# Therapy: the whys and wherefores

This article seeks to answer, in a straightforward way, some of the questions therapists are commonly asked. It also aims to give just enough theory and referencing to whet the appetite of those of you who would like to investigate further. Hopefully, you will take the parts which suit your needs best.

## What is therapy?

Counselling or psychotherapy is an activity where one person meets with another with the express purpose of enabling and supporting one person to understand themselves better. Their way of being, of making relationships, of working, of responding to other people and situations and of understanding what is going on both inside and outside of them, can all be considered. If an individual understands themselves and how and why they respond the way they do, they will have greater choice in learning or accepting different ways of being and behaving. Therapy is focused on enabling and supporting them in this process.

## Are counselling and psychotherapy the same?

There is much discussion about the differences or similarities between psychotherapy and counselling. Traditionally, psychotherapy was practiced by psychoanalytic or psychodynamic therapists and the focus was on longer term, psychologically deeper work. Counsellors were considered to work in shorter term contracts, with a more problem solving or goal orientated focus. Often the name used was related to the context within which the therapy was offered. Psychotherapy was traditionally practised in medical settings while counselling was not. These distinctions are **not** universally used or accepted now. Many practitioners calling themselves counsellors engage in deep, long term therapeutic work and many psychotherapists are now looking at shorter term, solution focused ways of working.

As a prospective client, and maybe as a therapist, the word used really is of no importance. What is important for a client is to know what different options are available and how to choose what might best suit them. What is important for a therapist is to be clear about the level of their training, competence and experience so that they may work appropriately with their clients.

Further confusion about counselling and psychotherapy arises because there are different theoretical approaches and understandings of the therapeutic process. In this country the majority of practitioners, whether they call themselves counsellors or psychotherapists, work from an integrative model, where they will draw on more than one approach to therapy.

## What are the different approaches to therapy?

Although approaches are numerous and constantly evolving, most fall under the broad umbrella of one or more of the three main branches of therapy.

***Psychoanalytic and psychodynamic therapy*** derives from the ideas and work of people like Sigmund Freud and Carl Jung. Mostly, they were people who were originally medically trained. This approach works from the basis that what happens to us and the way we are cared for in childhood forms the way we are and the way in which we respond to life. Our defences, set up in childhood, persist through life and as we grow they become less relevant, helpful or appropriate and

therefore lead to increased emotional difficulty. Psychodynamic theory is that we will continue our patterns and themes throughout life and we will reproduce them everywhere, including in the therapeutic relationship, so a focus on what is happening in the room with the therapist is informative about how the individual works outside. This is used as a way of helping the individual learn about themselves and how they work and brings to their conscious way of being the thoughts and feelings and responses which have been unconscious. With these insights, understandings and experiences of a different kind of relationship, gained in therapy, than the one experienced in childhood, the individual can learn and rehearse new and more appropriate ways of being and behaving.

***Cognitive/behavioural therapy*** was developed from two different angles. The behaviourist aspects developed by people such as J. B. Watson came from within the discipline of academic psychology and is seen as one of the most overtly "scientific" approaches. It worked on the basis that people could change by understanding why they behaved the way they did and identifying which conditions changed their behaviours. It was realised however, that defining behaviour also required looking at the person's internal thinking processes. So the cognitive aspect, which was being developed by people like Aaron Beck and Albert Ellis, became integrated with behavioural aspects. The cognitive focus was on identifying a person's way of thinking and understanding how this then shaped their feelings and behaviours. The focus of CBT today is on identifying and changing distorted thinking patterns and understanding how this impacts on behaviour patterns.

***Person-centred therapy*** was part of the ***humanistic psychology*** movement which included ***existential and phenomenological philosophy,*** which sought a way of including *the human capacity for creativity, growth and choice* in approaches to psychology. Person-centred therapy was developed in the 1940's originally by people such as Carl Rogers. Rogers was a psychologist and his ideas were developed through research. First he researched the role and behaviour of the counsellor in therapy, then the role and behaviour of the client and then aspects of the relationship between counsellor and client. This approach to therapy focuses on the therapeutic relationship, believing that the conditions provided within it will enable the client to understand themselves and their problem better, thus enabling them to find a way forward.

