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Dear Reader

Welcome to the second edition of The Family Institute Review – it seems to have been a longer time coming than we had hoped. Now that it has we believe you will enjoy it. The first review has generated interest and enthusiasm among those of you who have read it and highlights for us the important work which students do as part of their training.

The work submitted for this edition bears the names of those who wrote them but as they themselves will tell you – their papers reflect at different levels the exploratory conversations, private reflections and more public debates and discussions within the Institute and wider field. There is a certain kind of intimate camaraderie at work in these pieces.

We are interested in developing communities of practice with our students, clients and associates. As such we are always on the look-out for ways to facilitate and participate in useful conversations which attend to the many different ways of approaching problems with living. We hope that The Family Institute 'Dysgu' Review is one way of stimulating thinking and discussion between those of us interested in the whole ecology of therapeutic ideas.
Finally we dedicate this issue to the memory of Michael White who died suddenly in early April. His contribution to the field has been immense .He will be sadly missed.

Kieran Vivian-Byrne
Billy Hardy

A critical evaluation of the existential-phenomenological approach as a preferred model of psychotherapy and counselling

Siobhan Marie Scullion

Siobhan has worked as a refuge support worker for Pontypridd Women's Aid for over twenty years. In addition she has volunteered with CRUSE Bereavement Care since February 2006. She is currently studying in her final year BSc Counselling here at the Family Institute.

This paper will critically evaluate the existential-phenomenological model of counselling as described by Ernesto Spinelli as a preferred model of counselling. It will look at the context of the development of existential approach bringing in an explanation of my own predilection for this approach. The approach is rooted within an existential-philosophical framework, the paper therefore will look at the themes of being, and choice and anxiety as these are particularly significant to this model. The paper will examine how the existential-phenomenological model of self construct contributed to my preference of this model. I will then look at the therapeutic relationship and process. I will also examine some of the limitations of the model.

The Existential approach was developed in Europe by a disparate group of thinkers who where reacting against the prevalent orthodoxies of western thought. The study of human consciousness was informed by the mind-body dualism underpinning the scientific model based on the thoughts of Descartes (1596-1650). Existential thinkers such as Kierkegaard (1813-1855) and Husserl (1859-1938) argued that to understand human beings fully we needed to understand the meaning they gave to their lived experience. May (1983) suggests that the rise of existentialism during the Victorian period in Europe was reflective of the culture in crisis. "*On the surface the Victorian period appeared placid, contented, ordered; but this placidity was purchased at the price of widespread, profound, and increasing brittle repression.*" (pp. 64). That in crisis there was the potential to strip away old dogmas and find new truth. May suggests that this can happen both for the individual in therapy but also for a culture in a period of transition. The work of Biswanger, Boss and Frankl developed a philosophical model, concentrating on the crisis and anxieties of being and non being. They called their approach 'Daseinsanalyse', based on the work of Martin Heidegger. May and Yalom were prominent in popularising existentialism in America in the 1950's, its development was parallel to the development of humanist psychology, the 'third force'.

The British School

The development of the British school from the mid 1960's was influenced by Husserl's phenomenological method. Working in a descriptive way and rejecting a medical pathologising model of mental health, the work of Laing and Cooper critically reconsidered established ideas about mental health. Emily Van Deurzen was concerned with helping client's cope with the difficulties of living and had a profoundly philosophical approach.

It is the work of Ernesto Spinelli that I have chosen to concentrate on. Ernesto Spinelli influenced by social constructionist Kenneth Gergen, challenged established assumptions and can initially seem very critical of other therapeutic approaches. However I believe it is more to shake therapists out of their possible complacency rather than to deny the valuable knowledge they have.

My own professional development had previously been more sympathetic to phenomenology perspectives. I feel that the behaviourism and psychoanalysis have lost something of the whole person in their theories of the person. On a personal level I also tend to be sceptical of theories that have an

inbuilt tautology. Therefore, a way of working that focuses on trying to understand the client's way of understanding the world rather than superimposing a theoretical framework on the client suits me. Therefore it is the aspect of encountering people as they are and as they exist now that has made looking to an existential- phenomenological approach appealing to me.

Existential philosophy is a very broad school of thought with often divergent ideas but their common subject matter is human existence. There are basic themes of existential thought that inform existential psychotherapy, some of these are 'being', 'freedom/choice' and 'anxiety'.

The term 'Dasein' or 'being there' was a term used by Heidegger and Binswanger to encompass human existence as in the moment and self conscious. The existential concepts of 'Being-in-the-world' and 'being-with-others', root existence in the totality of human consciousness, the physical world and in relation to other. The impact of society on the individual and also then how the individual relates to society indicates that the human being is socially constructed. *"It proposes that each of our existences is fundamentally and primordially intertwined with the existences of others"* (P.19 Copper 2003). The existential-phenomenological model is about clarification with the client their way of being in the world, with the anxieties and difficulties that invokes rather than about symptom removal.

Not only is the person a 'being in itself' but also a 'being for itself', in that we are responsible for our own choices. The existential approach argues that humans are free to make their own choices; in fact we are destined to do so. This is not an argument that we are free to do anything we desire. Existentialism recognises the limitations of existence, such as death, suffering, or those situations that are not of one's making, what Heidegger referred to as 'thrownness'. However we are free to choose how we face or respond to these limitations. *"...we are not 'free to choose what we want' but, rather, free to choose how to respond to the 'stimuli' of the world"* (p. 296 Spinelli 1994).

Phenomenology

Existential-phenomenological thinking places anxiety at the centre of existence. May (1983) relates anxiety to the self-consciousness of threat to being which ranges from the everyday threat to our being, to the ultimate threat to non-being or death. *"Anxiety is the state of the human being in the struggle against what would destroy his being."* (p. 33 May)
In that making everyday decisions we have to make choices that affirm our own being, to be 'authentic', or deny it. Sartre called this 'bad faith' or being 'inauthentic'. In understanding and accepting, we can and do, make choices. We are responsible for ourselves alone and we can learn to be authentic. The existential perspective suggests that the awareness of our sole responsibility for our choices creates anxiety or 'Angst'. From an existential perspective we have nothing solid to base these choices on, other than what we have created ourselves. This sense of ultimate meaningless creates a sense of anxiety.
Existential-phenomenological perspective suggests that we create a way of being in the world that protects ourselves from awareness or facing our anxiety. The approach doesn't seek a cure for anxiety producing behaviour but helps the client understand its meaning in the context of their lives.

