AIPC's Five Therapies eBook

Behaviour
Cognitive Behaviour
Person-Centred
Solution-Focused
Gestalt

AUSTRALIAN INSTITUTE OF PROFESSIONAL COUNSELLORS

AIPC's Five Therapies eBook

2007

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Introduction

Most approaches in counselling and other disciplines (e.g. coaching) are influenced by five mainstream therapies: behaviour, cognitive behaviour, person-centred, solution-focused and gestalt.

Understanding each of these therapies' histories, concepts, applications, benefits, disadvantages and processes helps therapists to relate to clients and assist them develop efficient models for positive change and to cope with life's common challenges.

In our third eBook, AIPC's Five Therapies eBook, we introduce counselling's five mainstream therapies to anyone interested in counselling and seeking to understand the therapeutic process. This eBook can be used by counsellors for professional development, by counselling students for academic reference or by anyone else interested in therapy and human behaviour.

Please feel free to forward this publication to your friends, family and colleagues – we'll be distributing it at no cost as part of our commitment to educate industry participants and promote counselling both in Australia, and overseas.

Enjoy your reading and drop your comments or suggestions at Counselling Connection (www.counsellingconnection.com), the Institute's official Blog.

Kindest Regards,

Sandra Poletto

Sandra Poletto
Chief Executive Officer
Australian Institute of Professional Counsellors

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Behaviour Therapy

According to Seligman (2006) behaviour therapy focuses on the present not the past, observable behaviours rather that unconscious forces and short-term treatment, clear goals, and rapid change.

HISTORY

Behaviour therapy had its beginnings in the early 1900's and became established as a psychological approach in the 1950s and 1960s. At this time, it received much resistance from the current school of thought, psychoanalysis.

There have been a number of people that that have contributed to the development of behavioural therapy:

Ivan Pavlov (1849 – 1936)

Pavlov's contributions to behavioural therapy were accidental. He was originally studying the digestive process of dogs when he discovered that associations can develop when pairing a stimulus (food) that has a response (dog salivates) with a stimulus that has no response (bell). The stimulus with no response (bell) eventually develops the same response (dog salivates) as the stimuli that has the response (food). This type of learning is known as classical conditioning (Seligman, 2006).

John B. Watson (1878 – 1958)

Watson has been described as the "father" of behaviourism (McLeod). He used Pavlov's principles of classical conditioning as well as emphasizing that all behaviour could be understood as a result of learning. Watson's research involved the study of a young child called "Albert". "Albert" was initially not scared of rats. However, Watson paired the rat with a loud noise and this frightened "Albert". After this was repeated numerous times, "Albert" developed a fear of rats. He also developed a fear of things similar to a rat such as men with beards, dogs, and fur coats. This fear was extinguished after a month of not repeating the experiment (McLeod, n.d.a).

B.F. Skinner (1904 – 1958)

Skinner developed the theory of operant reinforcement theory which is the notion that how often a behaviour is executed depends on the events that follow the behaviour (Seligman, 2006). For example, if the behaviour is reinforced, the behaviour is more likely to be repeated. He emphasised observable behaviour and rejected the notion of "inner causes" for behaviour (McLeod, n.d.a)

John Dollard (1900 – 1980) & Neal Miller (1909 – 2002)

Dollard and Miller provided more understanding to behavioural theory. They believed that when a stimulus and response are frequently paired together and rewarded, the more likely it is for an individual to repeat the behaviour (Seligman, 2006). They identified this as a habitual response. Dollard and Miller also identified four elements in behaviour: drive, cue, response, and reinforcement (Seligman, 2006)

Joseph Wolpe (1915 – 1977)

Wolpe described a process known as reciprocal inhibition which is when "eliciting a novel response brings about a decrease in the strength of a concurrent response" (Seligman, 2006). Wolpe also developed the therapeutic tool of systematic desensitization which is used in the treatment of phobias (to be discussed further down).

Albert Bandura (1925)

Bandura applied the principles of classical and operant conditioning to social learning. Basically, people learn behaviours through observation of other's behaviour, also known as modelling (Seligman, 2006).

Current Focus

The traditional behavioural approach is no longer used as it once was. It has moved towards a more collaborative treatment with cognitive therapy and as such this has meant a more applicable approach (Seligman, 2006).

KEY CONCEPTS

CLASSICAL CONDITIONING

Classical conditioning is a type of learning when an *unconditioned stimulus (UCS)* such as food produces an *unconditioned response (UCR)* such as salivation. If a neutral stimulus such as a bell is then paired with the *UCS* to get the *UCR* and this is repeated, the neutral stimulus will create the response of salivation. The neutral stimulus is now the *conditioned stimulus (CS)* and the response is a *conditioned response (CR)*. Figure 1 demonstrates this process (extracted from McLeod, n.d.b).

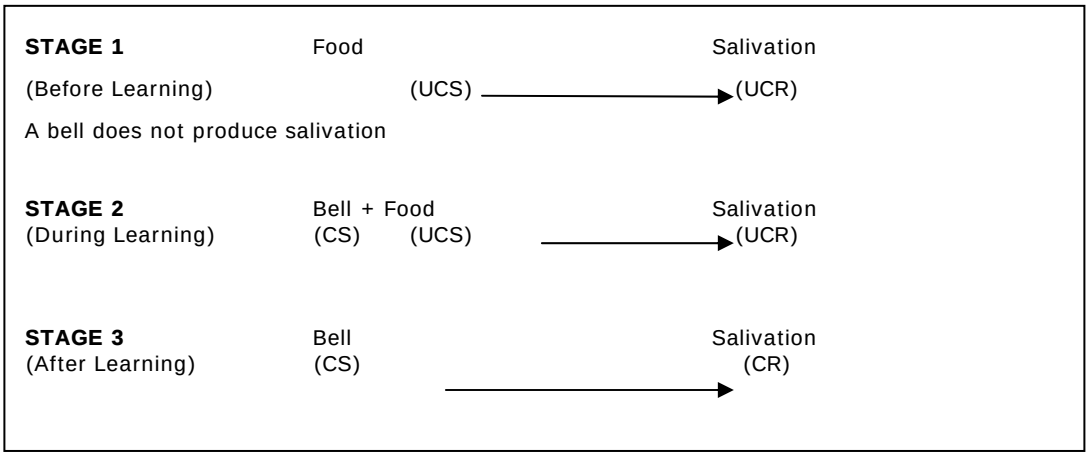


Figure 1: Example of Classical Conditioning Procedure

OPERANT CONDITIONING

Operant Conditioning (or instrumental learning) is the process whereby learned responses are controlled by the consequences (Weiten, 2007). There are two main processes involved in operant conditioning:

1) *Reinforcement* occurs when a response is strengthened by an outcome. There are two types of reinforcement, negative and positive reinforcement. Positive reinforcement occurs when a behaviour is strengthened by a positive reward (see Figure 2).

   For example, a child behaves well at the shops so is given a chocolate as a reward. This reinforces the good behaviour at the shops. Negative reinforcement occurs when behaviour is strengthened by the removal of a negative stimulus (see Figure 2). For example, doing a relaxation exercise when stressed. The relaxation exercise (response) reinforces this behaviour as the stress (aversive stimulus) has been removed.

2) *Punishment* occurs when a response to behaviour decreases the likelihood of the behaviour reoccurring (Weiten, 2007). There are also two types of punishment, negative and positive punishment. Positive punishment occurs when an aversive response to behaviour is used and therefore the behaviour is less likely to occur (see Figure 2).

   For example, a child is given chores when he or she has been naughty. The child therefore, has been given a punishment to reduce the likelihood of the bad behaviour continuing. Negative punishment occurs when something is taken away and therefore decreases the likelihood of the behaviour reoccurring (see Figure 2). For example, a person fails to secure a bike and this leads to the theft of the bike. This therefore decreases the likelihood of the person leaving property unsecured in the future.

PROCESS	BEHAVIOUR	CONSEQUENCE	EFFECT ON BEHAVIOUR
Positive Reinforcement	Child behaves well at shops →	Rewarded with a chocolate	Tendency to behave well at the shops
Negative Reinforcement	Stress →	Relaxation exercise	Tendency to not get as stressed
Positive Punishment	Child misbehaves →	Given chores	Tendency to not misbehave
Negative Punishment	Fails to secure bike →	Bike is stolen	Tendency to secure personal property in the future

Figure 2: Positive and Negative Reinforcement

SOCIAL LEARNING

Social Learning (or modelling) occurs when an individual (or animal) responds a certain way due to having observed the behaviour previously. *Social learning* is an extension of classical and operant conditioning in that an individual is conditioned indirectly by observing another's conditioning. For example, a child observes his or her older sibling setting the table for their parents. The older child receives praise for setting the table. The younger child's own tendency to set the table for the parents is reinforced as a result of the praise the older child receives (Weiten, 2007).

GENERAL IDEAS ABOUT PERSONALITY DEVELOPMENT

Seligman (2006) has identified "three basic building blocks of personality" that people are born with:

1) Primary drives
2) Specific reflexes
3) Innate responses to particular stimuli

The primary drives of an individual relate to drives such as toward food and warmth. Specific reflexes refer to processes such as sucking and blinking, and innate responses include behaviours such as reacting to pain (Seligman, 2006).

