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GENERIC ELEMENTS OF COUNSELLING AND PSYCHOTHERAPY

Individual clients could give their testimonies as to the efficacy of counselling and psychotherapy, some with glowing reports of dramatic changes in their lives, some with an acknowledgement of 'feeling better', others with stories of staying stuck through and beyond therapy and, sadly, others who have experienced a worsening of their problems. The majority (around 80 per cent according to most research) would claim neither miracles nor disasters but be appreciative of the outcome they gained. Is it therapy per se that produces this wide range of results or is it the person delivering it or, further, is it the person receiving the therapy who may bring a quality that another may not which affects the outcome?

The problem in assessing the effectiveness of counselling or psychotherapy is that the personal, qualitative views of clients do not match the demands of Western society for observable and scientific evidence. The twenty-first century has seen a heightening of this historic tension in the UK (with the government's Improved Access to Psychological Therapies (IAPT) drive) as well as in the rest of the western world. Health care providers are under financial and political pressure to give in to the desire for certainty which has led to a lionization of cognitive behaviour therapy as being pragmatic and brief. CBT colleagues are concerned that this is bound to lead to its denigration in the future when it turns out not to be 'the silver bullet' and service users (clients and patients) demand that more subtle and hidden levels of their pain be addressed. Darien Leader (2008b) calls this desire for certainty and brevity in therapeutic offering a 'Quick Fix for the Soul'.

Therapy deals with people and people are individuals. Individuals making changes in their lives do not always provide the comparable statistical evidence that science demands. The variables in people, the internal, historical, current, biological, hereditary, temperamental and cultural nuances of their individual lives, make such comparisons extremely difficult. The innate physiological, developmental thrust for

survival, life and actualization means that all human beings are changing at all their different levels, all the time. Our need of contact and cooperation with other human beings makes us socially interactive which will also bring about (and sometimes force) changes to ourselves and others.

In recent years, different and less quantitative ways of measuring how professionals assist in the 'change process' have become more prevalent. It seems that research methodology has needed to change creatively in order to measure the creative change in counselling and psychotherapy. Examples of such types of research can be found in Safran and Greenberg's (1991) *Emotion, Psychotherapy and Change*; Talley et al's (1994) *Psychotherapy Research and Practice: Bridging the Gap*; McLeod's (2001) *Qualitative Research in Counselling and Psychotherapy* and (2003) *Practitioner Research in Counselling* (2nd edn); Robson's (2002) *Real World Research* and Lebow's (2006) *Research for the Psychotherapist*.

Research findings suggest that therapy, broadly speaking, is effective in helping people make changes in their lives. But what are the generic or 'common' factors in counselling and psychotherapy, of whatever approach, that facilitate change? Important meta-analysis of psychotherapy outcome research (Asay and Lambert, 1999; Castonguay and Beutler, 2006; Hubble et al. 1999; Wampold, 2001) has identified certain factors that seem to be common to successful therapy. These are largely related to the existence, from the client's point of view, of an empathic, respectful relationship that remains accepting and non-judgmental, even after the client has exposed the parts of herself that she experiences as flawed or shameful. In addition, various authors have interpreted the research to identify other allied factors – such as the resourcefulness and courage of the client (e.g. Duncan et al., 2000; Hubble et al., 1999); the opportunity to learn and practise new skills and ways of thinking; receiving feedback (both directly and through the working through of projections) (see for example Goldfried, 1995; Meichenbaum, 2000). Research also suggests that the therapist's allegiance to a theoretical model (his belief in what he does and why he does it that way), whatever the model, has a positive influence on the effectiveness of the therapy. For a very readable account of research findings from not only twentieth-century outcome studies (from randomised controlled trials to qualitative studies) but also contributions and findings from new approaches of the twenty-first century (such as EMDR) see Cooper's (2008) *Essential Research Findings in Counselling and Psychotherapy: the facts are friendly*.

Another source of research guidance is from the world of neuroscience which provides insight into the importance of relationship in the development of the structure of the brain and mind and identity. Indeed Evans and Gilbert (2005) suggest that neurobiological understanding of the mind, self and identity development and the potential effect of psychotherapy could offer another method of integration. While this is a powerful invitation, we have not included it in this book for the reason that the brain and body-mind are so complex and the information about the topic is so constantly developing that we fear to set in aspic the current knowledge by using it as a framework for psychotherapy approaches.