The Existential-phenomenological model doubts the theory of the self as a fixed or stable concept. Rather thinks of it as something that is more a product of our experience, where we construct and reconstruct our perceptions of past events informing how we want to see ourselves going into the future. Spinelli suggests 'self construct' is a more useful term. The concept of 'Beings in the world' views self in terms of the person's lived experience and our reflection, consciousness and awareness of it informs how we exist in the world with others. We are not individuals in a bubble; rather we live

in a society. Therefore, our sense of self is informed by the culture around us. The construction of self-in-relation is in relation to 'other'. Self as portrayed by Spinelli is impermanent. We reconstruct our perspective of the past often differently each time we review it. Spinelli (1994) talks about how particularly strong beliefs about self, contribute to the self construct or 'sedimented beliefs'. Spinelli talks of the splitting or disowning of aspects challenging sedimented beliefs within the self construct. This he argues is a conscious denial borne out of inner dissonance rather than the unconscious of psychoanalysis. Neither is it the split between ideal and false selves of Person Centred counselling. It is this state of uncertainty that creates states of anxiety. In therapy the client will be divided as to whether they want to change. Any change will not only impact on them but on their relational selves. He draws attention to the impact and the responsibility the therapist has to be invitational in working with sedimented beliefs. I'm most aware of this in working with women who have experience domestic abuse. When a woman begins to rethink who and how she is as a partner, it then also has a ripple effect to future partners, to how she is as a mother, daughter, and colleague.

My beliefs.

A socially constructed self is more consistent with my beliefs and feelings about gender, influenced by the writing of Simone De Beauvoir. "One is not born but becomes a woman" (De Beauvoir p.297) recognising and accepting the basis of De Beauvoir's arguments for the social construction of femininity, I have followed this through into considering the 'self' as a social construct. This is not in the sense that society shapes us but it frames the environment we relate to, which we become conscious of, reflect on and react to.

I have completed most of my prior training within the Person Centred model and found it a 'best fit' but remained ill at ease with the concept of the 'ideal self'. I find the concepts of 'conditions of worth' and the 'self concept', as outlined by Rogers in 'On becoming a Person' (1961) useful. However I remain sceptical about Rogers's concept of the "ideal self" and the underlying belief that 'man' is basically positive. …*"when he is most fully man…then his behaviour is constructive"* (Rogers, 1957 p. 105). I feel it's inherently value laden to hold up the positive and constructive parts of 'man' as representing the "ideal self" and the negative or destructive parts of 'man' as essentially dysfunctional. Rogers does in fact talk about man needing to be aware of all parts of him-self to function fully, so I query the value of the 'ideal self'. I feel this aspect of person centred theory creates a value judgment at the very heart of the model.

My concern is that the pre-judgement that I feel that is inherent in the model cannot fail but to infiltrate the aspect of the therapist's view of the client. However with an existential-phenomenological perspective of a socially constructed self, the meaning comes from the lived experience of the client. The role of the therapist is to explore in the meaning attributed by the client. I feel this can only impact on the quality of the therapeutic relationship, as the less judgement felt, the fewer barriers to engaging there will be.

Not Knowing

In 'Tales of Unknowing', Ernesto Spinelli describes therapy as the *"act of revealing and reassessing the 'life stories' that clients tell themselves in order to establish, or maintain meaning in their lives"* (p1 Spinelli). The role of the therapist is to facilitate that process through the development of the therapeutic relationship. Spinelli (1994) argues that it is the 'encounter' between client and therapist that is central. From an existential-phenomenological perspective, the therapeutic relationship isn't something that is done to client but is co-created between therapist and client. Through the therapist-client relationship, the meaning and significance of the client's other relationships can be explored. Spinelli (1994) suggests that how the client is within the therapeutic relationship may be how they are in other relationships and the meaning of this for the client can be explored. For example:

When Penny repeatedly changed subject away from the bereavement when it got painful, I observed she was doing it and she said always did with her friends she found it hard to open up and let her people see her break down.

The aim of the therapist is to attempt to immerse themselves in the self of the other (the client). It is through Husserl's phenomenological method of 'bracketing' one's own ideas, assumptions and prejudices can one hear a description of the client's experience from the 'first person' point of view. Spinelli (1994) acknowledges this is an imperfect process. He likens the therapist putting themselves in the world of the client to a method actor taking on a part. Only then can the therapist attempt to experience the client's world view. Spinelli stresses this can only be an aspiration rather than something the therapist can fully achieve. It is only by doing this that the therapist can truly attempt to reflect and respond from the client's way of being.
However Spinelli stresses that the therapist must be aware that their own sedimented self construct could compromise their ability to enter the client's world.

It is this very immersion in the client's world that from a psychoanalytic model would prevent the therapist from being able to be objective and see what the client doesn't and interpret the information. A psychoanalyst would need to have some separation when interpreting transference relationships. From my own perspective, therapy needs to fit life as it is experienced by the client, not the theory world of the therapist. I feel it is the role of the therapist to get as close to the client's world as we can without our own theories getting in the way.

Spinelli (1994) suggests the focus of the therapist should be on being fully with and being for, the client rather doing. The skills and knowledge of the therapist, while of value, should not predominate in a mechanistic way. Spinelli discusses the listening skills outlined in Egan's "The skilled Helper" suggesting that skills applied without 'being' still doesn't allow the therapist to truly hear the client. However, I believe what Egan's model does is provide is a coherent examination of what listening looks and feels like to a novice therapist, which is absent from Spinelli's critique.
The therapist role is not to confirm or repudiate the client's subjective truth, but to acknowledge and stay with the client in order to explore it further. Spinelli (1994) argues that it should not be the therapist role to be a truth-bringer or healer in any directive manner as this would undermine hearing the client's story. The therapist mindset of how they will 'fix' the client gets in the way of hearing what the client is saying.
What is most powerful for me in the existential-phenomenological model of the therapeutic relationship is the emphasis on the client's meaning in their lives. As a way of working I feel it tries to retain the power and control for the therapeutic process with the client. When I read Spinelli (1997) I felt a resonance with how I try to work. In 'Tales of Unknowing' Spinelli demonstrates how the rush to address the symptoms of Edwin Jones, (a case history), would have pre-empted his own coming to understand of the meaning of his lived experience. It could also have diverted Edwin's attention from ever making that connection with his own way of being. What struck me is the strength of conviction it took in the face of pain to trust in the process and not ease the pain in the here and now.

> An example of a client recognising her capacity for choice and find her own meaning was work I did with a client I shall call Wendy. Wendy and her children were experiencing domestic abuse. Initially Wendy felt she had no choice and felt totally vulnerable. Clarifying what having no choice meant for her, Wendy not only focused in on the limited options available to her at the time but also on where she had actively made choices. Wendy began to see the situation in a different way and while it was still very distressing she felt less powerless.

There is a difference in emphasis between Spinelli and Van Deurzen. The existential approach of Van Duerzen although also focussing on the client's understanding of their being suggests that the existential practitioner *"functions as a mentor in the art of living."* (Van Deurzen 2002 p. 25) The

work of Van Deurzen will focus on helping the individual face up to the challenges of everyday life. From the existential perspective of Van Deurzen, Spinelli could be seen to be less philosophically inclined and more reflective of elements of Rogers.