Behavioural theorists believe that personality is shaped by learning and unlearning throughout the lifespan. They also believe that the environment in which a child is brought up in influences the personality of the individual. An example of how personality is developed through the eyes of a behaviourist is of self-efficacy. Self-efficacy refers to the way one believes in one's ability. High self-efficacy is often the result of responsive behaviour by parents, non-punitive techniques, and a warm family environment (Weiten, 2007).

THERAPEUTIC TECHNIQUES AND METHODS OF WORKING

Principles of Therapeutic Methods of Working

There are a number of principles behavioural therapists use when working with clients. The following principles have been sourced from Seligman (2006):

Table 1: Principles of Behavioural Therapy

▪ Although genetics play a role, individual differences are derived primarily from different experiences.
▪ Behaviour is learned and acquired largely through modelling, conditioning, and reinforcement.
▪ Behaviour has a purpose.
▪ Behaviour is the major determinant of habits, thoughts, emotions, and other aspects of personality.
▪ Behaviour therapy seeks to understand and change behavior.
▪ Therapy should be based on the scientific method and be systematic, empirical, and experimental. Goals should be stated in behavioral, specific, and measurable terms, with progress assessed regularly.

- The focus of treatment should generally be on the present. Even if behaviours are longstanding, they are maintained by factors in the current environment.
- However, behaviours must be viewed in context, and some exploration of the past is appropriate to provides that context and help people feel understood.
- Education, promoting new learning and transfer of learning, is an important aspect of behavior therapy.
- Strategies of behavior therapy need to be individualized to the particular person and problem.
- Clients have primary responsibility for defining their goals and completing homework tasks. The treatment plan is formulated collaboratively, with both client and clinician participating actively in that process.

Steps in Treatment

As well as working with the principles of behavioural therapy, there are a number of steps a therapist can utilise when in a session with a client (adapted from Seligman, 2006):

1) *Identify the problem*- This involves investigating what the problem is and its history. Also, identifying the baseline of the problem such as the frequency, duration and severity of the problem.

2) *Identify goals*- Identifying goals involves selecting goals related to the problem that are realistic, specific, and measurable. The goals also need to be relevant to the client and positive to help keep the client motivated.

3) *Strategies*- This involves identifying and developing strategies that will assist in the change process. The counsellor should teach new skills, provide relevant information and implement behavioural strategies to help the client to change. As well as a plan for change, a plan for how success will be monitored and having a written contract with the client is important.

4) *Implement the plan*- This involves the plan that has been developed being implemented for the process of change to occur.

5) *Assess progress*- The progress of the plan is assessed and the plan is evaluated. The plan is revised for any areas of need and successes are reinforced. Reinforcing success helps to keep the client motivated and ensures more success.

6) *Continue the process*- This is the process is continued by ensuring plans are continued and that plans include preventing relapse of problems.

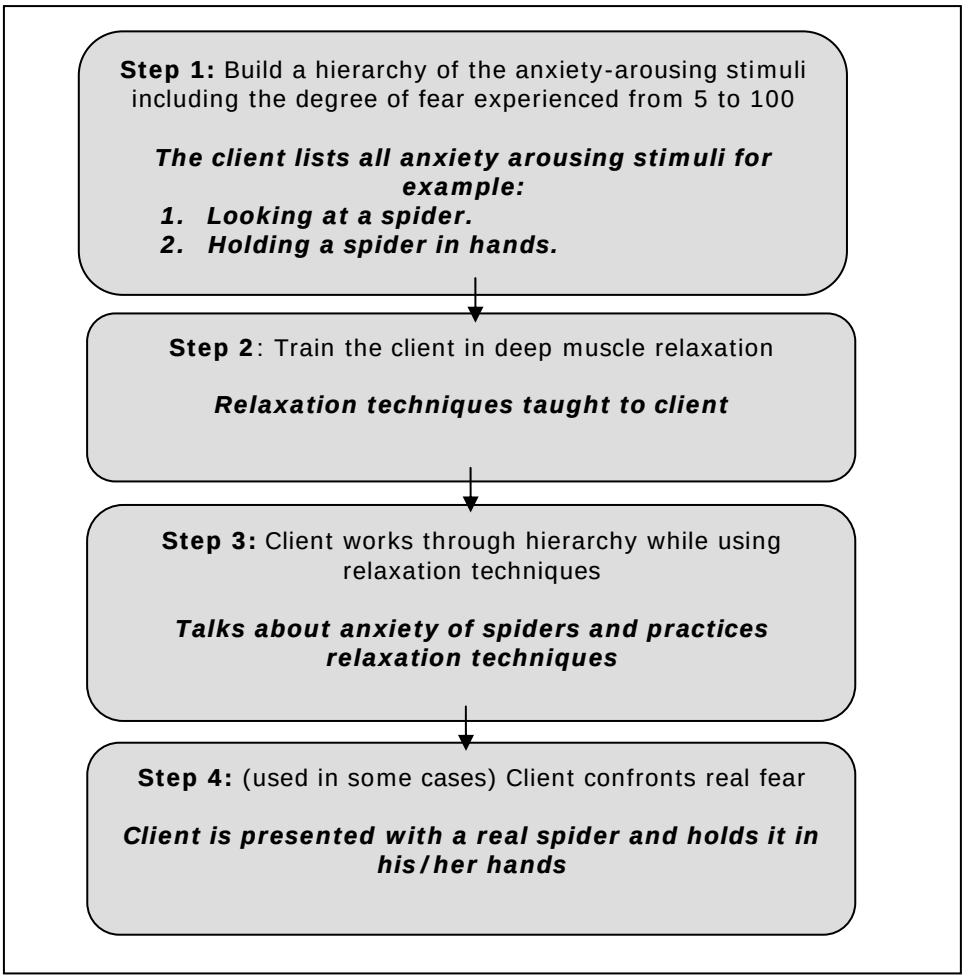
Treatment Types

Treatments in behavioural therapies apply the learning principles to change maladaptive behaviours (Weiten, 2007). The treatments do not focus on clients achieving insights into their behaviour, rather the focus is just on changing the behaviour. For example, if a behavioral therapist was working with a client that has an alcohol problem, the behavioural therapist would design a program to eliminate the behaviour of drinking but there would be no focus on the issues or pathological symptoms causing the alcohol problem.

There are a number of treatments used in behavioural therapy that have been scientifically validated as being successful approaches to treating symptoms:

- *Systematic Desensitization* – was developed by Joseph Wolfe and was designed for clients with phobias. This treatment follows a process of "counterconditioning" meaning the association between the stimulus and the anxiety is weakened (Weiten, 2007). The process of systematic desensitization is applied to an example of a client with a fear of spiders in Figure 3:

Figure 3: Systematic Desensitization



- *Exposure Therapies* - designed to expose the client to feared situations similar to that of systematic desensitization (Corey, 2005). The therapies included are *in vivo desensitisation* and *flooding*. *In vivo desensitization* involves the client being exposed to real life anxiety provoking situations. The exposure is brief to begin with and eventually the client is exposed for longer periods of time to the fearful situation. As with systematic desensitisation, the client is taught relaxation techniques to cope with the anxiety produced by the situation. The example of the client with a fear of spiders will be used to demonstrate *in vivo desensitization.* To begin with the client would be shown a spider in a container on the other side of the room for one minute. This would gradually increase in time as well as the client getting closer to the spider until eventually the client is able to be sitting near the spider for a prolonged period.

  Flooding involves the client being exposed to the actual or imagined fearful situation for a prolonged period of time. The example of the client with the spider fear would be that the client would be exposed to the spider or the thought of a spider for a prolonged period of time and uses relaxation techniques to cope. There may be ethical issues in using these techniques with certain fears or traumatic events and the client should be provided with information on the techniques before utilising them so he or she understands the process.

- *Aversion Therapy* - the most controversial of the behavioural treatments and is used by therapists as a last resort to an aversive behaviour (Weiten, 2007). This treatment involves pairing the aversive behaviour (such as drinking alcohol) with a stimulus with an undesirable response (such as a medication that induces vomiting when taken with alcohol). This is designed to reduce the targeted behaviour (drinking alcohol) even when the stimulus with the undesirable response is not taken (medication).

- *Social Skills Training* - a treatment that involves improving interpersonal skills such as communication and how to act in a social setting through the techniques modelling, behavioural rehearsal, and shaping. Modelling involves encouraging the client to watch friends and colleagues in their social settings to see how to act appropriately. Behavioural rehearsal involves clients rehearsing their social skills in the therapy session and eventually moving to real-life situations. Shaping involves the client gradually building up to handling difficult social situations.

- *Biofeedback* - involves the therapist getting feedback of the client's bodily functions and in turn providing the information to clients to help him or her engage in relaxation techniques (Weiten, 2007). For example, during a therapy session the client is hooked up to an electromyograph (EMG) to measure the skeletal-muscular tension in the body. This information is then used for the client to help control their physiological responses and implement relaxation techniques.

AREAS OF APPLICATION

Behavioral therapy can be used to treat many psychological disorders including anxiety disorders, sexual disorders, depression, interpersonal and marital problems, chronic mental conditions, childhood disorders, eating and weight disorders as well as prevention and treatment of cardiovascular disease (Corsini & Wedding, 2000).