It is interesting to notice that – even without research evidence – there is something 'right minded' about these findings. Many practitioners and theorists have postulated those elements which they consider contribute to the effectiveness of therapy,

and their opinions largely concur with the research findings. For example, Yalom drew up a list of curative factors in group psychotherapy from an existential standpoint:

> (1) Instillation of hope. (2) Universality. (3) Imparting of information. (4) Altruism. (5) The corrective recapitulation of the primary family group. (6) Development of socialising techniques. (7) Imitative behaviour. (8) Interpersonal learning. (9) Group cohesiveness. (10) Catharsis. (11) Existential factors. (Yalom, 1975: 3–4)

Garfield (in Norcross and Goldfried, 1992) points out that 'because the different forms of psychotherapy are derived from different theoretical orientations and use different terms and concepts, the various forms of psychotherapy can appear more different than may actually be the case. Consequently, some common variables or processes are viewed as different even when they are essentially similar. He describes several common factors present in most forms of psychotherapy which he believes are prerequisites for potential progress in psychotherapy:

- The relationship in psychotherapy.
- Emotional release or catharsis.
- Explanation, rationale and interpretation.
- Reinforcement.
- Desensitization.
- Facing or confronting a problem.
- Information and skills training.
- Time.

Below, we offer our own list of generic elements which we believe should form part of the foundation of any integrative approach. We have made sure that it includes those factors that have been highlighted by the research. However, we have found that we could leave this list largely unchanged from the one that we developed together in the 1990s based primarily on our experience as practitioners.

GENERIC ELEMENTS OF EFFECTIVE PRACTICE

Naturally, this list reflects our own bias and the reader may disagree with some elements. However, we believe that, in the main, the items on it are common to most practices and can inform any integrative therapeutic approach. We list them below before discussing them in more detail:

- Developing a therapeutic alliance.
- Providing the opportunity for 'double listening'.
- Acknowledging and respecting the client's experience, even when the client cannot.
- Offering empathy.
- Facilitating awareness and developing insight.
- Staying 'creatively indifferent'.

- Creating a quality of relationship that may have been lacking in the past.
- Being a model.
- Normalizing the client's experience.
- Challenging and confronting.
- Making space for self-reflection.
- Providing consistency and continuity.
- Creating the opportunity to practise new behaviour.
- Managing the transference and countertransference dynamic.
- Sharing humour.
- Checking the match of therapist and client.

Developing the therapeutic alliance

Research indicates that the therapeutic alliance (or working alliance) between therapist and client has a significant influence on the outcome of the psychotherapy. The alliance is seen as 'a positive emotional bond and a sense of mutual collaboration' (Wolfe and Goldfried, 1988) which is established between the therapist and client. Other researchers (Butler and Strupp, 1986; Horvath and Greenberg, 1994; Stiles et al., 1986; Strupp and Hadley, 1979) support the view that, over and above techniques, a 'good human relationship' is central to the efficacy of psychotherapy. Bordin (1979) identifies three important components of the working alliance: an agreement on goals, a concordance regarding the tasks with which the partnership will engage and the personal bonds developed between therapist and client which will affirm their common commitment and understanding of the activity. Importantly, we have framed this list of vital elements as tasks for the therapist, but many imply serious work for the client. All the researchers we have quoted stress the importance of client motivation, courage and determination in the endeavour. Asay and Lambert (1999) estimate that the largest factor (40 per cent) in the variance in therapeutic outcomes is attributable to client factors. We believe that an important part of the therapist's job in the early stages is to help the client understand how he is supposed to work in order that there is a mutual commitment to the work that becomes its main strength. What is more, we suggest that many of these tasks can only be accomplished if they are part of a mutual exchange.

'Double listening'

In therapy, clients will have the experience of being listened to and of listening to themselves in the presence of another for whom they have no responsibility whatsoever. This absence of distraction caused by a need to attend to the desires of the other is what distinguishes the experience from that of talking with a friend or colleague where attention is inevitably drawn to their experience or to the need for fairness in attention and sharing.