POWER

Power is a central theme for Spinelli, who criticised other approaches for not recognising the power relations inherent in the therapeutic relationship. In 'Demystifying Therapy' Spinelli discusses how he felt that the humanistic approach in its elevation of the 'ideal self' risked colluding in supporting 'superior' type behaviour in clients, trainees and therapists. For me, I was always trying to square a circle within person centred counselling which had a philosophy of being non judgemental and also having a core principal that assumes that human nature, given the right circumstances, will change towards positive growth and will self actualise. I've always been uncomfortable with the concept that if people make alternative choices, it's not that they just made different choices but they have also done something that was other than what should have been. The existential-phenomenological approach presented a client-therapist model where power differential was addressed and there was an active commitment of both parties.

The centrality of the therapeutic relationship to the counselling process within the existential-phenomenological model appeared initially to reflect the role of the therapeutic relationship within the humanistic approach in particular the Person Centred Model as described by Rogers. Person centred counselling as a therapeutic method I was familiar with, and was sympathetic to. However Spinelli highlights the risks in person centred counselling of the conditionality set in the assumption of the 'innate goodness of man', undermining the assumed unconditionally of the core conditions. Spinelli argues that if this core belief is held by the therapist, it may be felt as a judgement by the client. In the 'Discovery of Being' May was concerned that the philosophy of engendering therapeutic change by a relationship based on accepting love and affection may result in passivity in the client. *"common error in many circles of assuming that the experience of one's own being will be discovered automatically if only one is accepted by somebody else."* May (1983)

Limitations

A limitation for this approach may be its accessibility to clients in crisis and who may be living a chaotic lifestyle but are very distressed and are asking for something to change quickly. In 'Tales of Un-Knowing' Ernesto Spinelli said he would usually see a client for approximately two years. It requires a level of stability and financial commitment to maintain a therapeutic relationship for that long. The existential-phenomenological model doesn't focus on symptom removal but if the client is struggling with difficulties with issues of, for example substance use, or a mental health crisis., it may be that these real life crisis situations need to be addressed by other methods to enable this therapy to be successful? It is questionable how many clients can afford to pay for two years of therapy. While Spinelli addresses power within the therapeutic relationship, surely the length of the therapy process, cost, and accessibility is a basic issue for the analysis of power differential.

Existential therapy has the risk of appearing an intellectual approach, being more appealing to clients who want to focus on meaning rather than feelings. The influences of Phenomenology on the existential-phenomenological approach addresses this, possibly leaving it open to the charge of being less intellectually rigorous as the existential approach of for example Van Deurzen (Cooper 2003).

CONCLUSION

In this essay I have explored the concepts of the self and the therapeutic relationship within the existential-phenomenological model of counselling and how these fit my own philosophical and pragmatic perspective. In establishing a preferred model for counselling, it is important for me to be

client focussed. I have demonstrated the significance within the existential-phenomenological model of the client's own meaning, (although within a socially constructed framework) while also indicating where other models have differed in their approach. The approach may have limitations in the accessibility to clients in crisis and in terms of philosophical rigour. For those clients that the approach is suitable for, the existential-phenomenological approach provides a consistency in its philosophical position that is evidenced in its therapeutic approach. From its focus on 'being-in-the-world' to a commitment to client led decision making.

References

Cooper, M. (2003) *Existential Therapies*. London, Sage Publications.

De Beauvoir, S. (1983) *The Second Sex.* Harmondsworth Penguin Books Ltd

May R., (1983) *The Discovery of Being*. New York, W.W.Norton, and company

Rogers C. (1951) *Client Centred Therapy.* London, Constable and company

Rogers C. (1967) *On Becoming A Person*. London, Constable and company

Spinelli, E. (1994) *Demystifying Therapy*. London. Constable

Spinelli, E. (1997) *Tales of Unknowing, Therapeutic Encounters from an Existential Perspective,* Ross-On-Wye, PCCS Books

Van Deurzen, E. (2002) *Existential & Psychotherapy in practice,* (2nd edition) London, Sage Publications

Yalom, I. D. (1980) *Existential Psychotherapy*, New York, Basic Books

__Multimodal therapy (MMT) and technical eclecticism: Comparison to other approaches.__

Iliana Sardis

Iliana is currently doing research for people with learning disabilities and their families in the University of Glamorgan. My background is in Clinical and Counselling psychology. I decided to undertake the course because I believe that no man is an island. I am currently studying on the intermediate level course in Family Therapy.

INTRODUCTION

Multimodal therapy (MMT) is a systemic eclectic approach to counselling and psychotherapy. MMT is called multimodal because it has many dimensions when dealing with psychological problems. Arnold Lazarus, the most eloquent proponent of MMT (Norcross & Grencavage, 1989) calls his therapy systemic and *technical* eclecticism (Lazarus, 2000).

According to Lazarus, individuals have multiple dimensions to their personality. All individuals execute the same functions, them be emotional, mental or biological, but in a different way. Because every individual is unique, Lazarus argues, that each individual needs a unique approach in therapy and counselling. Lazarus's toolbox of techniques constitutes only of those techniques proven in research to be effective (Dryden & Mytton, 1999; Lazarus, 1989; Corey, 2001).

MMT is a pragmatic and a-theoretical approach, eclectic in its selection of techniques. This pragmatic approach in therapy constitutes the uniqueness of MMT (O'Connell, 2005, pp.114). A-theoretical translates as actuarial, which means that the therapist digs into empirically proven techniques to choose the ones that work best for every client. MMT does not use standard techniques in therapy. It is driven by the individual's needs and uniqueness (Gurman & Messer, 1995; Lazarus, 2000).

HISTORICAL DEVELOPMENT OF MMT

Lazarus' ideas are innovative, but not new. 2300 years ago, Hippocrates stressed the importance of the multilayered personality and the patient's historical background or anamnesis. Many holistic therapists such as Elliot Dacher (1996) are using Hippocrates's approach nowadays.

The first person that influenced Lazarus was Joseph Wolpe, a behaviourist. The second person was Joshua Bierer, an 'Adlerian'. Lazarus started his career practising psychoanalytic psychotherapy (Dryden & Mytton, 1999). Soon, he came to believe that behavioural methods were more effective than the verbal ones. This conclusion together with his excitement over Wolpe's *systematic desensitisation* method led Lazarus to become a fanatic behaviourist (Phares, 1992; Goldenberg & Goldenberg, 2000; Gurman & Messer, 1995). Lazarus (2000) was the first who coined the terms *behaviour therapy* and *behaviour therapist* in 1958 with the publication of his paper *"New methods in psychotherapy: A case study"* (Dryden & Mytton, 1999). Others support that Ogden Lindsley a student of Skinner (Gurman & Messer, 1995, pp.130) introduced the term.

Albert Bandura's social learning theory had a great influence on Lazarus' pragmatic approach in therapy. Lazarus started questioning the effectiveness of behavioural techniques during the time that he spent in the States with Bandura (Dryden & Mytton, 1999). He noticed that clients who had been cured with only behavioural techniques often relapsed in the future. On the contrary, clients

who had a more positive and optimistic attitude were more likely to maintain the effects of the therapy (Phares, 1992).