STRENGTHS & WEAKNESSES

Table 2: Strengths and Weaknesses of the Behavioural Approach

STRENGTHS	WEAKNESSES
▪ When using in therapy, it accomplishes what the theory predicts will happen (Guilliard, James & Bowman, 1994).	▪ Overdependence on animal research (Weiten, 2007).
▪ Treatment outcomes have been scientifically and empirically validated (Corey, 2005).	▪ Denies the existence of free will and the importance of cognitive processes (Weiten, 2007).
▪ Emphasizes ethical accountability (Corey, 2005).	▪ Treats symptoms rather than underlying issues (Corey, 2005).
▪ Wide variety of techniques that may be utilised in therapy (Corey, 2005).	▪ Does not provide insight (Corey, 2005).
	▪ Personality structure only focuses on stimulus-response associations. There is no emphasis on underlying concepts (Weiten, 1998).

CONCLUSION

Overall, behavioural therapies are not generally used on their own in treating psychological disorders however the techniques used in behavioural therapies are applicable to treatment in a wide variety of settings. Behavioral therapies have contributed to greater understanding of the learning processes and have also significantly influenced measurement strategies for identifying psychological problems such as anxiety disorders.

REFERENCES

Corey, C. (2005). *Theory and practice of counseling & psychotherapy*. (7th ed.). Belmont, CA: Thomson Learning.

Corsini, R.J., & Wedding, D. (eds.). (2000). *Current Psychotherapies.* (6th ed.). Belmont, CA: Thomson Learning, Inc.

Guilliard, B., James, R., & Bowman, J. (1994). *Theories and strategies in counseling an Psychotherapy.* (3rd ed.). Boston, MA: Allyn & Bacon.

McLeod, S. (n.d.a) *The behaviourist approach in psychology*. Retrieved February 14, 2007, from http://www.simplypsychology.pwp.blueyonder.co.uk/behaviourism.html

McLeod, S. (n.d.b). *Operant Conditioning.* Retrieved February 14, 2007, from http://www.simplypsychology.pwp.blueyonder.co.uk/Operant%20Conditioning.pdf

Seligman, L. (2006). *Theories of counseling and psychotherapy: Systems, strategies, and skills.* (2nd ed.). Upper Saddle River, New Jersey: Pearson Education, Ltd.

Weiten, W. (2007). *Psychology: Themes & Variations.* (7th ed.). Pacific Grove, CA: Thomson Publishing Inc.

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Cognitive Behaviour Therapy

Cognitive-behaviour therapy involves a specific focus on cognitive strategies such as identification and modification of maladaptive cognitive errors and restructuring of core beliefs and/or representations of the self. Further focus is on behavioural strategies that are designed to activate clients in the environment with a view to effect desired behaviour change.

Distinctive features of CBT:

- Use of homework and outside-of-session activities
- Direction of session activities
- Teaching of skills used by clients to cope with problems
- Emphasis on clients' future experiences
- Providing clients with information about the course of treatment
- An intrapersonal/cognitive focus

HISTORY

Albert Ellis

Ellis was born in Pittsburg (1913). He spent most of his life in New York. A natural counsellor, Ellis studied psychoanalysis and was supervised by a training analyst. Ellis, however grew increasingly frustrated by psychoanalysis which he concluded was unscientific and superficial (Corey, 2005).

In the early 1950s, Ellis experimented with other treatment frameworks, from humanism to behaviour therapy. From such experimentation, Ellis founded what is now referred to as Rational Emotive Behaviour Therapy (or REBT).

Aaron Beck

Beck, born in 1921, Providence, Rohde Island, was initially attracted to the study of neurology. It wasn't long, however, before he discovered psychiatry was a more fitting interest for him. Beck struggled with numerous fears throughout his life, including a fear of public speaking and anxiety about his health. Beck used these fears to help him understand himself and others which ultimately provided the basis on which he developed his cognitive theory (Corey, 2005).

Through his research, Beck discovered that people who are suffering from depression often reported thinking that was characterised by errors in logic. These errors, Beck called, 'cognitive distortions'.

ELLIS'S RATIONAL EMOTIVE BEHAVIOUR THERAPY (REBT)

Essential to Ellis's theory is the A-B-C sequence. This sequence describes the relationship between experience, beliefs and reactions.

Consider the model below:

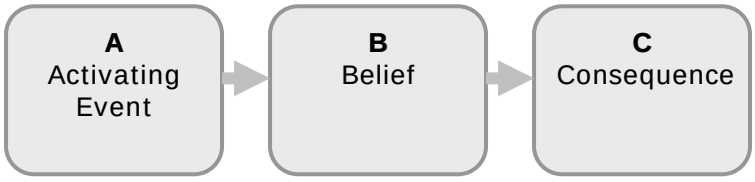

Figure 1 - **The A-B-C Sequence**

According to Ellis, we experience Activating Events (A) everyday that prompts us to look at, interpret, or otherwise think about what is occurring. Our interpretation of these events results in specific Beliefs (B) about the event, the world and our role in the event. Once we develop this belief, we experience Consequences (C) based solely on our belief.

Example 1 – Mel & Toni

Mel and Toni are work colleagues. Over coffee they begin discussing the project they are working on together. On completion of the project they are required to present their proposal to the board of directors. Mel hates doing presentations so Toni decides to volunteer to do the presentation on her own. But when Toni announces that she is going to do the presentation alone - Mel becomes upset.

Here's why:

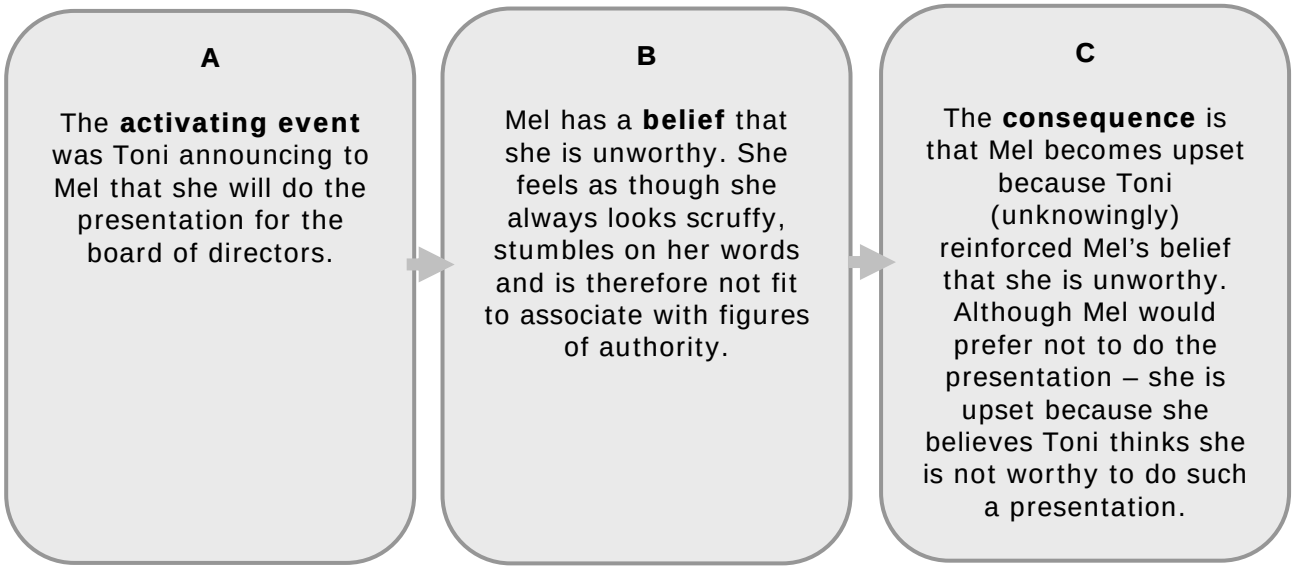

Figure 2 – **Mel and Toni**

The role of the counsellor is to **dispute** the irrational belief (B). Disputing has three parts: detecting, discriminating and debating irrational beliefs.

Disputing irrational beliefs

Detecting irrational beliefs

The counsellor's foremost role in the process of disputing irrational beliefs is firstly to assist clients in detecting them. Irrational beliefs can be detected through the examination of activating events (A) and consequences (C).

Discriminating between rational and irrational beliefs

The second step in disputing irrational beliefs is deciding whether the belief is irrational or not. A clue to the rationality of a belief is the use of terms such as *should, must* and *ought.* Use of such terms often indicates that a belief is irrational.

Debating irrational beliefs

Debating irrational beliefs is a large part of REBT. There are many techniques that can be used to debate irrational beliefs. Some of these include:

- Socratic debate
  The counsellor draws attention to the incongruence or inconsistency in the client's beliefs. The goal is to enable clients to critically examine their beliefs and not simply accept the counsellor's perception.

- Humour and creativity
  Stories and metaphors can help clients gain new insight or a fresh perspective on their beliefs.

Developing new rational beliefs

There are numerous methods for assisting clients in developing new rational beliefs. Some of these include:

- Coping self-statement
  Coping statements can strengthen newly formed rational beliefs. "For example, an individual who is afraid of public speaking may write down and repeat to himself several times a day statements such as "I want to speak flawlessly, but it's alright if I don't," "No one is killed for giving a poor speech," and "I'm an articulate person." (Sharf, 2004, 336).