**Should therapy be long term or short term?**

It depends on the individual and the challenges facing them. Some people are basically psychologically sound, well functioning people who have generally appropriate and useful ways of thinking and behaving who have become stressed or overwhelmed by a particular circumstance or set of circumstances. In these situations it is quite likely that the counselling contract will be brief, with a focus on specific difficulties.

Other people will have less appropriate life management mechanisms and may have been aware of difficulties of one sort or another for a large part of their lives. They may, or may not, know where their sense of unease is rooted. It is likely that these individuals may benefit more from longer term, deeper therapy which helps them understand why and how they first established their coping patterns, how these impact on their current life, and how they may want to change them.

The idea of 6 sessions being optimal has evolved, despite Department of Health guidelines (2001) which clearly state that this is a financial consideration only and that there is **no** research evidence to support it. They say that "Therapies of fewer than eight sessions are unlikely to

be optimally effective for most moderate to severe mental health problems" (p. 39). By moderate to severe they mean any individual presenting with more than one issue, or who has underlying, long held issues, or who has repeatedly accessed therapeutic or medical support for an emotional difficulty.

## Does therapy help?

In addition to individuals saying they find therapy helpful, there are many research studies which show it is effective. For example, Smith *et al.* (1980) confirmed that groups of people engaging in psychotherapeutic work fared better than those who didn't; Lambert *et al.* (1986) say "There is now little doubt…..that psychological treatments are, overall and in general, beneficial, although it remains equally true that not everyone benefits to a satisfactory degree"(p. 158).

Why do some people benefit more than others? Is it because some approaches are more useful than others? Comparative studies show that most mainstream approaches are equally effective. For example, King *et al.* (2000) compared person-centred and cognitive behavioural therapy and routine practitioner care for people suffering with depression and anxiety. At four months they found no difference between the efficacy of person-centred and cognitive behavioural therapy but found that both were more effective than routine practitioner care. Interestingly, at 12 months they found those who engaged with the person-centred therapy had maintained their changes more successfully.

Is it because some therapists are more effective than others? Undoubtedly this will be the case. The key issue is finding the right therapist for the client, and then through a sound therapeutic relationship the right approach or mix of approaches becomes apparent. Mearns and Cooper (2005) echo the thoughts and findings of many researchers when they cite King, *et al.*, (2000) who report that clients consistently say therapies which are focused on relationship are better (p. 160).

## Why does therapy help?

### *Context*

Most of us know what is troubling us, and we may have a fair idea of how to sort it out, but thinking about it on our own is too frightening. Knowledge is often deeply hidden, from ourselves as well as others and it is only when we talk with another that we are able to uncover it. This is when client and therapist become '…engaged in a process in which layers of meaning, experience and feeling are gradually being uncovered…' (Merry, 2002, p. 81).

Therapists are alert to patterns and may be useful in helping a client fit their patterns together and see how the same pattern plays out in different contexts, "…when a discrete piece of knowledge is suddenly seen fitting into a wider unified pattern – the mind is illuminated with a healing light." (Symington, 2006, p. 22)

Therapy helps us understand the way in which our defences and coping strategies were formed and allows us to re-examine their appropriateness in our life today and it gives us a safe place within which to practice different behaviours.

### *Relationship*

If we have a part of our selves with which we are not comfortable, or are even ashamed of, we find it hard to share this with people who are close to us, as we worry more about how it will impact on them and their relationship with us. It is easier to share difficult parts of ourselves with people who we know have no daily contact with us. People will share with their doctor, priest or even a stranger, things they would not want their friends and family to know or be burdened with. We all learn about ourselves through our relationships with others. This is true of

therapy also, although there is debate about which elements within the relationship are helpful in bringing about change. Richo (2002) suggests a healthy relationship offers attention, acceptance, appreciation, affection and allowing, and that it is these which make the difference to the other person.