As a client, problems are caught up in the complexity of inner thought, feeling and sensation. The avenue opened up between client and therapist by the art of intelligent,

attentive, active listening provides the client with a pathway along which to propel their stream of consciousness. While converting rambling thoughts, confusing images or disturbing feelings into spoken language, the client is given the time and perspective to be able to really hear their dilemma, and have it heard, in a more manageable form. As they struggle to bring inchoate experience to conscious awareness, they may use metaphor, imagery and allusion which can become the bridge from the 'unthought known' (Bollas, 1987) of their non-conscious mind.

William, on discussing his envy at a colleague's promotion, sighs and says 'I'm absolutely green with envy at his luck.'

The therapist responds by simply reflecting back, 'Green with envy' and emulates his sigh. William continues, 'Yes, I am just so green. Funny that, I'm probably too green to get the job really. I don't have his experience.'

Acknowledging and respecting the client

The therapist helps to create a relationship between herself and her client in which the client's individuality is respected and valued irrespective of the behaviours which the client may present or report on. Part of this is also a recognition of him as a separate person who acts in and on the world. The therapist may not agree with or approve of some of the client's actions or even their beliefs, but will nonetheless retain the genuine attitude of meeting that client with acceptance.

Childhood is controlled by judgements and conditions laid down by parents, family and society. Therapy works when, at last, the client has a relationship in which, for the most part, these conditions do not exist. The client can take the permission to experiment by stating their views on life without the need to continue crouching behind the various successful defences which they created in childhood to allay their fears and to prevent a fantasized annihilation.

Clients often come to the therapy situation believing that because they have problems they are therefore 'bad'. They are not at all accepting of their 'human frailties', but often critical, cruel and overly demanding of themselves. The therapist, by his non-judgemental acceptance of his client, redresses this balance and offers greater safety to his client to start exploring the problems from a more open perspective. Through his own personal work, the therapist will hopefully have grown enough to be able to hold a greater acceptance of his own 'humanity'.

Without this acceptance being perceived by the client there is the high possibility that the client's childhood experiences will simply be replicated by adapting in an attempt to please the therapist. The therapist's non-judgemental and accepting position provides a container in which it is safe enough to explore the transference and other dynamics.

Philip says, 'I've been afraid to tell you this because I'm afraid you'll never want to see me again.'

The therapist responds, 'You sound as if you're carrying something very heavy for you.'

'Yes,' replies Philip. 'I'm dreading that you will be very shocked.'

'You might be imagining that I am unable to hold on to all that I respect in you once you tell me this,' says the therapist.

Philip replies, 'Yes, it's awful.'

The therapist suggests that Philip selects two objects in the room, one to represent this unspeakable thing, the other to represent the man she knows and respects unconditionally. He gives them to her to hold for a while.

Offering empathy

The *Oxford English Dictionary* defines empathy as 'the power of identifying oneself mentally with (and so fully comprehending) a person or object of contemplation'. We would expand this definition to include demonstrating to the other that one's comprehension of their position is multi-levelled such that their thoughts, feelings, sensations and behaviours associated with the situation are integrated within this understanding. The empathic therapist shows her client that his/her experiences are really being seen and understood.

We believe, along with Rogers and Kohut (and, more recently, Stern, Bozarth and Erskine), that with our basic human need to be loved and to be put first in at least one other person's relational orbit, being accepted and being the primary focus of our therapist's attention is inherently healing. It is this quality of attunement (Stern, 1985) which makes possible the bearing of the unbearable and the managing of the unmanageable.

Recent developments in neuroscience have shown the presence of 'mirror neurons' in primates which respond equally when we perform an action and when we witness someone else performing the same action (Rizzolatti et al., 2007). However, we believe that being empathic also requires a therapist to actively suspend their own frame of reference in order to step into their client's. It is an 'as if' experience whereby the therapist experiences what it is like to be sitting opposite herself in the self of the client, absorbing herself in the other's phenomenological reality while retaining enough of herself to therapeutically process and respond to that reality. This involves a simultaneous attunement and objectivity.

In order for the therapist to feel empathic she must be coming from a position of goodwill towards the self of the client. Where this is lacking, empathy is unlikely. To promote effective change, the client needs to experience this benevolent goodwill tangibly from the therapist. But how is empathy shown? We have explored our own experience as practitioners and clients and think that an important channel of empathy is eye contact. Perhaps this is a reflection of the empathic mirroring through the eyes between a baby and mother or primary caretaker. For this same reason, non-verbal responses are also felt as deeply empathic. Sometimes an attunement at the feeling level which is then translated into words can feel enormously empathic.