- Cost-benefit analysis
  This is the process of comparing the costs and the benefits of holding a particular belief or set of beliefs. Clients are encouraged to think about the advantages and disadvantages on a regular basis.

- Psycho educational methods
  Self-help books, audio CDs and other learning tools may supplement counselling sessions and serve as a reminder of strategies learnt in counselling.

- Teaching others
  Clients are encouraged to teach others to dispute their irrational beliefs. This serves as a learning tool and a reinforcer of strategies learnt in counselling.

BECK'S COGNITIVE THERAPY

Beck's Cognitive therapy teaches clients to identify faulty patterns of thinking. Clients are introduced to intervention strategies that assist in changing thought patterns and consequently changing behaviour. Cognitive therapy is founded on the notion that our core-beliefs, thoughts, emotions and behaviours are all inter-connected (see diagram below).

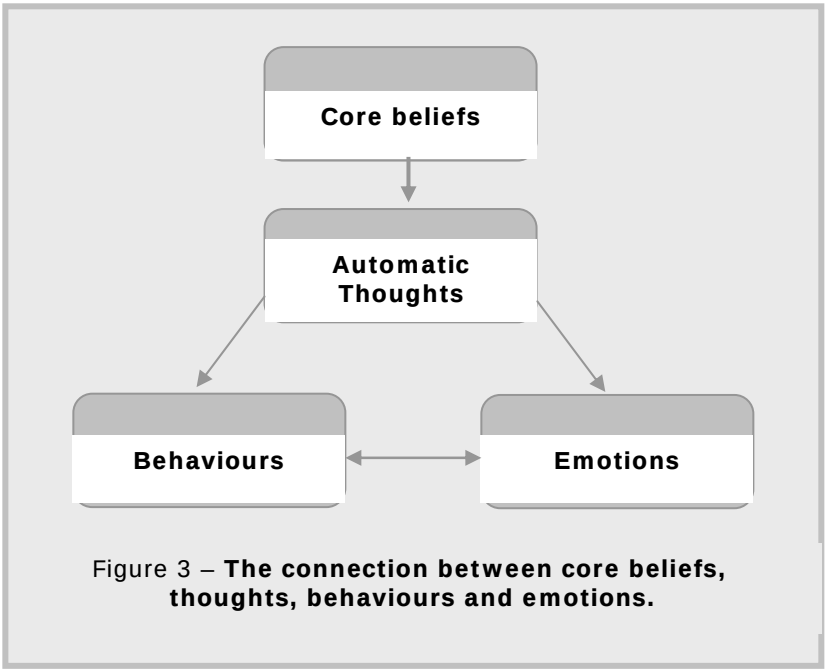

Figure 3 – **The connection between core beliefs, thoughts, behaviours and emotions.**

Example – David & James

Imagine two men – David and James. Both of these men have bought a new self-assemble bookshelf and are trying to build it from the brief instructions enclosed. Read through the table below as it outlines the different thought processes David and James may go through as they complete this building project.

(Next page table)

	David	James
Core Belief	David has a core belief that he is unlikely to succeed at anything.	James has a core belief that says with effort he can accomplish anything.
Automatic Thought	As David reads through the instructions, he thinks, "I don't get it! I never understand this stuff."	As James reads through the instructions, he thinks "I don't get this! Where am I going wrong?"
Emotion	David begins to feel frustration and anger.	James begins to feel determined to find answers.
Behaviour	As a result of his thinking David decides to walk away from the half-assembled bookshelf and never completes it.	As a result of his thinking James revises the instructions and finally completes the assembly of the bookshelf.

Both men in the above scenario are doing the same thing (assembling a bookshelf from brief instructions) yet they behave very differently. The Cognitive Behaviour approach suggests that these men were motivated by their thoughts which were triggered by the core beliefs they hold about themselves.

From the example outlined above, the impact people's belief system and thought processes could have on their actions was obvious. It is the role of the Cognitive Behavioural therapist to assist clients in identifying core beliefs or thoughts that are interfering with their life and then teach them strategies to change the pattern.

Cognitive Distortions

Beck labelled information processing errors, cognitive distortions. They are often logical, but they are not rational. They can create real difficulty with one's thinking.
Below is a list of some of the most common cognitive distortions.

1. **All-or-nothing thinking**: You see things in black and white categories. If your performance falls short of perfect, you see yourself as a total failure.

2. **Overgeneralization**: You see a single negative event as a never-ending pattern of defeat.

3. **Mental filter**: You pick out a single negative detail and dwell on it exclusively so that your vision of all reality becomes darkened, like the drop of ink that discolours the entire beaker of water.

4. **Disqualifying the positive**: You reject positive experiences by insisting they "don't count" for some reason or other. You maintain a negative belief that is contradicted by your everyday experiences.

5. **Jumping to conclusions**: You make a negative interpretation even though there are no definite facts that convincingly support your conclusion.
    - **Mind reading**: You arbitrarily conclude that someone is reacting negatively to you and don't bother to check it out.
    - **The Fortune Teller Error**: You anticipate that things will turn out badly and feel convinced that your prediction is an already-established fact.

6. **Magnification (catastrophizing) or minimization**: You exaggerate the importance of things (such as your goof-up or someone else's achievement), or you inappropriately shrink things until they appear tiny (your own desirable qualities or the other fellow's imperfections). This is also called the "binocular trick."

7. **Emotional reasoning**: You assume that your negative emotions necessarily reflect the way things really are: "I feel it, therefore it must be true."

8. **Should statements**: You try to motivate yourself with shoulds and shouldn'ts, as if you had to be whipped and punished before you could be expected to do anything. "Musts" and "oughts" are also offenders. The emotional consequence is guilt. When you direct should statements toward others, you feel anger, frustration, and resentment.

9. **Labelling and mislabelling**: This is an extreme form of overgeneralization. Instead of describing your error, you attach a negative label to yourself: "I'm a loser." When someone else's behaviour rubs you the wrong way, you attach a negative label to him, "He's a damn louse." Mislabelling involves describing an event with language that is highly coloured and emotionally loaded.

10. **Personalization**: You see yourself as the cause of some negative external event for which, in fact, you were not primarily responsible.

Source: Burns, D.D. (1989). *The Feeling Good Handbook.* New York: William Morrow.

Regularly occurring cognitive distortions can create psychological distress and may lead to depression, anxiety or other difficulties. An examination of cognitive distortions is used in cognitive counselling to assist client in identifying and modifying their maladaptive thought patterns.

The process of cognitive therapy is briefly outlined in the figure below.

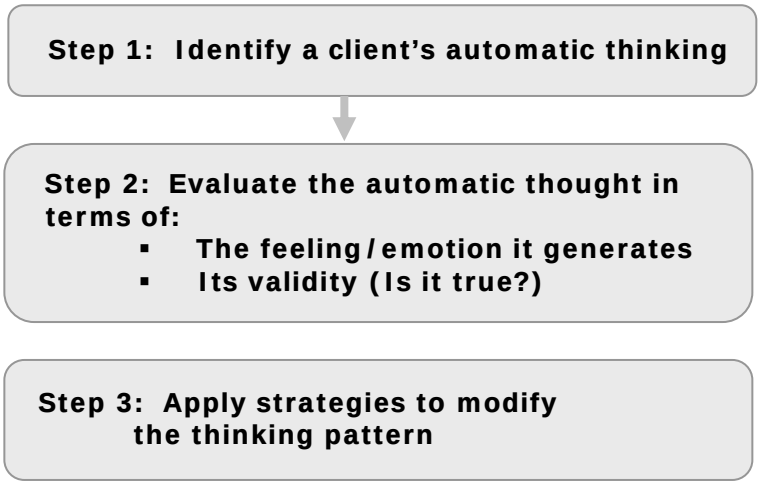

Figure 4 – **Overview of Cognitive Behaviour therapy process**

A counsellor may ask a number of questions in order to evaluate a client's automatic thoughts (step 2). Some questions a counsellor may ask are listed below.

Table 1 **– Questioning automatic thoughts**

1.	What is the evidence? What is the evidence that supports this idea? What is the evidence against this idea?
2.	Is there an alternative explanation?
3.	What's the worst that could happen? Could I live through it? What is the best that could happen? What is the most realistic outcome?
4.	What is the effect of my believing the automatic thought? What could be the effect of changing my thinking?
5.	What should I do about it?
6.	What would I tell_____(a friend) if he or she were in the same situation?

Source: Beck, J. (1995). *Cognitive therapy: Basics and beyond.* New York, NY: Guilford Publications.

In addition to the questioning techniques listed above, there are a number of additional strategies to assist clients in challenging their thought patterns. Some of these include:

- Challenging absolutes
  When clients use language such as, *everyone, always, never, no one, always*, counsellors challenge these *absolute* statements. For example:

  (Next page table)

Client:	Everyone is getting better grades than me.
Counsellor:	Everyone?
Client:	Well, maybe not. There are some people, I suppose, whose grades I don't know.
Counsellor:	Whose grades do you know?
Client:	Jillian's and Petra's.
Counsellor:	Notice how we went from everyone having better grades to only two people with better grades.
Client:	I guess, it's just those girls. They are always doing so well.