Later, influenced by Albert Ellis, Lazarus moved from a strictly unimodal behavioural approach to a bimodal approach in therapy – behavioural (Phares, 1992) and cognitive (Gurman & Messer, 1995; Beck, 1991). Consequently, he was heavily criticised by Wolpe (1984) and other behaviourists of the time (Gurman & Messer, 1995). After this incident, Lazarus (1977) became more sceptical towards therapeutic techniques. Despite the effectiveness of the bimodal approach, some patients were still complaining about symptoms that were neither behavioural nor cognitive, but had to do with other aspects of their existence such as thinking and physiology (Dryden & Mytton, 1999). Then Lazarus concluded that in order to fully comprehend and support his clients he needed to draw on other techniques (Gurman & Messer, 1995; Phares, 1992). Thus, the seven-dimensional BASIC ID approach was born, which according to Lazarus covers all aspects of human personality and can be tailored to the client's needs. The first publication on MMT was in 1973 (Dryden & Mytton, 1999; Gurman & Messer, 1995). According to Lazarus the seven modalities or dimensions of all humans are:

1. **B**ehaviour
2. **A**ffect (feelings)
3. **S**ensation
4. **I**magery
5. **C**ognition (thought)
6. **I**nterpersonal relationships
7. **D**rugs/biology (Herman, 1998)

THEORIES BEHIND MMT

Most influential in Lazarus's way of thinking have been Perry London and Joshua Bierer. London preferred to adopt a more pragmatic approach in therapy that stood somewhere between complexity and simplicity using techniques rather than theories. Bierer planted in Lazarus the idea of *faulty learning* that results in psychological problems. According to Lazarus:

> *Multimodal therapy is an eclectic approach: selecting what has been shown to be effective from many different methods and ideas.....He* [Lazarus] *called the multimodal approach systematic technical eclecticism – systematic because it is characterized by careful method and planning, technical because it is more concerned with techniques than theory* (Dryden & Mytton, 1999, pp.142).

MMT is not a blend of other theories, but rather it has borrowed principles from theories that have been empirically researched (Dryden & Mytton, 1999).

Personality theory

Lazarus believes in the *principle of parity*, which states that all human beings are equal. As Ellis supported, everybody has limitations and assets, an argument that Lazarus embraced in his approach. The seven modalities of the BASIC ID fully describe the human personality. The modalities are described separately. However, their main characteristic is that they interact; a change in one modality will induce changes in the other modalities (Dryden & Mytton, 1999). For a description of BASIC ID modalities look at *APPENDIX 1.*

Social learning theory

According to Bandura, people are using thinking and reasoning in order to learn through imitation and observation (Dryden & Mytton, 1999). Based on Bandura's theory, Lazarus (2002) argues that the process of learning is affected by all seven modalities. Lazarus (nd) believes that during the learning process as described by Bandura (and also earlier by Pavlov, Thorndike, and Skinner) a number of actions can take place, which will then lead to the disruption of the individual's personality.

Systems theory

Systems theory sees society as a system and individuals as part of this system interact with their family, friends, and other people. According to systems theory, a situation can improve only if individuals are looked into as part of the system. On these grounds, MMT will often make use of family and/or group therapy (Dryden & Mytton, 1999; Christensen, 2001; Smith & Southern, 2005).

Communication theory

Communication theory simply states that is impossible not to communicate. Behaviours, verbal or non-verbal, convey a message that affects the listener in different ways. Besides transferring messages, communication affects relationships between individuals (Dryden & Mytton, 1999).

THE THERAPY

All seven modalities have to be addressed for the therapy to be successful and to have long-lasting effect. The techniques need to be decided on in concert with the individual's needs. Lazarus supports the *uniqueness* of each individual. Hence, he stresses that even for the same problem two individuals might need to be cured in a different way. MMT is based on the *principle of individuality* and does not consent to a single approach as true, but instead is driven by the *"goodness of fit"* (Dryden & Mytton, 1999). According to Lazarus, six distinctive features differentiate multimodal approach from all other approaches:

1. *The specific and comprehensive attention given to the entire BASIC ID.*
2. *The use of second-order BASIC ID assessments.*
3. *The use of modality profiles.*
4. *The use of structural profiles.*
5. *Tracking the modality firing order.*
6. *Deliberate bridging procedures to enhance the therapeutic relationship* (Dryden & Mytton, 1999, pp.151).

Multimodal approach is a counselling approach and as such, the main intention is to establish a good therapeutic relationship. Lazarus seeks to answer a number of questions *(13 determinants)* by the end of the first or second meeting. By asking these questions, the multimodal therapist gathers important information about the client and about how this information relates to the seven modalities of the specific individual (Dryden & Mytton, 1999). *(See APPENDIX 2 for a detailed description of all 13 determinants).*

After the assessment, a *modality profile* is built which seeks to address the modality/ies that require urgent intervention and the techniques that will be of use to the particular client. Following the *modality profile*, the *structural profile* is drawn. For that, the client has to rate himself for each of the seven modalities of the BASIC ID. For an example of questions, look at *APPENDIX 3.* The *structural profile* reflects the reality of the client, and after that, a *desired profile* is drawn. That provides clear aim for the therapy and informs the therapist of the approach that is tailored to the client. If the problem persists then a *second-order BASIC ID* needs to be assessed. A good multimodal therapist should know the *firing order of the modalities.* That is, first to treat those, which

come first and are more urgent and then with the ones that are secondary. He also needs to be honest with himself. If a therapist does not feel competent to deal with a certain modality (e.g. prescription of medicines) then he should refer the client to a relevant specialist. Lazarus describes the multimodal therapist as *"authentic chameleon"*. With this term he wants to emphasize the main attribute that a multimodal therapists needs to acquire in order *to bridge the therapeutic relationship*. That is, to be flexible enough to accommodate the therapy according to the client's needs (Lazarus, nd; Dryden & Mytton, 1999).

Techniques

MMT does not use a strict repertoire of therapeutic techniques. Instead, it collects techniques that have been established to be effective and uses only those that seem to fit each client. MMT uses techniques that address all seven modalities. The therapist must be flexible enough to borrow techniques from one modality and to apply them to another. The seven modalities are described separately but they inter-correlate and so do the techniques. The techniques used in MMT are seven: **b**ehavioural, **a**ffect-emotional, **s**ensory, **i**magery, **c**ognitive, **i**nterpersonal relationships, and **d**rugs/biological techniques (Dryden & Mytton, 1999, pp.161-170; Phares, 1992). (See *APPENDIX 4* for examples of all techniques).

Behavioural techniques: these techniques are based on learning theory and on the argument that as behaviours can be learned, they can be unlearned as well, and can be substituted for healthier behaviours instead.

Affect-emotional techniques: Lazarus argues that emotions cannot be dealt with directly, but only through the other modalities.