Adele describes an horrific incident in her childhood where her mother viciously beat her with a stick for some minor misdemeanour.

Adele says 'Do you know, besides the pain, one of the worst moments for me was seeing our neighbour look through the window and then just hurry away.'

The therapist gazes at Adele and shakes her head to show she feels the depth of Adele's distress, 'You were totally abandoned to your mother's madness.'

Adele cries deeply.

A last word on empathy: we are persuaded by the thoughts of Silberschatz (2007) who asserts that empathy cannot be uni-directional. In other words, for the client to feel the therapist's empathy he must be, in a sense, empathic with the therapist; and indeed for the therapist to feel empathic, she must feel met by the client's empathy. Suddenly the relational nature of the encounter becomes key.

Facilitating awareness and developing insight

No matter how warmly the client feels met and understood, she will not necessarily be able to take charge of her own life without insight: 'the capacity of understanding hidden truths etc., especially of character or situations' (*Oxford Encyclopaedic English Dictionary*, OUP, 1991). In the process of therapy the client will be facilitated towards gaining insights into their situation and experience. There are many levels of insight but often even simple insights will have been missed by the client because of their distress and anxiety. Other insights may involve perspectives on the unconscious or on intrapsychic dynamics including deeply held assumptions and self-limiting thoughts.

Gaining insight and understandings of our situations, pleasant and unpleasant, may occur through several means. Many of these insights will emerge in the very act of being listened to and listening to oneself without any further intervention from the therapist. Simply providing the space or the one-way focus allows the client to identify patterns, underlying dynamics and habitual tendencies. The therapist may assist in the process of gaining insight by giving the client information through the techniques of specification, interpretation, explanation, illustration, and so on. Gaining insight empowers the client through widening the perspective of a situation or experience such that their choices are expanded.

Rosemary presents at her therapy session with anxiety about the possibility that she has contracted a venereal disease. As she yet again expresses her fears and fantasies, she hears herself caught in a cycle of negativity and worry. She brightens and tells her therapist, 'This worrying is unhelpful. I could sit here forever and never get to know the facts.'

The therapist nods empathically and adds, 'Or then deal with the facts.'

Later in the session the counsellor asks Rosemary how she could have her health situation verified. She states that she needs to have herself checked out but then becomes concerned about confidentiality. The counsellor helps Rosemary to see that she is again caught up with giving energy to worrying rather than exploring possible solutions.

Staying 'creatively indifferent'

The term 'creative indifference' comes from gestalt therapy (Perls, 1972/1951). It means holding an attitude of involvement and engagement without being invested in any particular outcome. Bion (1959) Wurged that we should be without memory

and without desire in order to genuinely meet our clients and their experiences. Similarly, Winnicott advises that 'cure' is not something the therapist does to the patient but rather that cure 'at its root means care'. He maintains that the therapist must have 'the capacity … to contain the conflicts of the patient, that is to say to contain them and to wait for their resolution in the patient instead of anxiously looking round for a cure' (1970: 2).

While the therapist has an intrinsic belief in the healing process of psychotherapy it is vital that she has no personal agenda about the changes that could be made, otherwise she may find ways of pushing or controlling the client to move in a certain direction. She may feel impelled to make her client feel better rather than inspired towards health. This may at times be very difficult for the therapist. It can be very unsettling to sit and witness another's distress without instantly intervening to alleviate the pain. However, one of the major ways in which pain is relieved is through its sheer expression and any intervention to prevent it may merely repress and exacerbate the client's distress in the long term. Equally, intervening with solutions or comfort, while tempting, may be disempowering of the client's own potential for growth and change.

This is not to say that the therapist does not have a professional investment in assisting the client to change. It means that within the crucible of benevolent goodwill and the suspension of personal investment, the therapist brings to bear her knowledge, skills and experience in the service of the client. A sense of treatment direction, for example, is an important component of the therapy situation, but it necessitates bracketing off any countertransferential issues the therapist may have concerning taking that direction. The treatment direction is a guide for both therapist and client. It is not a blueprint that the client must follow. If the therapist is heavily invested in the success of a particular direction or intervention, the outcome will most likely be counterproductive.