- Reattribution

  This is a techniques counsellors use to more fairly distribute the responsibility of an event as clients often heavily blame themselves. For example:

Client:	I stuffed up! I let my daughter down. I said I would be there to watch her swimming race and I missed it.
Counsellor:	Weren't you running late because of a meeting that ran well past schedule?
Client:	Yes.
Counsellor:	Were you in control of the time the meeting would end?
Client:	No. But I told my daughter I would be there.
Counsellor:	So there were other factors involved in your schedule?
Client:	Yes, I guess so.

- Listing the advantages and disadvantages

  By considering the advantages and disadvantages of a particular thought, clients can be encouraged to assess the thought in terms of its usefulness. For example:

A client might think, "I *must* earn a promotion." Some advantages and disadvantages of this thought may include:

Advantages

May generate motivation to achieve

Inspires optimism

Disadvantages

May create undue pressure

May impact negatively on performance in current role

Listing the advantages and disadvantages may help clients to moderate their thinking from an all-or-nothing approach to a more balanced perspective on the matter at hand.

APPLICATIONS

Cognitive approaches have been applied as means of treatment across a variety of presenting concerns and psychological conditions. Cognitive approaches emphasise the role of thought in the development and maintenance of unhelpful or distressing patterns of emotion or behaviour.

Beck originally applied his cognitive approach to the treatment of depression. Cognitive therapy has also been successfully used to treat such conditions as anxiety disorders, obsessive disorders, substance abuse, post-traumatic stress, eating disorders, dissociative identity disorder, chronic pain and many other clinical conditions. In addition, it has been widely utilised to assist clients in enhancing their coping skills and moderating extremes in unhelpful thinking.

CHALLENGES OF CBT

When the client has difficulty identifying emotions and thoughts

It is common for clients to experience emotion prior to any conscious recognition of their preceding thought(s). This can make it difficult to ascertain the actual thought(s) that activated the emotional response.

To assist clients in identifying their thoughts, counsellors may need to use specific questioning techniques to isolate thoughts. Such as, "What were you telling yourself at the time?" or "What was going through your mind?" In addition, role playing the situation and stopping the scene at crucial (emotional) times in the sequence may help clients recall their thinking.

When clients agree with principles but can't seem to alter their thinking

Frequently, clients report an understanding of the principles of cognitive therapy on an intellectual level, but cannot seem to apply that understanding in a way that promotes real change (Sanders & Wills, 2005). Reinforcing that change takes time and even pre-empting the difficulty of shifting from "the head level to the gut feelings" can be helpful ways of preparing clients to stick with the strategies (p. 167). It may simply be a matter of repetition and practice for clients working through change from the 'head' through to the 'heart'.

Clients have limited motivation for change

For clients that are not attending counselling of their own free will, it is essential that counsellors establish motivating factors for the client in the initial stages of therapy. Client may, for example, be attending counselling to keep harmony in a significant relationship or to elicit help to get someone 'off their back'. Whatever the reason for attendance, counsellors should focus on the possible benefits an individual may receive by being involved in the counselling process.

STRENGTHS AND WEAKNESSES

Table 2 – **Strengths and Weaknesses**

STRENGTHS	WEAKNESSES
▪ Well supported by scientific research	▪ Requires clients to be attuned to nuances in mood or attentive to previously unconscious thoughts
▪ Wide application	▪ Can be overly prescriptive and ignore individual factors
▪ Has been used successfully with personality and mood disorders	▪ Requires the ability to think abstractly (i.e. to think about thinking).
▪ Provides a structured plan and sequence for therapy	▪ May not be as depth orientated as some clients may prefer or see as necessary for change

CONCLUSION

All counselling approaches have both their merits and their limitations. Cognitive behaviour therapies are popular for their broad application, scientific validation and the structure they can create for counselling. Cognitive behavioural approaches teach clients the skills of evaluating their own thought patterns, and as such, this approach can be successfully transferred to situations outside of the counselling room.

Effective application of cognitive behavioural counselling requires not only a comprehensive understanding of cognitive concepts but also an appreciation for the time it can take to alter thought patterns and an awareness of the fact that clients may need much practice before realising the benefits of cognitive strategies

REFERENCES

Beck, J. (1995). *Cognitive therapy: Basics and beyond.* New York, NY: Guilford Publications.

Burns, D. D. (1989). *The feeling good handbook.* New York: William Morrow.

Corey, G. (2005). *Theory and practice of counselling and psychotherapy.* (7th ed.). Belmont, CA: Brooks/Cole.

Sanders, D., & Wills, F. (2005). *Cognitive therapy: An introduction.* (2nd ed.). London: Sage.

Sharf, R. (2004). *Theories of psychotherapy and counseling: Concepts and cases.* (3rd ed.). Pacific Grove, CA: Brooks/Cole.

3

Person-Centred Therapy

- History
- Key Concepts
- General Ideas About Personality Development
- Therapeutic Techniques and Methods of Working
- Applications
- Strengths and Weaknesses
- Conclusion
- References

HISTORY

The person-centred approach was developed from the concepts of humanistic psychology. The humanistic approach "views people as capable and autonomous, with the ability to resolve their difficulties, realize their potential, and change their lives in positive ways" (Seligman, 2006). Carl Rogers (a major contributor of the client-centred approach) emphasized the humanistic perspective as well as ensuring therapeutic relationships with clients promote self-esteem, authenticity and actualisation in their life, and help them to use their strengths (Seligman, 2006).

The person-centred approach was originally focused on the client being in charge of the therapy which led to the client developing a greater understanding of self, self-exploration, and improved self-concepts. The focus then shifted to the client's frame of reference and the core conditions required for successful therapy such as ensuring the therapist demonstrates empathic understanding in a non-judgemental way.

Currently, the person-centred approach focuses on the client being able to develop a greater understanding of self in an environment which allows the client to resolve his or her own problems without direct intervention by the therapist. The therapist should keep a questioning stance which is open to change as well as demonstrating courage to face the unknown.

Rogers also emphasized the attitudes and personal characteristics of the therapist and the quality of the client-therapist relationship as being the determinants for a successful therapeutic process (Corey, 2005).

KEY CONCEPTS

The humanistic influence on person-centred therapy

As previously mentioned, the humanistic approach has been a major influence on person-centred therapy. Person-centred therapists believe that clients are capable and trustworthy and they focus on clients' ability to make changes for themselves.

Actualisation

People have the tendency to work towards self-actualisation. Self-actualisation refers to developing in a complete way. It occurs throughout the lifespan as the individual works towards "intrinsic goals, self-realization and fulfilment, involving autonomy and self-regulation" (Seligman, 2006).

Conditions of worth

Conditions of worth influence the way in which a person's self-concept is shaped from important people in his or her life. Conditions of worth refer to judgemental and critical messages from important people that influence the way the individual acts and reacts to certain situations. When an individual has conditions of worth imposed on him or her, self-image is often low. Also, if the individual is exposed to overprotective or dominating environments, this can also have a negative impact on self-image (Seligman, 2006).

The fully functioning person

The fully functioning person is an individual who has "ideal emotional health" (Seligman, 2006). Generally, the fully functioning person will be open to experience, lives with a sense of meaning and purpose, and trusts in self and others. One of the main goals of person-centred therapy is to work towards becoming "fully functioning".

Phenomenological perspective

The phenomenological approach refers to the unique perception by each individual of his or her own world. The individual experiences and perceives own world and reacts in an individual way. Person-centred therapy focuses on the individual's own experience informing how treatment will work.

GENERAL IDEAS ABOUT PERSONALITY DEVELOPMENT

There are a number of general ideas about personality development with regard to person-centred therapy. Basically, person-centred therapy states that personality can be fully actualised when the individual is exposed to unconditional positive regard.

An individual who has been exposed to conditional positive regard can have low self-esteem and low feelings of worth. An individual who is self-actualised will be more open to experience and less defensive, will learn to live in the moment, will trust own decision-making skills, will have more life choices and be more creative.

THERAPEUTIC TECHNIQUES & METHODS OF WORKING

GOALS OF THERAPY

The goals of person-centred therapy are (Seligman, 2006):

1. To facilitate client's trust and ability to be in the present moment. This allows the client to be honest in the process without feeling judged by the therapist.
2. To promote client's self-awareness and self-esteem.
3. To empower the client to change.
4. To encourage congruence in the client's behaviour and feelings.
5. To help people to gain the ability to manage their lives and become self-actualised.

TECHNIQUES

The techniques employed in person-centred therapy are different from those employed in other therapies. The difference is that other therapies are often focused on something the client can do during the therapy session, whereas the techniques used in person-centred therapy are employed by the therapist to create an environment that facilitates the process of self-awareness.

The following techniques will be discussed in relation to the person-centred approach: congruence, unconditional positive regard and acceptance, empathy, and reflection of feelings.

Congruence

Congruence is whether or not therapists are genuine and authentic in what they say and do. Quite often, if the therapist is saying one thing but the body language is reflective of something else, clients are aware of this and may impact on their trust and openness in the therapeutic relationship (Seligman, 2006). For example, a therapist may say "I understand where you are coming from" to a client but have a confused look on his or her face. The client can see this confusion and feels uncomfortable with expressing feelings from this point forward.