Sensory techniques: these techniques deal both with specific – such as sexual – and general problems.

Imagery techniques: little research evidence exists to support the usefulness of imagery techniques. However, there is a list of techniques that can be used during therapy. The therapist needs to be particularly careful, since these techniques are designed to enhance the client's imagery skills and not to evoke past unpleasant memories.

Cognitive techniques: these are either purely cognitive techniques or techniques used in other therapies such as rational emotive therapy.

Interpersonal relationships techniques: this group of techniques are better to be practiced in groups – such as assertiveness training groups – since they refer to problems in social relationships. What the client needs to do is to learn a repertoire of new behaviours.

Drugs/biological techniques: these techniques have a mainly educational purpose and aim to promote a healthier lifestyle. The therapist often needs to collaborate with the relevant specialists.

COMPARISON TO OTHER APPROACHES

Traditional therapies

On *Table 1* MMT is compared with psychoanalysis, person-centred therapy and rational emotive therapy. The psychoanalytic and person-centred approaches to therapy have an exploratory nature in contrast to rational-emotive and multimodal therapies, which are problem solving oriented. The former two delve into therapy with the relationship between the therapist and the client as the medium. On the other hand, the latter two aim to use a variety of techniques to provide therapy. MMT shares many similarities with the other three therapies. The difference of MMT is that it is a

pragmatic and flexible approach. While for example psychoanalysis focuses on the *there-and-then*, person-centred explores the *here-and-now* with an empathetic approach, and rational-emotive therapy has a cognitive stance focusing on the problem. MMT, however, does not approach the client through a specific spectrum and with predetermined stance, but it is client driven and can borrow any of the above depending on the clients needs (Dryden & Mytton, 1999). It can be argued that what distinguishes MMT from other therapies is its flexibility, its systemic eclecticism that enables the client to form the approach of his therapy (Lazarus, 2000).

Table 1 Comparison of MMT with psychoanalysis, person-centred therapy and rational-emotive therapy (this table has been adjusted from Dryden & Mytton (1999, pp.194-197), but Gurman & Messer (1995) and Phares (1992) writings have also been consulted)

	Therapies			
Characteristics	**Multimodal**	**Psychoanalysis**	**Person-centred**	**Rational-emotive**
Theoretical constructs	• Learning theory • Social learning theory • Systems theory • Communication theory	• Childhood • Unconscious • Sexuality • Transference	• Self-concept • Internalised locus of evaluation	• Irrational beliefs
Aims	• Client's aims & objectives	• Insight • Ego • Unconscious	• Inner world • Self validation	• To teach tasks & techniques
Therapeutic style	• Flexible	• Non-directive	• Non-directive	• Actively directive
Therapeutic feelings	• Self-disclosure • Self-efficacy	• Safety • Freedom	• Safety • Empathy	• Self-direction
Techniques	• Broad • Specific • Important	• Not comfortable with	• Not specific	• Balance between therapeutic relationships & techniques
Possible problems	• Passivity • Compliance • Non-compliance	• Passivity • Negative transference	• Attachment • Dependency	• Non-compliance • Disorientation

Systemic eclectic therapies

Mahalik (1990) has written an extensive article on systemic eclectic therapies. He does not discuss every single therapy that is labelled by its creator as systematic and eclectic, since many of these have been accused of being *"lazy"*, unsystematic, and inconsistent. Instead, he deals with only four of them, the most fully explicated:

- Beutler's eclectic psychotherapy,
- Howard, Nance and Myers' adaptive counselling and therapy,
- Lazarus' multimodal therapy, and
- Prochaska and DiClemente's trans-theoretical approach.

According to Mahalik (1990), what distinguishes MMT lies not only on its holistic and individualistic approach, but also on the careful selection of techniques through empirical research and clinical practice, even if not in the context of MMT. However, the main drawback of MMT is that there is little evidence to support basic reliability and validity of its special components, i.e. modality and structural profiles, bridging and tracking, and second-order BASIC ID analysis.

Despite lacking evidence for basic reliability and validity, MMT has been proven to be effective on a variety of psychosocial (Lazarus, 2005; Martin-Causey & Hinkle, 1995) and psychiatric (Allen, 2002; Lazarus, 2002) problems. It has been used in both individual therapy and group therapy (Smith & Southern, 2005; Christensen, 2001), and in different groups of clients in services (Brunell, 1978; Roberts et al., 1980; Richard, 1999; Munson, 1990). Finally, MMT has been adapted and used in combination with other therapies (Prout, 2007).

Integration

MMT is not compared only with therapies from other schools and with other eclectic approaches. After being baptised a heretic by Wolpe (Dryden & Mytton, 1999) the next biggest debate for Lazarus was this with the integrationists. Integration is an umbrella term for systematic eclecticism, common factor integration, and theoretical integration (Beitman, 1989; Norcross & Grencavage, 1989). Integrationists support the integration of different approaches in therapy and they combine theories not techniques (Lazarus, 1989). Theoretical integration is philosophically coloured with the characteristic of *"unity discovery"*, meaning that it merges different points of view. According to integrationists, theoretical integration is feasible and practical; it combines the psychodynamic, cognitive, and behavioural therapies, and creates a *super-ordinate umbrella*, something which eclectic psychotherapy is accused of not being able to achieve (Fear & Woolfe, 1996).

Norcross and Grencavage (1989) in their paper *"Eclecticism and integration in counselling and psychotherapy: Major themes and obstacles"* are taking a more diplomatic position. They describe MMT as *empirical pragmatism* (thus, accepting that techniques are empirically sound) and theoretical integration as *theoretical flexibility* (*Table 2*). The authors argue that although proponents of both approaches differentiate themselves, they do not differ much since *"no technical eclectic can totally disregard theory and no theoretical integrationist can totally ignore technique"* (Norcross and Grencavage, 1989, pp.234). Eclecticism was favoured around 1975 and integration was most favoured around 1986. Norcross and Grencavage (1989, pp.234) argue very wittingly that this theoretical progression might as well resemble the social progression of the time: *"from segregation to desegregation to integration"*.

Table 2 Eclecticism versus integration (Norcross & Grencavage, 1989, pp.233)

Eclecticism	Integration
Technical	Theoretical
Divergent (differences)	Convergent (commonalities)
Choosing from many	Combining many
Applying what is	Creating something new
Collection	Blend
Selection	Synthesis
Applying the parts	Unifying the parts
Atheoretical but empirical	More theoretical than empirical
Sum of parts	More than sum of parts
Realistic	Idealistic

Lazarus has tried to separate himself from integrationists, however, some publications refer to his MMT as such (Smith & Southern, 2005; Corey, 2001). Beitman (1989), an integrationist himself,

is separating Lazarus from the integrationists, because Lazarus' approach is not merely systematic eclecticism, but systematic *technical* eclecticism. He is contrasting himself to Lazarus, because he believes that Lazarus *"ignores engagement, self-observer alliance and termination among other critical concepts for the counselling relationship"* (Beitman, 1989, pp.260). Lazarus' answer to this accusation is that integration is an unsystematic eclecticism that is based upon the therapist's personal preference and subjective judgment. On the other hand, systematic and technical eclecticism is client-centred as it is driven by the client. In addition, it uses only specific and empirically proven techniques by a professional clinician. According to Lazarus, theoretical integrationists are *fusionists* who try to merge divergent points of view (Lazarus, 1989).