David arrives at his weekly therapy session and immediately launches into his problems in a tense, frustrated voice. 'I've had the most terrible nightmares this week and I've hardly slept at all. It's been such a bad time. I'm so angry. Mary and I had a row about the kids and my boss at work was bloody critical of my performance. The kids being ill hasn't helped and when my mother said she was coming down for the week-end … '

The therapist makes a gesture with her hands to suggest the large number of issues in the air.

David acknowledges her gesture, 'Yes, there's just so damn much – please help me. Where on earth shall I start?'

'There is a lot happening,' replies the therapist.

'It all feels out of control,' says David. 'I'm angry at feeling this way.'

'It sounds like your anger is uppermost right now,' the therapist observes.

'Yes, I think my nightmares have been angry ... '

Creating a quality of relationship which may have been lacking in the past

In the movement and development towards adulthood, people live through a variety of experiences of different relationships, with many positive and negative aspects

to them. Where these were insufficient for the task of growing up and embracing adulthood with responsibility, reality and spontaneity, therapy may offer the opportunity to address and redress these deficits.

Often for the client, being in a relationship with a person who listens non-judgementally will help to resolve unsatisfactory aspects of relationships from the past. The seemingly simple experience of being met in the here and now by another person who is able to attend to past, present and future relationship concerns with acceptance and empathy can facilitate the healing of hurts and confusions that may still be manifesting in the present. This is the reparative relationship described among others by Kohut (1971, 1984), Schiff et al. (1975), Clarkson (1990) and Hargaden and Sills (2002), the importance of which is supported by neurobiological discoveries into how the brain develops in relationships.

For one of our clients it was therapeutically healing simply that the therapist was sitting ready and waiting for her when she arrived for her sessions. Her experience when younger was that of a 'latch-key' child who would have to let herself in to her empty home after school and wait for her parents to come home later. She rarely experienced being welcomed or acknowledged by her parents who were too full of their days' events to give her attention even when they did arrive home. She told the therapist how important and reparative her new experience was in seeing herself as worthy of being acknowledged and greeted on arrival.

Being a model

Effective therapists will have, for the most part, spent time and energy not only in their training, but also in exploring themselves within their personal therapy. It is to be hoped that this process of self-development will lead to a person becoming congruent (namely not hiding behind a front or adaptation) so that what the client perceives in their therapist is a person whose inner experience or state of being is matched by her outward manner.

Where such congruence in openness and relating is not present, the client is likely to feel uneasy with the therapist. The building of trust – so essential for the therapeutic relationship to be effective – will be lacking. Part of congruence is the therapist's own faith in the process of counselling or psychotherapy which will be communicated to the client through their attitude during times of struggle, sticking points, pain and despair, as well as during times of well-being and progress within the work together. Part of what the therapist models at these times might be at an unconscious level of relating – the capacity to manage and metabolise difficult and confusing feelings. Congruence is not, of course, the same as unreserved communication. A therapist may choose to disclose none of her thoughts and feelings yet still convey congruence.

We do not mean that counsellors and psychotherapists are supposed to be perfect examples of what it is to be human. They too are dealing with the vicissitudes of life. They get ill. They have problems. They have bad days and good days. They make mistakes. While it is necessary for therapists to bracket off their own concerns so that

they do not intrude into the therapeutic work, an honest and genuine recognition and ownership of aspects of the therapists' experiences, especially their countertransference when influenced by outside factors, are vital parts of congruence within the relationship. Mistakes or enactments of transferential binds, if acknowledged and explored by the therapist and client, can often prove to be turning points within the relationship when examined honestly and openly as part of the ongoing therapeutic journey. Such honesty models the ability to be in the here and now in the presence of the client without agitation over the client's or their own concerns within or outside the consulting room.

Roddy, the client, is holding back his tears as he tells the therapist of the death of his father when he was a child. The therapist experiences a sudden feeling of powerlessness which momentarily diverts his attention from the client. He imagines this is what the client is feeling as he tells his story but is also aware that this sense of powerlessness is part of his own past experience.

The client, somewhat angrily, says. 'Are you listening to me! Perhaps, you don't understand what it was like for me to watch my father dying.'

The therapist says, 'I'm sorry, Roddy. I was hearing what you were saying but, you're right, I was not giving you my complete attention just then. I was reminded of my own father's death and I felt the powerlessness I experienced then.'

Roddy, now crying freely, says, 'So you do know what it was like for me.'