Therefore, a major role of therapists is to be aware of their body language and what they are saying as well as being in the present moment. If confusion arises, the therapist needs to be able to address this with the client. Going back to the previous example of the therapist stating understanding and having a confused look, the therapist notices the client looks uneasy after the comment about understanding and goes on to explain to the client why and how he or she understands the statement. This puts the client at ease and ensures the continuation of trust.

Unconditional positive regard

Unconditional positive regard refers to the therapist accepting, respecting and caring about clients (Seligman, 2006). It does not mean the therapist has to agree with everything the client says or does, however, the therapist should see the client as doing the best he or she can and demonstrate this by expressing concern rather than disagreeing with him or her. Unconditional positive regard allows clients to express how they are thinking without feeling judged, and help to facilitate the change process by showing they can be accepted.

Empathy

Empathy is a skill used by person-centred therapists to show understanding of the clients emotions. Empathy is different to sympathy in that sympathy is often seen as feeling sorry for the client whereas empathy shows understanding and allows the client to further open up (Seligman, 2006). An example follows:

Client: *I feel as though no one cares about me and that I am all alone.*
Empathy: *So you are feeling alone at the moment and as if no one cares.*
Sympathy: *I'm sorry that you feel that way.*

Nondirectiveness

The person-centred approach utilises nondirectiveness as a technique by its therapists. Nondirectiveness refers to allowing clients to be the focus of the therapy session without the therapist giving advice or implementing strategies or activities.

Other Techniques

Other techniques that person-centred therapists use in the therapeutic process include reflection of feelings, open questions, paraphrasing and encouragers. Examples of each follow:

Reflection of feelings

Client: I didn't know what to do; I was so confused and angry.

Counsellor: So you are feeling confused and angry.

Open Questions

Client: I had a car accident the other day and the other person got out and started abusing me.

Counsellor: And how did that make you feel?

Paraphrasing

Client: I have been feeling depressed for the past 2 months since I broke up with my partner. I am having trouble sleeping and can't concentrate at work.

Counsellor: So the feeling of depression is impacting on your everyday life.

Encouragers

Client: It makes me feel like crying, I don't know what to do.

Counsellor: Uh-huh

APPLICATIONS

The person-centred approach can be applied to working with individuals, groups and families (Corey, 2005). The person-centred approach has been successful in treating problems including anxiety disorders, alcoholism, psychosomatic problems, agoraphobia, interpersonal difficulties, depression, and personality disorders (Bozrath, Zimring & Tausch, as cited in Corey, 2005).

It could also be used in counselling people with unwanted pregnancy, illness or loss of a loved one. When compared with other therapies such as goal-focused therapies, person-centred therapy has been shown to be as effective as them (Corey, 2005).

STRENGTHS AND WEAKNESSES

Table 1 – **Strengths and Weaknesses**

STRENGTHS	WEAKNESSES
▪ Offers a perspective that is up-to-date and optimistic (Seligman, 2006)	▪ The approach may lead therapists to just be supportive of clients without challenging them (Corey, 2005).
▪ Many aspects are relevant to a multicultural perspective (Seligman, 2006).	▪ Difficulty in therapists allowing clients to find their own way (Corey, 2005).
▪ Has provided a basis for many other therapies such as the emphasis on the client-therapist relationship (Seligman, 2006).	▪ Could be an ineffective way to facilitate therapy if the therapist is non-directive and passive (Corey, 2005).
▪ Research has substantiated the importance of the client-therapist relationship (Seligman, 2006).	▪ Simplistic and unrealistically optimistic (Seligman, 2006).
▪ Clients have a positive experience in therapy when the focus is on them and their problems	▪ Person-centred therapy does not draw on developmental, psychodynamic or behavioural therapy thus limiting the overall understanding of clients (Seligman, 2006).
▪ Clients feel they can express themselves more fully when they are being listened to and not judged.	▪ Listening and caring may not be enough (Seligman, 2006).
▪ Clients feel empowered from person-centred therapy as the responsibility is on them to make decisions.	▪ Not appropriate for those who are not motivated to change.
	▪ May not be useful with significant psychopathology (Seligman, 2006).
	▪ Fails to prepare clients for the real world due to the unconditional positive regard of the therapist (Seligman, 2006).
	▪ Lacks techniques to help clients solve problems (Seligman, 2006).

CONCLUSION

The person-centred approach has been developed by Carl Rogers who took a humanistic approach to therapy. Humanistic psychology "views people as capable and autonomous, with the ability to resolve their difficulties, realize their potential, and change their lives in positive ways" (Seligman, 2006).

Overall, person-centred therapy is a non-directive, optimistic therapy that focuses on the client's ability to make changes in his or her life and that clients strive for self-actualisation.

REFERENCES

Corey, C. (2005). *Theory and practice of counseling & psychotherapy.* (7th ed.). Belmont, CA: Thomson Learning.

Corsini, R.J., & Wedding, D. (2000). *Current Psychotherapies.* (6th ed.). Belmont, CA: Thomson Learning, Inc.

George, R.L., & Cristiani, S. (1995). *Counseling, theory and practice.* Boston: Allyn and Bacon Publishers.

Rogers, C. (1961). *On becoming a person: A therapist's view of psychotherapy*. London: Constable.

Seligman, L. (2006). *Theories of counseling and psychotherapy: Systems, strategies, and skills.* (2nd ed.). Upper Saddle River, New Jersey: Pearson Education, Ltd.

4

Solution-Focused Therapy

HISTORY

Solution focused therapies are founded on the rationale that there are exceptions to every problem and through examining these exceptions and having a clear vision of a preferred future, client and counsellor, together, can generate ides for solutions. Solution focused therapists are competency and future focused. They highlight and utilise client strengths to enable a more effective future.

Historically, psychotherapeutic approaches of the early-mid 1900s focused primarily on client pathology and problems. By the late 1950s a moderate shift in practitioner direction was occurring. Therapists were shifting from a focus on the past to a 'here and now' approach.

Nonetheless the focus on client pathology and problems remained. By the late 1970s, practitioners, particularly family therapist, were taking note of their own biases. Contextual factors became the focus as clinicians began to challenge traditional pathologizing and power-orientated practices (Bertolino & O'Hanlon, 2002).

Solution focused practice emerged with the idea that solutions may rest within the individual and his or her social network. As postmodernism sparked questions about the superiority of the therapist's position and the idea of a universal truth, the therapeutic relationship began to transform - the client now recognised as the expert in his or her own life. This created a more collaborative approach to counselling (Bertolino & O'Hanlon, 2002) and established a context in which solution focused practice could flourish.

SOLUTION-FOCUSED TECHNIQUES

Basic Assumptions

The following assumptions provide the framework on which solution focused therapy is founded:

- There are significant advantages in focusing on the positive and on solutions for the future. Focusing on strengths and solution-talk will increase the likelihood that therapy will be brief.
- Individuals who come to therapy *do* have the capacity to act effectively. This capacity, however is temporarily blocked by negative cognitions.
- There are exceptions to every problem.
- Clients tend to present one side of the problem. Solution focused therapists invite clients to view their problems from a different side.
- Small change fosters bigger change.
- Clients want to change, they have the capacity to change and they are doing their best to make change happen.
- As each individual is unique, so too is every solution.

Source: Corey, G. (2005). *Theory and practice of counseling and psychotherapy. (7th ed.)*. Belmont, CA: Wadsworth.

The Miracle Question

The miracle question is a technique that counsellors can use to assist clients to think 'outside the square' in regard to new possibilities and outcomes for the future.

"The miracle question has been asked thousands of times throughout the world. It has been refined as practitioners have experimented with different ways of asking it. The question is best asked deliberately and dramatically.

> *Now, I want to ask you a strange question. Suppose that while you are sleeping tonight and the entire house is quiet, a miracle happens. The miracle is that the problem which brought you here is solved. However because you are sleeping, you don't know that the miracle has happened. So, when you wake up tomorrow morning, what will be different that will tell you that a miracle has happened and the problem which brought you here is solved? (de Shazer, 1988, p. 5.)*

Asked this way, the miracle question requests clients to make a leap of faith and imagine how their life will be changed when the problem is solved. This is not easy for clients. It requires them to make a dramatic shift from problem saturated thinking to a focus on solutions. Most clients need time and assistance to make that shift. (De Jong & Kim Berg, 2002)

Exception Questions

Having created a detailed miracle picture, the counsellor has started to gain some understanding of what the client hopes to achieve and the counsellor and client can begin to work towards these solutions. This is achieved through highlighting exceptions in a client's life that are counter to the problem. This helps empower clients to seek solutions.

Exception questions provide clients with the opportunity to identify times when things have been different for them.

Examples of exception questions include:

- *Tell me about times when you don't get angry.*
- *Tell me about times you felt the happiest.*
- *When was the last time that you feel you had a better day?*
- *Was there ever a time when you felt happy in your relationship?*
- *What was it about that day that made it a better day?*
- *Can you think of a time when the problem was not present in your life?*

"When exploring for exceptions, be aware that such questions can be phrased to ask for the client's perception of exceptions (individual questions) and the client's perception of what significant others may notice (relationship questions). Examples of each follow:

Exceptions related to the miracle.

1) Elicit

So when the miracle happens, you and your husband will be talking more about what your day was like and hugging more. Are there times already which are like the miracle – even a little bit?

If your husband was here and I were to ask him the same question, what do you think he would say?

