how to access it yet. She is therefore confident of the future, especially if her core need of feeling valued is able to be met.

Given the information we have so far, the working hypothesis is that Emily is overwhelmed with the number and intensity of adjustments and demands that have occurred as a result of the changes she has recently experienced, resulting in a devalued sense of self and a reduced capacity to find meaningful solutions. This is likely exacerbated by beliefs and narratives that have developed through previous significant relationships. The therapeutic relationship should be marked by the support and validation that Emily has said has already resulted in her feeling calmer and with a plan to talk to her husband. Granting this, due to the immediate concern of breaking through the 'fog', in the short term it is proposed to focus counselling on solution-focused processes. The aim of this is to open up a variety of best-fit practical options, such as self-care, increased support, or reviewing interactions with children (or others). In the long-term there is scope for restructuring cognitions or re-authoring narratives to challenge unhelpful thinking and/or reconnect with a more enriched sense of self.

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