Normalizing the client's experience

Often when people come into therapy they are immersed in self-definitions. They perceive themselves as 'wrong' or 'bad' or negatively unique in some aspects. This grandiosity flies in the face of self-acceptance and holds them back from the liberation they seek. While respecting the client's feelings and self-perception, the therapist will find ways of helping the client to see himself more tolerantly and to accept that to be human is to be fallible. It is a balance of acknowledging the client's own uniqueness within the universal experience of being human. This does not mean to say that attention, credence and empathy are not given to the very personal aspects of the situation that the client may be experiencing but at the same time a widening of perspective expands the possibility of change. As noted earlier, Yalom (1975) cites this aspect of universality of problems as one of his 12 'curative factors'.

Feelings also may require normalizing for the client. Sometimes people will feel 'bad' or 'guilty' simply for having a feeling. They will see themselves as having some weakness that should be expunged. An aspect of supportive therapy is the normalizing of human feelings and the natural, physiological expression that they require in everyone. Sometimes, the normalizing of an emotion may be instrumental in transforming that emotion within the client. For example, an anxious client was helped to see that the experience of anxiety might have another perspective when his therapist quoted Kierkegaard's (1980) assertion that 'anxiety is the giddiness of freedom'. For the client this held a sense of shared humanity and the transformation of anxiety into the excitement of uncertainty.

Challenging and confronting

Once there is a real working relationship between the therapist and client, the therapist can creatively challenge and confront the client without fear of damaging that therapeutic alliance. Confrontation has many manifestations. It can mean drawing attention to those aspects of the client's behaviour, thinking or feeling which may be self-restricting or even damaging. These confrontations or challenges need to be experienced as beneficial interventions into the process rather than as an attack upon the person.

Wendy, while exploring with her therapist her ability to be over-controlled, laughs as she recounts how the previous evening she was even controlled enough to drive home while well over the legally permitted alcohol limit. The therapist points out that driving home while drunk lacks a protective control of herself as well as others. The client argues for a while that she had been perfectly safe but soon recognizes that the therapist is making an important confronation. Through acceptance of the challenge she makes the connection between her own potentially destructive behaviour and that of the alcoholic father at whose hands she suffered.

Another definition of confrontation (Berne, 1966) states that it involves pointing out inconsistencies between different client statements. For example, the therapist could comment, 'You say you are evil, yet you are also worrying about harming your friends in your contact with them. Would a really evil person care about something like that?' We like Egan's (1990) suggestion that confrontation can be seen as an invitation to become aware. This is an acknowledgement that any new awareness constitutes a challenge to a person's frame of reference. Thus, a simple reflection such as, 'Your colour changed as you said that' or 'I'm struck by your use of the word "horrific"' can invite an awareness of a person's half-conscious feelings or assumptions. Or a question such as 'Have you asked your boyfriend what his Hindu culture teaches about your Jewishness?' can open up avenues of exploration.

Even in psychotherapy styles in which the therapist remains mostly silent, we believe that clients become aware of the minutest movements and breathing patterns of their therapist and can feel confronted within that context as well.

Making space for self-reflection

For many people whose lives are busy and structured into activities of one kind and another like work, family, classes, chores, and so on, the weekly counselling sessions provide a rare time and space for self-reflection. While there may be the need to work on the issue of finding more time for themselves, it is clear that for many clients this is their first real experience of valuing the importance of giving time to themselves.

Many clients make remarks like 'This is the only time I have to sit down and be with myself in the whole week' or 'I was so relieved it was Wednesday. I'd saved things up during the week for this island of time which is mine.'

Space for self-reflection is essential to allow pre- or non-verbal experiences and feelings to emerge into the realm of the conscious where they can be expressed,

recognized and named. In a longer counselling or psychotherapy relationship, it is not just the session of an hour or 50 minutes, it is also the ongoing consistency and continuity of relationship, space and time which clients can value and use effectively. Within the 50 minutes, the therapist holds in mind the life experience of the client and is able to weave threads of continuity through their past, present and future. For example, the client may be presenting a current issue within the session and while he does this, the therapist holds in her awareness the context of this in his past and also potentially in his future. She may feel that drawing attention to these other related aspects of the client's life would help the client get a more integrated perspective of his current situation.