> "Attention from others leads to self-respect. Acceptance engenders a sense of being inherently a good person. Appreciation generates a sense of self-worth. Affection makes us feel lovable. Allowing gives us the freedom to pursue our own deepest needs, values, and wishes." (Richo, 2002, p. 26)

The therapist offers these qualities encouraging the client to accept, then appreciate, these qualities in themselves. This fuller sense of self allows the client to understand and accept those aspects of themselves or their life they had previously fought to distance from or deny. This change in understanding their own inner emotions helps them consider new and different ways of behaving or being in the world.

The Department of Health (2001) recognises the importance of the quality of the relationship saying, "'therapeutic alliance' is the single best predictor of benefit" and "If this is lacking, the therapy is less likely to be helpful, whatever other research evidence may recommend it in general terms"(p. 39).

### The drawbacks of sticking rigidly to one approach to therapy

Since Freud, therapists have understood that simply imparting knowledge to a client will not usually be helpful to a client struggling to live more effectively. Using any approach in a purist way carries the increased danger of the therapist holding a more rigid view of how the world and therapy works and of "fitting the patient to the clothes rather than the clothes to the patient." (Symington, 2006, p. 21) Remembering that it is vital for the client to feel listened to and accepted, if therapists hold a certain view of the world and insist on the client working from that view, there is the possibility that the client's stress will increase rather than decrease. Totton (2000) suggests that therapists have a certain way of understanding the world and clients are required to learn the therapeutic language and way of understanding in order to engage with therapy. It seems likely that the more rigid the approach the greater this danger becomes. This enhances the therapist's power, which is contradictory to the aim of facilitating another individual to be self- responsible. In addition, if the therapist is only looking at the client through one particular lens or way of understanding, parts of the client's experience will be missed.

### The value of an integrated approach to counselling

Most therapists understand that human beings are complex and will find different things useful in engaging in therapy so they will integrate more than one approach to therapy in their practice. Integration matters because:

> "…no single theory is comprehensive enough to account for the complexities of human behaviour." (Corey, 2001. p. 459)

Integrationists aim to recognise and value the uniqueness of each client by saying *I will not fit you to a single theory*, instead I will develop my theory to embrace your differences, your uniqueness (Goldfried, 2005). It is the job of the therapist to learn the theories, ask what different circumstances may suggest different approaches and know the client well enough to offer appropriate ways of working.

One might assume that where clients come with a specific problem one specific approach may be most suitable. However, many clients give only one aspect of their problem at the start of therapy, and it

may not be the most important one, (Symington, 2006) so their greatest need may only emerge once therapy has started. Therapists working from an integrated approach may be more able to manage this complexity. Focusing on the *client*, rather than an *approach* enhances the chances that the therapy will be forged "on an intimate (unscripted) therapist-patient relationship forged in genuineness" (Yalom, 2002, p. 223).

### How do we evaluate therapy?

The effectiveness of therapy can be evaluated in a number of different ways:

- ask the client, both during and at the end of therapy;
- consider the academic research;
- consider the practitioner research; and
- make a systematic review of return rates and issues.

Of these, asking the client seems the most relevant. If an individual has been feeling suicidal and they now don't – that is significant and is surely more important than the findings of a randomised control trial into suicidal ideation. Of course how the information is gleaned from clients is important and care must be taken to exclude therapist influence.

### Research

Research is an interesting term. What exactly does research mean? And does it always say what we think it is saying? There are many important issues in assessing the usefulness of any particular research so in the interests of brevity they will be highlighted only.

We should note that there are arguments about the relative value of academic research as opposed to practitioner research. It is worth noting the Department of Health's (2001) statement that *"Nowhere is the gap between research and practice wider than in this field. Most psychological therapy in the NHS is pragmatic and eclectic, where therapists use a judicious mix of techniques drawn from varying theoretical frameworks. Most psychotherapy research, on the other hand, is on standardized interventions of 'pure' types of therapy".* This may mean much of the research findings are less useful in the real world of therapeutic practice.

We should be aware that there is very little research which seeks the clients' views of therapy, so their experiences are not being used to shape therapy. (Foskett, 2001; Pilgrim, 1997; Etherington, 2001).