EPILOGUE

Being flexible and with an artistic flavour, MMT does not lose on its scientific and structured approach (Lazarus, 2005). MMT is not a *speculative conceptualization*. It is a rather *heuristic* therapy, which uses operationalised processes and pragmatic techniques in the interests of its clients (Lazarus, 1989). MMT is based on the principle of scientific investigation and uses only experimentally supported treatments.

Lazarus moved from psychoanalysis, to behaviour therapy, to cognitive-behaviour therapy and finally to systematic technical eclecticism (Lazarus, 2000). Through his career, he has been accused by behaviourists of being unethical (Wolpe, 1984) and by integrationists of not being scientific (Beitman, 1989).

The debates between Lazarus, integrationists, behaviourists and other therapists on knowledge acquisition (Norcross & Grencavage, 1989) resemble the famous science wars between traditionalists and relativists to find the scientific truth (Pinch, 2001). Lazarus argues that he is using only techniques based on scientific research. However, his opponents accuse him of not doing so. No matter what the truth is, it should be born in mind that scientific research is conducted by *humans* and that *humans* are not infallible. Causal and explanatory accounts of phenomena always receive attention from different perspectives such as scientific, sociological, spiritual, theological, historical political and financial. Accordingly, Lazarus successfully utilizes different perspectives with the BASIC ID. However, it could be questioned, how can <u>all</u> these perspectives offer good or else to say *"scientific"* evidence? In addition, how can a therapist without an empirically *and* theoretically based background in his therapeutic approach offer valid scientific explanations? In conclusion, this essay will support the effectives of MMT, as it has been proven through numerous research studies, but will argue with Lazarus' stance that his approach is not theoretically led. Lazarus has worked as a psychoanalyst, as a behavioural therapist and as a CBT therapist. He believes in theories as learning theory, social learning theory, personality theory, systems theory, and communication theory. Consequently, even unconsciously, these theories must have been integrated inside Lazarus before MMT was born.

<u>References</u>

Allen, B. (2002) 'Multimodal behaviour management for people with dementia'. <u>American Journal of Alzheimer's Disease and other Dementias</u>, 17(2): pp.89-91. Available from: http://aja.sagepub.com/cgi/reprint/17/2/89.pdf [Accessed: 23rd February 2007].

Beck, A. T. (1991) <u>Cognitive therapy and the emotional disorders</u>. England: Clays Ltd.

Beitman, B. D. (1989) 'Why I am an integrationist (Not an eclectic)'. <u>British Journal of Guidance and Counselling</u>, 17(3): pp.259-273. Available from:

http://www.drbeitman.com/Papers/Why%20I%20am%20an%20Integrationist.pdf [Accessed: 23rd February 2007].

Brunell, L. F. (1978) 'A multimodal treatment model for a mental hospital: Designing specific treatments for specific problems'. Professional Psychology, 9: pp.570-579.

Christensen, T. M. (2001) 'A Bold perspective on counselling with couples and families: An interview with Arnold A. Lazarus'. The Family Journal: Counselling and Therapy for Couples and Families, 9(3): pp.343-349. Available from: http://tfj.sagepub.com/cgi/reprint/9/3/343 [Accessed: 23rd February 2007].

Corey, G. (2001a) 'Designing an integrative approach to counselling practice'. IN: G. Corey, The Art of Integrative Counselling, Pacific Grove, CA: Brooks-Cole/Wadsworth. Available from: http://counselingoutfitters.com/vistas/vistas04/29.pdf [Accessed: 23rd February 2007]. pp.271-291.

Dacher, E. (1996) Whole healing, New York: Dutton.

Dryden, W. and Mytton, J. (1999) Four Approaches to Counselling and Psychotherapy, New York: Routledge.

Fear, R. and Woolfe, R. (1996) 'Searching for integration in counselling practice'. British Journal of Guidance and Counselling, 24(3): pp.399-411. Available from: http://docserver.ingentaconnect.com/deliver/connect/routledg/03069885/v24n3/s10.pdf?expires=1172226797&id=35597509&titleid=596&accname=University+of+Glamorgan&checksum=1EABC754CEDE7146EAFE4390A9BD07A6 [Accessed: 23rd February 2007].

Goldenberg, I. and Goldenberg, H. (2000) Family Therapy: An Overview. USA: Brooks/Cole, Publishing Company.

Gurman, A. S. and Messer, S. B. (1995) Essential psychotherapies. New York: The Guildford Press.

Herman, S. M. (1998) 'The relationship between therapist-client modality similarity and psychotherapy outcome'. Journal of Psychotherapy Practise and Research, 7(1): pp.56-64. Available from: http://jppr.psychiatryonline.org/cgi/reprint/7/1/56 [Accessed: 23rd February 2007].

Lazarus, A. A. (2002) Multimodal Therapy: A Primer. Continuing Education Course. Available from: http://www.continuingeducation.com/psychology/mmtherapy/mmtherapy.pdf [Accessed: 23rd February 2007].

Lazarus, A. A. (1977) 'Has behaviour therapy outlived its usefulness?'. American Psychologist, 32(7): pp.550-554.

Lazarus, A. A. (1989) 'Why I am an eclectic (Not an integrationist)'. British Journal of Guidance and Counselling, 17(3): pp.248-258. Available from: http://taylorandfrancis.metapress.com/media/2pw78ah4th0qvm4arqau/contributions/n/3/1/t/n31tu078656x81hr.pdf [Accessed: 23rd February 2007].

Lazarus, A. A. (2000) 'Will reason prevail? From classic psychoanalysis to new age therapy'. American Journal of Psychotherapy, 54(2): pp.152-155.

Lazarus, A. A. (2002) 'Client readiness for change, cultural concerns and risk taking: A multimodal case presentation'. Clinical Case Studies, 1(1): pp.39-48. Available from: http://ccs.sagepub.com/cgi/reprint/1/1/39.pdf [Accessed: 23rd February 2007].

Lazarus, A. A. (2005) 'The case of "Ben": A flexible, holistic application of multimodal therapy'. Pragmatic Case Studies in Psychotherapy, 1(1): pp.1-15. Available from: http://pcsp.libraries.rutgers.edu/include/getdoc.php?id=262&article=46&mode=pdf [Accessed: 23rd February 2007].

Mahalik J. R. (1990) 'Systematic eclectic models'. The Counselling Psychologist, 18(4): pp.655-679. Available from: http://tcp.sagepub.com/cgi/reprint/18/4/655 [Accessed: 23rd February 2007].