Jack talks about giving up his job and working his way through Africa. His therapist, at some later point, asks him to consider how he has given up his job on previous occasions, with exciting prospects in mind, and has each time ended up disillusioned. She invites him to explore his current thinking in light of these past experiences to find ways of making a decision from which a more positive outcome is likely.

Another aspect of consistency in therapy is the consistency of the environment. Therapy usually takes place each time in the same space and, where possible, in a space where the surroundings remain approximately the same week after week and where privacy is assured. This means that the client's attention is not distracted, for instance, by a stimulus from the environment, but that their energy can be used to examine their own world rather than that of some changing panoply. It is also an important part of the safe container (Winnicott, 1965) which allows a person to explore the unknown parts of self. This also applies to the therapist's overall approach to her work. Her style here will become familiar to the client such that the client can work within a sufficiently predictable relationship which is safe enough to make explorations and take risks. (We expand further on this sense of safety later.) Some forms of therapy are far more predictable than others. Although structure is important for safe containment, it is also important not to sacrifice flexibility and creativity in its formation. Neither, of course, should the therapist restrict her growth and development as a practitioner. A balancing point must be found between an excessive rigidity of structure and the chaos of total freedom – the area of 'bounded instability' (Critchley, 1997) which contains the possibility of change.

In relation to consistency, practitioners need to give consideration to such issues as giving advance notice of breaks, arranging locums if appropriate, and so on.

Creating the opportunity to practise new behaviour

Effective therapy ensures that the client learns to bridge their learning within the therapy room to take this into their everyday lives. The therapist can make interventions which will assist in the process of their clients' learning to generalize their specific insights. Some practitioners, especially those who work with groups, will encourage active roleplay practice in sessions. In any case, through the articulation of different options, a client can introduce herself to new possibilities. Some forms of therapy actively encourage this process with 'homework' assignments or contracts,

while others support it through their ongoing attention to the 'reporting back' that clients often do prior to concentrating on a specific area of work or interest.

Joe makes a commitment to telephone at least two people in the course of the following week as part of his work on wanting to increase his social skills. After 'reporting back' his success in this task and receiving confirmation and encouragement from his therapist, the next step is discussed and it is agreed that he will invite these people round for a meal.

Managing the transference and countertransference dynamic

Transference is the process whereby the client repeats and reconstructs within their relationship with the therapist the very dynamics of the problems which they are bringing to the therapy. It is part of the counsellor's responsibility to recognize, understand and creatively work through the ways in which the client is, albeit unconsciously, evoking this parallel situation and to own and work with their (the therapist's) part in the co-creation of this dynamic. Countertransference is the therapist's response to this process – either because she is captured in the transference dynamic or from some vulnerability of her own – or both. We will expand upon transference and countertransference dynamics in Chapter 7.

Lucy usually arrives late for her sessions. She spends several minutes at the beginning of each session apologizing and listing the many reasons for her lateness and leaves expressing dissatisfaction that she hasn't dealt with what she was wanting to work on in her therapy. How the therapist chooses to respond to this situation will vary according to his/her chosen approach. One therapist may share her observation that Lucy seems to be re-enacting with her how there was never enough time in Lucy's family of origin for the youngest child – namely, Lucy. With that insight Lucy may see how she is depriving herself and repeating that childhood experience. Another therapist might work within the transference either at an early stage by exploring Lucy's anxious apologies or later on when an empathic response to her angry dissatisfaction leads to the expression of her deep pain and rage. And so on.

Sharing humour

Having access to humour is a vital part of being human. We need it to express our joy and excitement as well as to acknowledge and come to terms with the absurdity of life. Handled with care, humour can be a vehicle for insight, an affirmation of the working alliance, a true moment of meeting in the person-to-person relationship or a gentle means of confrontation. Handled clumsily, it can be humiliating, shaming, reinforcing of negative beliefs (as in 'gallows' laughter), confusing or patronizing. The important difference between these ways of handling humour is in the mutuality of the experience. Even when used as a gentle confrontation, the humour must be shared as an illumination and not at the expense of the client. We believe that

humour can also provide a sort of 'third position' where therapist and client can have a moment of meeting and simultaneously change their frame of reference in an enjoyable way.

Not only are humour and laughter emotionally freeing and relationally bonding, they also have the effect of sharpening the mind to think more flexibly and with more complexity. A (1991) study by Isen et al. demonstrated the enhanced and more creative problem-solving skills of a group who previously had been shown a humorous video as compared to those who had watched a maths film or had been exercising.

