Three types of counselling approaches and intervention techniques psychology essa...

The person-centred approach was developed by the American psychologist Carl Rogers in the 1940-1950’s (Rogers 1942, Rogers 1951) and this approach, also known as the client-centered or non-directive approach, continues to be used widely to this day. As the name of the theory implies, within the client-centered approach the counselling process places a heavy emphasis on the client’s own ability to resolve their problems. At the time it was developed, Rogerian therapy marked a distinct departure from the traditional psychotherapy in that the person being consulted was not termed to be the ‘ patient’. Carl Rogers believed in the client’s own capacity to develop and improve based on their resources rather than as the result of some techniques employed by the counsellor. The role of the counsellor changed into that of a facilitator rather than a doctor, and the function of the therapy was to help the client tap into their own resources.

The person-centred approach presupposes six core conditions required for therapeutic change: psychological contact between the client and the therapist; client incongruence; therapist congruence; therapist unconditional positive regard; accurate empathic understanding; client perception of the empathic understanding and unconditional positive regard (Corey 2009). These six conditions are considered to be sufficient and necessary for the success of a therapeutic relationship.

The first condition, psychological contact, is the sense of dependency between the counsellor and the client that goes beyond the obvious sensory contact. The relationship between the two is characterised by equality – both the therapist and the client are on the path of discovery, and both share

intimate information. Therapists have the role of a guide on this journey because they are more experienced, but it is a mutual journey nevertheless.

The condition of client incongruence the clients sense of unrest and anxiety. Within the framework of Rogerian theory, personality incongruence is the imbalance between the self-concept, the ideal self, and organismic experience. The client's sense of incongruence stems from the desire to achieve a balance between these three components (Rogers, 1951).

Therapist congruence, on the other hand, is the therapist's level of authenticity in their relationship with the client. In other words, the therapist must be completely open with the client, sharing their emotions, attitudes and reactions that develop in the course of the interaction. The role of the therapist is to serve as a model of a human being who is at peace with their inner-self and accept themselves and others without inhibition or false pretences. In a successful therapeutic relationship, the therapist will be genuinely moved to communicate personal information and will be genuinely engaged in their relationship with the client.

The second important quality on the part of the therapist is unconditional positive regard for their client. The therapist is accepting of their client without approving or disapproving of their behaviour, there are no judgmental feelings and no conditions for approval. As Fall et al. (2004, p. 202) point out " Unconditional positive regard is more than acceptance; it is an unwavering respect for the humanity of the client that is not affected by the behaviour demonstrated by the client".

Another cornerstone of person-centered approach is the concept of accurate empathic understanding. This part of the therapist-client relationship consists in the therapist’s ability to experience the client’s feelings as if they were his own. Such empathy will allow the therapist to arrive at an accurate understanding of those parts of the client’s experience that remain not verbalised directly. The therapist is then able to help their client to clarify and work through feelings that lie only at the edge of their conscious awareness.

Finally, the success of a therapeutic relationship also depends on the client’s perception of the therapist. The three qualities need to be sufficiently communicated to the client so they feels safe to disclose their inner world to the therapist. This final quality of the relationship speaks to the dynamic nature of the person-oriented approach – the therapist creates the necessary conditions for the client to progress, but the ultimate success hinges upon the client’s perception and the client’s willingness to take advantage of those conditions.

The second therapeutic modality discussed is the cognitive behaviour therapy (CBT). In its modern version the theory came into being in the 1980’s and 1990’s as the result of convergence of two earlier counselling approaches developed by Albert Ellis and Aaron Beck. The main difference of this therapeutic modality from the person-centered approach is that in CBT there is a stricter control by therapist in terms of the intervention techniques used. Cognitive behaviour approaches are based on the principle that the client’s improvement is the result of cognitive restructuring and acquisition

of new cognitive skills and thinking patterns. Such learning is directed by the therapist through a series of focused, goal-oriented intervention techniques.

Cognitive behaviour therapy is an umbrella term that covers a variety of therapy types, and is thus more dispersed in terms of the specific intervention techniques used. Some examples of the more widely used and discussed cognitive behaviour therapies are Cognitive Analytic Therapy, Rational Emotive Behaviour Therapy, and Multimodal Therapy. However, there are certain principles that form the basis of the different specific applications.

The Association for Behavioural and Cognitive Therapies outlines the basic cognitive and behavioural interventions as: ‘ clients learn to distinguish between thoughts and feelings; become aware of the ways in which their thoughts influence their feelings in ways that are not helpful; evaluate critically the veracity of their automatic thoughts and assumptions; develop the skills to notice, interrupt, and intervene at the level of automatic thoughts as they happen’ (ABCT, 2010).

To distinguish between thoughts and feelings allows the client to recognise the rational thoughts that regularly become precursors to the emotions. Once such a distinction has been established the client is then encouraged to identify the unjustified and unreasonable aspects of their reactions to their own thoughts or stimuli. They further learn to take control of thoughts and feelings at the unconscious level, and engage in cognitive restructuring – forming new patterns of thinking and new reactions to events.

The behavioural strand in CBT brings in the two key principles of classic conditioning and operant conditioning, which both aim at encouraging positive reinforcement of positive (adaptive) behaviours and minimize reinforcement of destructive (maladaptive) behaviours. Fall et al. (2004) point out that in behavioural approaches to counselling, the counsellor focuses less on the past, and more so on the present and future, seeking to identify aspects of the client's environment that can be modified in order to reinforce adaptive behaviour patterns.