Martin-Causey, T. and Hinkle, J. S. (1995) 'Multimodal therapy with an aggressive preadolescent: A demonstration of effectiveness and accountability'. Journal of Counselling and Development, 73(3): pp.305-310.

Munson, W. W. (1990) 'Therapeutic recreation for handicapped youth offenders: A multimodal approach'. IN: G. L. Hitzhusen and J. R. Gigstad (eds.), Global Therapeutic Recreation: Selected Papers from the 1st International Symposium on Therapeutic Recreation, Columbia: MO, University of Missouri. pp.12-18. Available from: http://www.lin.ca/resource/html/yg001%5B3%5D.pdf [Accessed: 23rd February 2007].

Norcross, J. C. and Grencavage, L. M. (1989) 'Eclecticism and integration in counselling and psychotherapy: Major themes and obstacles'. British Journal of Guidance and Counselling, 17(3): pp.228-247. Available from: http://taylorandfrancis.metapress.com/media/274ee7trrk7qun6kducy/contributions/r/5/5/r/r55r45j57310654h.pdf [Accessed: 23rd February 2007].

O'Connell, B. (2005) Solution-focused therapy, London: SAGE Publications.

Phares, E. J. (1992) Clinical Psychology: Concepts, Methods, and Profession. Pacific Grove, California: Brooks/Cole Publishing Company.

Pinch, T. J. (2001). 'Does science studies undermine science? Wittgenstein, tuning, and Polanyi as precursors for science studies and the science wars'. IN: J. A. Labinger and H. Collins (eds.), The One Culture? A Conversation about Science. Chicago: University of Chicago Press. pp.13-26.

Prout, H. T. (2007) 'Counselling and psychotherapy with children and adolescents: Historical developmental, integrative, and effectiveness perspectives'. IN: H. T. Prout and D. T. Brown (eds.) Counselling and Psychotherapy with Children and Adolescent: Theory and Practice for School and Clinical Settings. 4th ed. New Jersey: John Wiley and Sons Inc.

Richard, J. T. (1999) 'Multimodal therapy: A useful model for the Executive coach'. Consulting Psychology Journal: Practice and Research, 51(1): pp.24-30.

Roberts, T. K., Jackson, L. J. and Phelps, R. (1980) 'Lazarus' multimodal therapy model applied in an institutional setting'. Professional Psychology, 11: pp.150-156.

Smith, R. and Southern, S. (2005) 'Integrative confusion: An examination of integrative models in couple and family therapy'. The Family Journal: Counselling and Therapy for Couples and

Families, 13(4): pp.392-399. Available from: http://tfj.sagepub.com/cgi/reprint/13/4/392.pdf [Accessed: 23rd February 2007].

Wolpe, J. (1984) 'Behaviour therapy according to Lazarus'. American Psychologist, 39: pp.1326-1327.

APPENDIX 1

7 Modalities

1. ***B**ehaviour:* this modality refers to actions and it works as a response to the other six modalities

2. ***A**ffect:* it refers to the emotions that an individual experiences. According to Lazarus, the therapist can only change an affect through other modalities.

3. ***S**ensation:* sensation has a two-way interaction with al other modalities. It can also cause emotions or accompany them.

4. ***I**magery:* it includes both visual and auditory thinking that can also take place in dreams. Imagery can cause other modalities to happen.

5. ***C**ognitions:* this modality is all about thoughts that individuals have; it impacts on behaviours and affects

6. ***I**nterpersonal relationships:* it refers to social interactions in general with other people.

7. ***D**rugs/biology:* Lazarus argues that biology is the basis of all human existence and in return, there is a reciprocal relationship with the other six modalities. Through this modality, Lazarus is trying to promote a healthy lifestyle in his clients.

(Dryden & Mytton, 1999, pp.143-144)

APPENDIX 2

13 determinants

These questions are based on the 12 determinants of Lazarus (1992: 240 cited in Dryden & Mytton, 1999, pp.152):

1. Are there any signs of psychosis?
2. Are there any signs of any organic problems?
3. Is there any evidence of depression? Self-blame, suicidal, or homicidal tendencies?
4. What problems has the client brought to counselling and what seems to have triggered them?
5. Why is the client coming for counselling now and not last week, last month, or last year? Is anyone forcing them to come or strongly influencing them? Or has some crisis occurred?
6. What factors seem to have preceded the difficulties? How did it all start?
7. Is there someone or something that is maintaining their problems, preventing the client from solving them?
8. Is it clear what the client hopes to gain from coming to counselling?

9. Are there any indications that one particular therapeutic style is more helpful or more unhelpful than another? Is a directive or non-directive style referred by the client?
10. Are there any indications that it would be best for the client to be seen individually, or as part of a dyad (e.g. with partner or souse) or as part of a family unit, or in a group?
11. Can a relationship develop that is satisfactory to both client and counsellor or should the client be referred elsewhere?
12. What are the client's strengths, what are the positive attributes?

To this list compiled by Lazarus, Palmer and Dryden (1995, cited in Dryden & Mytton, 1999, pp.152) have added an important thirteenth question:

13. Has the client had previous experience of counselling and if so, what was the outcome? What did the client find helpful or unhelpful?

APPENDIX 3

Structural profile questions

Behaviour: How much of a doer are you?
Affect: How emotional are you?
Sensation: How aware are you of your bodily sensations?
Imagery: How imaginative are you?
Cognition: How much of a thinker are you?
Interpersonal: How much of a social being are you?
Drugs-biology: To what extend are you health conscious?
(Dryden & Mytton, 1999, pp.156)

APPENDIX 4

B A S I C I D techniques

Behavioural techniques
- Behaviour rehearsal
- Modelling
- Nonreinforcement
- Recording and self monitoring
- Response cost or penalty
- Stimulus control
- Systematic exposure

Affect-emotional techniques

According to Lazarus in order to cure emotional disorders, the therapist needs first to address one of the other six modalities.

Sensory techniques
- Relaxation
- Hypnosis
- Biofeedback
- Sensate focus training

Imagery techniques
- A white board technique
- The common object
- Anti-future shock imagery
- Imaginal exposure
- Positive imagery
- Step-up technique
- Time projection imagery

Cognitive techniques
- Disputing strategies
- Semantic precision
- Rational coping self-statements

- Bibliotherapy
- Self-instruction
- Problem solving
- Correcting misconceptions

Interpersonal relationships techniques

- Behaviour rehearsal
- Modelling
- Role playing
- Assertiveness training
- Communication training
- Friendship/intimacy training
- Social skills training

Drugs/biological techniques

- Exercise
- Diet
- Rest, relaxation and leisure

(Dryden & Mytton, 1999, pp.161-170)

The Historical Development of Interventive Interviewing in Family Therapy

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Introduction and aims

"The desire to relieve mental pain and suffering and to produce healing" organises therapeutic conversations (Karl Tomm, 1988). As therapists, we are naturally inclined to *want* to help families. However, one of my professional dilemmas has been the fact that we do not know what families are thinking, or what they desire from the session, therefore, how do we help families to come to their own conclusions about what will be helpful for them with out influencing them? Cecchin (1987) suggests that it is, '...impossible to be neutral with regards to language. All behaviour, including language, is politically laden'. What we say can lead a family towards a conclusion that we or the team may subconsciously feel to be 'right', but if we look closely, this conclusion may be 'right' simply because it feels comfortable to us. The aims of this piece of work are to outline the challenges that I as a member of a family therapy team have encountered as regards adhering too closely to a hypothesis; to examine the work of Karl Tomm as a means of beginning to overcome these challenges; to use a case study as a means of critiquing some of Tomm's ideas, and to place his work in a developmental framework within the overall development of family therapy ideas.