This is not to suggest that therapists become stage comedians with their clients or introduce jokes into the sessions in order to 'cheer them up' from their depression. In many instances, humour would obviously be inappropriate and an avoidance of serious concerns. This said, however, humour has a place in psychotherapy when the intent is clearly of therapeutic value and insight for the client and part of a secure and developed working alliance.

A client who suffered from endometriosis thought of herself as 'making a fuss' if she mentioned it. When talking of a situation with her friend, Demitrios, she inadvertently refers to him as 'Endometrios'. Catching the therapist's smile, she realized what she has said and burst into laughter. 'I don't suppose he'd be flattered to be called that! But I suppose it's a sign that I do want to talk about it.'

Checking the match of therapist and client

Even when all the above qualities and conditions are present, there can still arise the question of why sometimes a therapy does not work for a particular client with a particular therapist. This may not be anything to do with the competence of the therapist or the particular problems of the client. Sometimes the chemistry between two people, in this case client and therapist, jars to such an extent that it interferes with the therapy process. Hopefully, this mismatch will be discovered in early sessions so that the client may be referred on with no ill-feeling from either party. Whereas people will have had no choice about the temperamental matching of themselves and their parents, for a healing therapeutic experience this is not only possible but might also be essential.

Research in the area of matching has considered, for example, such variables as gender, language, introversion/extroversion and race. Garfield (1986) considers compatibility in terms of background, class, education and values. A review by Beutler et al. (1986) of research findings on variables affecting the process and outcomes of counselling and psychotherapy points to the beneficial significance of cultural similarity and attitudinal difference. However, recent research by Kim et al. (2005) indicates that the matching of a shared world view plays a more important part than ethnicity. A trawl of the literature reveals hundreds of references to 'goodness-of-fit' studies and with a few exceptions, they tend to refer to the client's perception of the chemistry between client and therapist. Mostly, studies tend to emphasize the working alliance – with client factors and therapist factors both being analysed (e.g. Elvins and Green, 2008; Kramer et al., 2008; Saketopoulou,

1999; Silberschatz, 2007). A useful overview of these therapist and client variables can be found in Cooper (2008).

Matching according to personality is difficult to assess. Garfield writes:

> Rather than a strict matching process, what actually occurs is a selection or acceptance process. Ideally, therapists should select patients for therapy whom they feel they can help. This should be the only criterion … therapists should try to be as honest and forthright as possible in their appraisal of the patient and should not let other considerations, such as economic factors, pride, and egotism, influence their judgment … if the therapist experiences feelings of anxiety, fear, hostility or heightened sexual arousal toward the client, a referral elsewhere should be made'. (Garfield, 1986: 142)

For the person in the more vulnerable, often distressed and sometimes uninformed position of being the client, such considerations are more difficult. However, it is good practice in the initial interview to make it clear that any assessment is mutual and that the decision to work together needs to be made by both client and therapist. Many directories, leaflets and booklets aimed at helping people to find a therapist suggest they 'shop around' for some one whom they feel is most likely to work well. For some, this will be the therapist with whom they feel most comfortable. For others, it will be the one who makes them feel most challenged. For others, compatibility of age (older, younger, the same), personality or even regional accent may be the important factors. Whatever these are, more effective therapy is likely to take place if the client is an active and informed participant in the selection process.

GENERIC ELEMENTS AND THEIR EMPHASIS

Differing integrative approaches will emphasize different aspects of this list. It is likely that a therapist whose bias is psychodynamic would place more emphasis on the gaining of insight than on some of the other elements mentioned. A more fundamentally person-centred therapist might place empathy at the top of their list while a therapist whose strength is behavioural might choose to emphasize modelling and the practising of skills. However, though there may be different emphases given by differing therapists, we believe that versions of these elements are common to all integrative approaches. It is this commonality of elements in the process of counselling and psychotherapy which gives rise to the feasibility of integration across and between the different schools. Of course, the content, conceptualization and theoretical construction of the therapies may vary, but these identifiable, common (and perhaps essential) elements allow for co-operation, understanding and discussion between schools and can lead to the possibility of integration not only in terms of these elements but also in terms of the variety of theories from which they have evolved.