The two strands, cognitive and behavioural, merge in CBT approaches to produce treatment that is usually short-term and skills-based. This means that most of the client's progress happens outside of the counselling sessions, in the real world, where they practice the behaviours and thinking patterns pointed out in the counselling sessions. CBT is, thus, empirically based both in theory and practice, as the client's progress is measured by reports of practical successes in their attempts to change both their environment and their reactions to their environment.

Finally, the third therapeutic modality is the feminist approach to therapy. It emerged as the outcome of the revision of traditional counselling theories from the feminist perspective. Such a revision brought about a new agenda and a new vision of women's mental health as a unique category separate from concerns that are characteristic of the male population. Worell & Remer (2004, p. 6) name 15 issues in the traditional psychotherapy that stimulated the emergence of feminist approaches. Among them are ' dissatisfaction with the traditional theories of female and male development and behaviour that depicted stereotyped male traits as the norm and females as deficient

by comparison', and ' frustration with the continuing omission of women from the knowledge base of psychology'.

Although the term ' feminist therapy' also cuts across a variety of approaches and techniques in therapeutic practice, according to Worell & Remer (2004, p. 23), there are four core principles that form its foundation: attention to the diversity of women's personal and social identities; a consciousness-raising approach; an egalitarian relationship between client and therapist; and a woman-valuing and self-validating process.

Attention to the diversity of women's personal and social identities is the belief that women hold multiple roles in their personal and social lives. These roles and identities are discussed and analysed in order to determine their influence on the client's behaviour. The consciousness-raising techniques aim to raise the client's awareness of the external social forces that have an influence on the way they live their lives and experience reality. A distinction between socially-conditioned behaviour and intrapsychic sources of behaviour is made with an exploration of the politics of sexist and racist societal structures that may exist. Furthermore, the relationship between the client and the therapist is that of equality – the client's resourcefulness is emphasised and valued. The therapist empowers the client not so much through sharing their own judgments and wisdom, as through facilitation of the self-exploration processes and self-healing resources that the client is assumed to have. This vision of the client-therapist relationship integrates with the goal to foster such qualities as emotional expression, concern for others and community-building among women. Such woman-valuing process

is further enhanced by linguistic framing, e. g. ‘ enmeshing’ or ‘ fused’ may be reframed as ‘ caring’ or ‘ nurturing’ (ibid).

Worell & Remer (2004) also present an Empowerment Model that is an application of the above principles for counselling purposes. The purpose of Empowerment counselling is not only to reduce whatever dysfunctional symptoms the client may exhibit and not only to return them to their baseline normal level of functioning, but to ’empower’ them and make them more resilient than before. There are ten components of a woman’s well-being that the Empowerment Model aims to achieve as the result of counselling: improved self-evaluation; improved comfort-distress ratio; gender- and culture-role awareness; personal control/ self-efficacy; self-nurturance; problem-solving skills; assertiveness; increased access to social, economic, and community support; gender and cultural flexibility; and social activism.

The specific intervention techniques that may be employed in order to achieve the above goals are at the discretion of individual therapists, since feminist therapy cuts across a variety of different counselling theories. As Worell & Remer (2004, p. 26) note, ‘ Some theories may be more conducive to this transformation process than others, depending on the extent to which they endorse gender-biased or ethnocentric concepts or procedures’. For example, the authors indicate that they personally rely on two approaches while working within the framework of the Empowerment Model – cognitive-behavioural and psychodrama.

However, it is still possible to identify several approaches that lend themselves best to feminist philosophy and objectives: gender-role analysis, power analysis, and demystifying methods. In gender-role analysis the treatment focuses on analysing gender-specific stereotypes and expectations imposed by society and ways that they relate to the client's life. Power analysis, focuses is on ways which the distribution of political, social or economic power between genders has shaped the client's personality and life choices. The clients are led toward a deeper understanding of both advantages and destructive consequences of such power distribution. Finally, demystification is used as an ancillary technique in order to reduce the power balance between the client and the therapist. More recently, feminist therapy engages cultural perspectives in order to account for client's diverse cultural backgrounds. Such diversity of perspectives relates directly to the attention that feminist therapy pay to honouring and accounting for the multiple roles and identities of a woman.

The three therapeutic modalities described in this paper are different by their structure, therapeutic goals, and practical techniques. With a single founder, the person-centered approach is the most unified of the three as a theory and method. There are easily identifiable six core concepts that form the foundation of the approach. The cognitive-behavioural theory stems from two theoretical sources and has branched out into a variety of different specific applications. It is characteristic of CBT applications to be disorder-specific. Finally, feminist therapy is more of a philosophy of counselling than a practical method and draws on other therapy types, such as CBT, to find practical intervention techniques most suitable for their target population.

Feminist therapy is also different in its assumption that therapy cannot be universally applied to all populations and that women require approaches fine-tuned to their particular contexts.

There are certainly also similarities across the different approaches. In all of them, an open, non-judgmental nature of the relationship between client and therapist is a key to the success of the therapy. However, the relationship between client and therapist in feminist approaches are closer to being person-centered than cognitive-behavioural. In both feminist and person-centered philosophy of counselling, the client is seen as the source of their own well-being. The therapist takes the role of a more experienced peer rather than a mentor leading the client towards well-being.