We should acknowledge the problem of deciding whether or not therapy is an activity which can be reduced to its component parts, as research evidence seeks to do. Dr. Ronald Levant, recent president of the American Psychological Association and professor of psychology at Nova Southeastern University, suggests the enthusiasm for scientific evidencing of therapeutic techniques is too extreme and assumes there is a science for everything we do. He, like many practitioners, bemoans the narrow standards being used and researched. He reminds us that therapy is both an art and a science and we ignore either perspective at our peril.

We should be mindful of the questions of where research is carried out, who pays for it and why they won't pay for research into a wider range of therapies, or conduct longer term studies or follow up research. Remember that King *et al.* (2000) found a difference in outcome at four months and twelve months. We should be aware of the differences we would find depending on who defines "a successful outcome" – the client, the therapist, the service provider, the employer or family members of the client?

All these aspects are important if we are to understand whether or not the research evidence is relevant. However, there is a deeper problem, which is that we need to question whether the evidence is reliable. If

we look at medical research as an example, and take a study which was academic, rigorous and based on the sound principles of randomized control trials, we will find it offers salutary lessons about accepting research findings without question. In the research into the use of Seroxat with teenagers, it was found that the author of the research, an eminent professional, had not actually undertaken the research, nor written up or even read the results of the research in full. The work had been undertaken by other professionals and had been written up by a ghost writer, employed by a public relations company, employed by the company seeking to find research evidence for the efficacy of its drug! He had accepted payment from the drug company and in return they could use his good reputation to promote their product. The findings of three separate trials were distorted and in some cases, excluded from the final report.

Surely though, this type of behaviour doesn't happen in the UK? According to Dr. Fiona Godlee, Editor, British Medical Journal, one of the most esteemed professional medical journals in this country and abroad, we cannot be so smug. She says distortion or manipulation of research findings in not unknown and seems to be on the increase. If this sort of behaviour is possible in straightforward medical research, what hope for the more complex issues of psychotherapeutic research?

The findings of some of the research evidence relating to psychological therapies in the NHS in the UK makes interesting reading. CBT is often recommended as the treatment with best evidence. On reading the fuller accounts what this means is CBT was most effective if evidence is taken only from systematic reviews of randomised control trials. There is an acknowledgement that other therapies have not been systematically reviewed. This does not mean they have not been researched, just that there are no systematic reviews of the research done. This is likely to be because there is less value in reviewing studies which are seeking to learn rather than test a hypothesis. Taking only randomised control trial evidence as best evidence ignores the widespread and deep ranging debate amongst professionals and academics about the value of different approaches to research in social sciences where the variables are so vast and where unique personal experience is so important.

So all research evidence needs to be questioned and examined thoroughly before its results can be considered of value.

**Where does this leave the individual or organisation seeking therapeutic support?**

How can any individual, or organisation, not conversant with the competing theories and ideas and debates touched on above, make any kind of choice about the kind of help which will be most helpful for them? There is only one golden rule: ask.

All therapists should be ready, willing and able to discuss with clients, individual or organisational, existing or prospective, how they work, why they choose to work this way and what the advantages and drawbacks might be. They should be clear about what they seek to do, why and how. They should be able to explain how they come to their conclusions about their approach. They should make information on other approaches and ideas available and be prepared to discuss openly any issues or questions which may arise. Above all, the therapist should be clear that the golden rule for them is twofold: finding the most satisfactory way forward for the client and being as transparent as possible about their decision making process.

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## Further reading

If you are interested in reading more about any of the main approaches to therapy you might look for writings by the authors mentioned below.

***Psychodynamic***
Sigmund Freud, Carl Jung, Melanie Klein, John Bowlby, Bruno Bettelheim, Michael Jacobs, Roger Casement.

***Cognitive / Behavioural***
Aaron Beck, Albert Ellis, Burrhus Frederic Skinner, Donald Woods Winnicott.

***Person centred***
Carl Rogers, Dave Mearns, Brian Thorne, Jerold Bozarth, Mick Cooper

***Existential***
Martin Heidegger, Søren Kierkegaard, Ronald David Laing, Marcel Merleau-Ponty Viktor Frankl, Rollo May, Irvine Yalom, Emmy Deurzen-Smith, Ernesto Spinelli.


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