2) Amplify

When was the last time you and your husband talked more and hugged more? Tell me more about that time. What was it like? What did you talk about? What did you say? When he said that, what did you do? What did he do then? How was that for you? Was else was different about that time?

If he were here, what else might he say about that time?

3) Reinforce

Nonverbally: Lean forward raise eyebrows, take notes. Do what you naturally do when someone tells you something important.

Verbally: Show interest. (Was this new for you and him? Did it surprise you that this happened?) And compliment. (Seems like that might have been difficult for you to do, given everything that's happened in the relationship. Was it difficult?)

4) Explore how the exception happened

What do you suppose you did to make that happen?

If your husband was here and I asked him, what do you suppose he would say you did that helped him to tell you more about his day?

Use compliments: Where did you get the idea to do it that way? That seems to make a lot of sense. Have you always been able to come up with ideas about what to do in difficult situations like this?

5) Project exceptions into the future

On a scale of 1 to 10, where 1 means every chance, what are the chances that a time like that (the exception) will happen again in the next week (month, sometime in the future)? What will take for that to happen?)

What will it take for that to happen more often in the future?

Who has to do what to make it happen again?

What is the most important thing for you to remember to do to make sure that _____(the exception) has the best chance of happening again? What's the next most important thing to remember?

What do you think your husband would say the chances are that this (the exception) will happen again? What would he say you could do to increase the chances of that happening again? Suppose you decide to do that, what do you think he would do? Suppose he did that, how would things be different for you…around your house... in your relationship with him?" (De Jong & Kim Berg, 2002, pp. 302-303)

Scaling Questions

Scaling questions invite clients to perceive their problem on a continuum. Scaling questions ask clients to consider their position on a scale (usually from 1 to 10, with one being the least desirable situation and 10 being the most desirable). Scaling questions can be a helpful way to track coachees' progress toward goals and monitor incremental change.

"To use these types of questions, the therapist begins by describing a scale from one to ten where each number represents a rating of the client's complaint(s). The therapist might say, "On a scale of one to ten, with one being the worst this problem has ever been, and ten being the best things could be, where would you rate things today?"

Once a therapist is given a number, he or she explores how that rating translates into action-talk. For example, if the client rates his or her situation at a three, the therapist asks, "What specifically is happening to indicate to you that it is a three?" The next step is to determine the goals and preferred outcomes.

To do this the therapist asks the client where things would need to be for him or her to feel that the goals of treatment have been met or that therapy has been successful...

We aim for small changes that will represent progress in the direction of goals and preferred outcomes."*

** Bertolino & O'Hanlon, 2002, pg. 4.*

Examples of scaling questions include:

- *You said that things are between a 5 and a 6. What would need to happen so that you could say things were between a 6 and a 7?*

- *How confident are you that you could have a good day like you did last week, on a scale of zero to ten, where zero equals no confidence and ten means you have every confidence?*

Presupposing change

When clients are focused on changing the negative aspects (or problems) in their lives, positive changes can often be overlooked, minimized or discounted due to the ongoing presence of the problem.

The solution focused approach challenges counsellors to be attentive to positive changes (however small) that occur in their clients' lives. Questions that presuppose change can be useful in assisting clients to recognise such changes. Questions such as, *"What's different, or better since I saw you last time?"* This question invites clients to consider the possibility that change (perhaps positive change) has recently occurred in their lives.

If evidence of positive change is unavailable, counsellors can pursue a line of questioning that relates to the client's ability to cope.

Questions such as:

- *"How come things aren't worse for you?*
- *What stopped total disaster from occurring?*
- *How did you avoid falling apart?*

These questions can be followed up by the counsellor positively affirming the client with regard to any action they took to cope. (Geldard & Geldard, 2005)

APPLICATIONS

Solution focused counsellors are more concerned with solutions than how or why a problem originated. For this reason, solution focused practice has a broad application. The solution focused approach can be brief due to its focus on 'what works' and its emphasis on action as a significant factor in change. This makes it an approach that can be well integrated into the typically fast-paced lifestyle of the contemporary client.

As such, solution focused therapy has been successfully applied to a variety of client concerns, including drug and alcohol abuse, depression, relationship difficulties, relationship breakdown, eating disorders, anger management, communication difficulties and crisis intervention to name but a few. In addition, solution focused approaches have been effectively applied to a vast array of client groups, including children, families, couples and mandated clients.

STRENGTHS AND WEAKNESSES

Table 1 – **Strengths and Weaknesses**

STRENGTHS	WEAKNESSES
▪ Collaborative in its approach ▪ Focuses on client competencies ▪ Can be brief	▪ Clients expecting depth therapy or analysis may dismiss the solution focused approach for its simplicity

CONCLUSION

The solution focused approach provides counsellors with a framework for exploring and utilising clients' existing resources; their strengths, support networks, ideas and theories of how change occurs. Solution focused counselling seeks to redirect client thinking from being problem-focused to solution-focused. This can be a difficult task, particularly when the client has lived with a particular concern for many years. Techniques such as the miracle question and exception questions can serve as useful tools for inspiring new ways of thinking and generating ideas for solution building and the establishment of a preferred future.

REFERENCES

Bertolino, B., & O'Hanlon, B. (2002). *Collaborative, competency-based counseling and therapy.* Needham Heights, MA: Allyn & Bacon.

Corey, G. (2005). *Theory and practice of counselling and psychotherapy.* (7th ed.). Belmont, CA: Brooks/Cole.

De Jong, P., & Kim Berg, I. (2002). *Interviewing for solutions. (2nd ed)*. Pacific Grove, CA: Wadsworth.

de Shazer, S. (1988). *Clues: investigating solutions in brief therapy.* New York: Norton.

5

Gestalt Therapy

- History
- Key Concepts
- General Ideas About Personality Development
- Therapeutic Techniques and Methods of Working
- Applications
- Strengths and Weaknesses
- Conclusion
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Gestalt Prayer

"I do my thing and you do your thing.
I am not in this world to live up to your expectations
And you are not in this world to live up to mine.
You are you and I am I,
And if by chance we find each other, it's beautiful.
If not, it cannot be helped."

(Fritz Perls, 1969, in Gladding, 2000)

HISTORY

Gestalt therapy was developed in the 1940's by Fritz and Laura Perls and further influenced by the likes of Kurt Lewin and Kurt Goldstein (Corsini & Wedding, 2000).

It was developed as a revision to psychoanalysis and focuses on an experiential and humanistic approach rather than analysis of the unconscious which was one of the main therapeutic tools at the time Gestalt therapy was employed.

Gestalt therapy rejects the dualities of mind and body, body and soul, thinking and feeling, and feeling and action. According to Perls, people are not made up of separate components, this is, mind, body and soul, rather human beings function as a *whole*. In doing so, one defines who one is *(sense of self)* by choice of responses to environmental interactions *(boundaries)*. The word "Gestalt" (of German origin) refers to a "whole, configuration, integration, pattern or form" (Patterson, 1986).

The form of Gestalt therapy practiced today utilises ideas, data and interventions from multiple sources, as well as some of the original techniques known to be 'Gestalt therapy techniques'. It is noted that Gestalt therapy has a history of being an approach which creates or borrows specific techniques that are focused on assisting the client to take the next step in their personal growth and development.

KEY CONCEPTS

Several key concepts underlie Gestalt therapy, many of which are similar to that of person-centred and existential therapy. However, what does differentiate Gestalt therapy from these therapies are some of the ideas added by Perls and associates as well as distinctive therapeutic techniques that will be covered further down (Seligman, 2006). The following are the key concepts of Gestalt therapy:

Wholeness and Integration

Wholeness refers to the whole person or the individual's mind and body as a unit rather than as separate parts (Seligman, 2006). Integration refers to how these parts fit together and how the individual integrates into the environment. Often people who come to therapy do not have these parts fitting together in their environment, Gestalt therapy is about facilitating clients to integrate themselves as whole persons and help restore balance in their environment.

Awareness

Awareness is one of the most important elements in Gestalt therapy as it is seen as a "hallmark of the healthy person and a goal of treatment" (Seligman, 2006). When individuals are "aware", they are able to self-regulate in their environment. There are two main causes lacking awareness:

- Preoccupation with one's past, fantasies, flaws and strengths that the individual becomes unaware of the whole picture.

- Low self-esteem.

There are three ways people may achieve awareness through therapy:

1) *Contact with the environment:* This is through looking, listening, touching, talking, moving, smelling, and tasting. This enables the individual to grow in his or her environment through reacting to the environment and changing.

2) *Here and now:* This is the individual is to live in and be conscious at the present moment rather than worrying about the past or the future.

3) *Responsibility:* This refers to the individual taking responsibility for his or her own life rather than blaming others.

Energy and blocks to energy

Gestalt therapists often focus on where energy is in the body, how it is used, and how it may be causing a blockage (Corey, 2005). Blocked energy is a form of resistance, for example, tension in a part of the body, not breathing deeply, or avoiding eye contact. Gestalt therapy is about finding and releasing the blockages that may be inhibiting awareness.

Growth Disorders

Growth disorders refer to emotional problems that are caused by people who lack awareness and do not interact with their environment completely. In doing so, people are unable to cope with the changes in their lives successfully and, instead deal with the problems in a defensive manner (Seligman, 2006).

Unfinished business

Unfinished business refers to people who do not finish things in their lives and is often related to people with a "growth disorder" (Seligman, 2006). People with unfinished business often resent the past and because of this are unable to focus on the here and now. One of the major goals of Gestalt therapy is to help people work through their unfinished business and bring about closure.

GENERAL IDEAS ABOUT PERSONALITY DEVELOPMENT

Gestalt therapy deems that people cannot be considered as separate from their environment or from interpersonal relations. The individual is seen as being self-regulating and is able to motivate oneself to solve problems. Individuals are able to work towards growth and develop as their environments allow.

A psychologically healthy person is someone who is self-regulating through the changes in life and has developed a sense of "wholeness" between mind and body (Corsini & Wedding, (2000).

THERAPEUTIC TECHNIQUES & METHODS OF WORKING

GOALS OF THERAPY

The most important goal of Gestalt therapy is that Gestalt therapists do not aim to change their clients. The therapist's role is to assist clients in developing their own self-awareness of how they are in the present moment. This will therefore allow them to rectify issues affecting his or her life.

> *"The therapist's job is to invite clients into an active partnership where they can learn about themselves by adopting an experiential attitude toward life in which they try out new behaviours and notice what happens" (Perls, Hefferline and Goodman, 1954, in Corey, 2005).*

A focus of developing awareness is that of clients' awareness of their own realities. In order to do this, clients must first accept responsibility for choosing their present situations. Language plays a big part in accepting responsibility. The client may attempt to use avoidance responses or project individual traits onto other people or external causes, for example "She makes me so angry"; "It's his fault". Both avoidance responses and projection of traits attempt to displace ownership and responsibility onto an external cause.

Another goal of Gestalt therapy is that therapists should work to create an "I-thou" relationship with clients in which both the therapist and client are present in the here-and-now rather than focusing on the past or future (Seligman, 2006).

Also, an understanding of the whole of the client's experience is required by the therapist. This involves considering the client's verbal and non-verbal communication. In fact, the nonverbal communication is seen to provide more information about the real essence of the person. Thus, an important function of the Gestalt therapist is paying attention to the client's body language such as the client's posture, movements, gestures, voice, and hesitations as the body language is considered to be reflective of what the client is going through at that point in time.

TECHNIQUES

Experiments

Gestalt therapists use the technique of experiments or learning experiences with their clients. The experiments are designed for the individual and take the form of an enactment, role play, homework, or other activity which promotes the individual's self-awareness (Seligman, 2006).

An example of this technique is with a man who feels insecure in social situations. He has a work function to go to in two weeks time so the therapist gives him the experiment of starting a conversation at the function with someone he does not normally speak to. Spending time thinking about what he might say promotes self-awareness and the experiment itself gives him more confidence in social situations.

Use of Language

Gestalt therapists choose language that will encourage change in the client. The following are ways that this can be accomplished (Seligman, 2006):

1) Emphasis on statements rather than questions to highlight a collaborative client-therapist relationship.
2) "What" and "How" questions (when questions are used) to keep the client in the present and promote integration.
3) "I" statements are used to promote clients ownership of feelings rather than placing blame on others.
4) The present tense is used so the focus is on the present rather than the past.
5) Encouraging responsibility for clients of their words, emotions, thoughts, and behaviours so they recognize and accept what they are feeling.

Empty Chair

The empty chair technique is a "method of facilitating the role-taking dialogue between the patient and others or between parts of the patient's personality. It is generally used in a group situation" (Patterson, 1986). Two chairs are placed facing each other: one represents the patient or one aspect of the patient's personality, and the other represents another person or the opposing part of the personality. As the patient alternates the role, he or she sits in one or the other chair.

The therapist may simply observe as the dialogue progresses or may instruct the patient when to change chairs, suggest sentences to say, call the patient's attention to what has been said, or ask the patient to repeat or exaggerate words or actions.

In the process, emotions and conflicts are evoked, impasses may be brought about and resolved, and awareness and integration of polarities may develop – polarities or splits within the patient, between the patient and other persons, or between the patient's wants and the social norms (Patterson, 1986).

Topdog – Underdog

A commonly utilised Gestalt technique is that of the *topdog-underdog dialogue.* This technique is used when the therapist notices two opposing opinions/attitudes within the client. The therapist encourages the client to distinguish between these two parts and play the role of each in a dialogue between them (Patterson, 1986).

The tyrannical 'topdog' demands that things be a particular way whilst the 'underdog' plays the role of disobedient child. The individual becomes split between the two sides struggling for control.

Dreams

Dreams are used to bring about integration by the client. The focus of a client's dream is not on the unconscious, rather on projections or aspects of the dreamer (Seligman, 2006). The therapist would get clients to talk about their dream/s in terms of the significance of each role in the dream and this allows clients to take responsibility for the dreams and increase awareness of their thoughts and emotions.

Fantasy

Fantasy is used in Gestalt therapy to increase clients' self-awareness of their thoughts and emotions and to bring about closure to unfinished business (Seligman, 2006). Therapists use guided imagery techniques (fantasy) to encourage clients to imagine situations such as what they would do in a certain situation or by projecting themselves into different roles.

The Body as a Vehicle of Communication

Gestalt therapy sees that not only are thoughts and emotions important to creating a feeling of "wholeness" for the client, the physical sensations are also important. Seligman (2006) has identified three strategies to help with focusing attention on the physical sensations:

1) *Identification* - Gestalt therapists should be able to recognise physical signs of their clients. For example, a client might be tapping their feet on the ground. The therapist may say "Become your leg and give it a voice?" This creates awareness of the client's physical sensations and emotions.

2) *Locating emotions in the body* - Gestalt therapists may ask clients where they are experiencing the emotion in their body. For example, a client may say they are feeling nervous about something. The therapist may ask where this is coming from in the body and the response from the client may be that the feeling is butterflies in the stomach. This helps the client to bring about more awareness into sensations and their emotions.

3) *Repetition and exaggeration* - If there is repetition such as the example of the client tapping their feet on the ground, the therapist would get them to exaggerate the movement and talk about feelings that come up. This in turn focuses on the emotion and should help to release the blocked awareness.

Confusion

The technique of dealing with confusion of the client is about drawing attention to the client's hesitation in talking about something unpleasant. The hesitation can be shown through avoidance, blanking out, verbalism and fantasy (Patterson, 1986). By drawing attention to the hesitation, it creates self-awareness for the client and allows the client to work through the issue.

Confrontation

In Gestalt therapy, confrontation means 'to challenge or frustrate the client'. The client is challenged with sensitivity and empathy on the part of the therapist to face the issues important to them. It is an invaluable tool for bringing clients into clear awareness of their realities, when used appropriately. However, confrontation is not a technique that can be used with all clients.

APPLICATIONS

Originally Gestalt therapy was predominantly used to treat individuals who were anxious and/or depressed and who were not showing serious pathological symptoms. Although still used in the treatment of anxiety and depression, Gestalt therapy has been effective in treating clients with personality disorders such as borderline personality disorder.

Gestalt therapy is also effective in counselling groups, couples, and families (Corsini & Wedding, 2000).

STRENGTHS AND WEAKNESSES

Table 1 – **Strengths and Weaknesses**

STRENGTHS	WEAKNESSES
▪ There is empirical research to support Gestalt therapy and its techniques (Corsini & Wedding, 2000). Specifically, Gestalt therapy is equal to or greater than other therapies in treating various disorders, Gestalt therapy has a beneficial impact with personality disorders, and the effects of therapy are stable.	▪ For Gestalt therapy to be effective, the therapist must have a high level of personal development (Corey, 2005).
▪ Works with the past by making it relevant to the present (Corey, 2005).	▪ Effectiveness of the confronting and theatrical techniques of Gestalt therapy is limited and has not been well established.
▪ Versatile and flexible in its approach to therapy. It has many techniques and may be applied to different therapeutic issues.	▪ Potential danger for therapists to abuse the power they have with clients (Corey, 2005).
	▪ It has been considered to be a self-centred approach which is concerned with just individual development.
	▪ Lacks a strong theoretical base.
	▪ Deals only with the here and now.
	▪ Does not deal with diagnosis and testing.

CONCLUSION

Gestalt therapy focuses on the integration between the "whole" person and his or her environment. This therapy sees a healthy individual as being someone who has awareness in his or her life and lives in the here and now rather than focusing on the past or future. Gestalt therapy has a number of successful techniques that are applicable in therapy today and may be utilised across a broad spectrum of emotional issues.

REFERENCES

Corey, C. (2005). *Theory and practice of counseling & psychotherapy.* (7th ed.). Belmont, CA: Thomson Learning.

Corsini, R.J., & Wedding, D. (Eds.). (2000). *Current Psychotherapies.* (6th ed.). Belmont, CA: Thomson Learning, Inc.

Gladding, S.T. (2000). *Counseling: A comprehensive profession.* (4th ed.). Upper Saddle River, NJ: Prentice-Hall, Inc.

Paterson, C. H. (1986). *Theories of counselling and psychotherapy.* New York, NY: Harper & Row.

Seligman, L. (2006). *Theories of counseling and psychotherapy: Systems, strategies, and skills.* (2nd ed.). Upper Saddle River, New Jersey: Pearson Education, Ltd.

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