Challenges

Burnham (1986) suggests that therapists, prior to beginning the session, can use a 'range of systemic interviewing techniques ....to evaluate hypotheses'. He goes on suggest that the therapist selects from this range in a 'deliberate rather than an intuitive way.' Similarly Carr (2000) argues that family therapists do not usually enter into sessions with a 'completely open mind', and that they tend to enter sessions armed with a hypothesis. I tend to agree with these ideas, but with a certain amount of reservation.

I agree with Cecchin's (1987) sentiments that neutrality is almost impossible to achieve, and that as human beings, we naturally form opinions about situations, usually based on past experience, values and beliefs. However, I also feel very strongly that there is a danger of these opinions clouding our judgement as therapists. In my experience as a therapist, I have felt reassured and safe when beginning a session 'armed' with a hypothesis. However, I have looked beyond this and examined my need to feel reassured, and on several occasions I have concluded that my need to feel safe during a session has been an obstruction to the families I have been working with. If I am clinging on to a hypothesis, no matter how well thought out, I am subconsciously leading a session in such a way that my own needs are met before those of the family. The challenge, for me, is to break away from my own 'comfort zone', and to therefore become a more useful resource for the family.

Of course, this dilemma is not a new one, and many workers have attempted to overcome it. Cecchin (1987) developed the idea of neutrality to include concepts such as curiosity and irreverence, and therapists such as Michael White (1989) have travelled further down the road of irreverence by suggesting that 'traditional' practices, in whatever field, need to be challenged. He uses diagnosis as an example, suggesting that

to label and diagnose negates a person and turns them into an object. He argues that systems theory can have a similarly negating effect upon families, because it relies upon identifying problematic interpersonal interactions, and encourages these to be replaced by less problematic ones. White argues that by simply replacing a problem-behaviour with a less problematic behaviour serves to maintain the reliance of the family upon patterns, and that the problematic patterns just change in nature. My personal view is that patterns of interaction are impossible to discount. Simply by entering into a conversation with a family, you are becoming, albeit transiently, an agent of interaction. For me, the real skill of a therapist lies in the level of self-awareness achieved, and how language is used.
The work of Karl Tomm (1987a, b, 1988) has, for me as a therapist, allowed me to tackle these internal dilemmas with an increased amount of confidence. I shall attempt to put Tomm's work into the wider context of the development of family therapy ideas, before offering a critique of his ideas by using case examples.

Context

The work of Karl Tomm has been described as being part of the social constructionist school of thought, the aim of therapy being to facilitate a collaborative partnership that will enable the family and the team, "... to co-construct new belief systems" (Carr, 2000). Social construction is defined by Goldenberg and Goldenberg (2004) as, '..the post-modern theory that there is no objective 'truth', only versions of the 'reality' constructed from social interaction, including conversation, with others.'
Other major works within the social constructionist movement are the reflecting team approach developed by Andersen (1987, 1991), and the collaborative language system approach developed by Goolishian and Anderson (1987, 1988).
Further interpretations of the social constructionist stance were offered in deShazer's (1985, 1988) work on solution focused therapy. Here, to summarise, the aim is to not only identify problematic interactional patterns, but to identify those infrequent patterns where problems may occur, but in fact do not (Carr, 2000). The work is then focused around building upon these interactions.

Narrative

Michael White and David Epston (White, 1989, White and Epston, 1989) developed social constructionist ideas, and arrived at the narrative approach, where the idea of systems and patterns of interactions has been replaced by the theory that it is stories that shape our experiences, rather than systems. Families often have negative stories that they tell about themselves, stories of failure, rejection, loss etc. that are upheld by myths and accepted family values. Narrative therapy looks at helping families to reframe these negative stories in a positive way, thus creating a new, positive narrative. My view is that stories, myths and legends are also patterns of interaction, as they shape family relationships, so for me, the idea of systems cannot be discounted.

It can be argued that the social constructionist approach is rooted in the Milan model, pioneered by Mara Selvini -Palazzoli, Gianfranco Cecchin, Luigi Boscolo and Guiliana Prata in the 1970's. This model was itself influenced by the work of Gregory Bateson and the Palo Alto group in California. Bateson's (Bateson and Ruesch, 1951, Bateson,1972,1979) work on communication, and on systems theory has been key to the development of family therapy as a whole, as he recognised that in many families there are patterns of communication that are rigid, unmoving and repetitive. Repeated exposure to these 'double binds', as he termed them, is damaging and creates

confusion. Bateson also suggested that such communication patterns are dependent upon different levels of communication, for example the actual message and the implied message. An example is that of a mother saying to her child, “please tidy your room, if you loved me you wouldn’t let it get into this state”. The actual message here is to tidy the room. However, the confusing message that is implied is that, “because your room is untidy, you don’t love me”. The whole exchange is used to provoke feelings of guilt and self-doubt.

It is this theory of family systems that has had a significant effect upon the development of Family Therapy, and from where it could be argued most branches of Family Therapy theory have their roots, including the social constructionist stance from within which Karl Tomm has based many of his ideas.

As already stated, the social constructionist stance was influenced by the Milan approach of the early 1970’s; an approach which was strongly influenced by Bateson's ideas regarding the role of systems within the family. They described the family as a, “self-regulating system which controls itself according to the rules formed over a period of time through a process of trial and error” (Selvini-Palazzoli et al, 1978). Reiss (1981), highlighted ‘belief-systems’ as examples of self-regulating systems. This suggests that families operate within a conceptual and behavioural framework, which “regulates and maintains family balance” (Burnham, 1986).

Scripts

Byng-Hall (1995) phrases such interactions as ‘family scripts’, scripts that are passed on and repeated by different family members throughout generations. I feel that indeed, these family ‘scripts’ are important interactions that shape behaviour. An example from my own practice is that of a young mother experiencing difficulties in controlling her eight year old son. It became apparent that her mother had been a constant source of criticism, and that her grandmother appeared to be the ‘keeper’ of the family values and beliefs. These family values, over time, had turned into scripts by which every family member was expected to live their lives. However, it seemed that many of these scripts had become distorted, and were now myths. For example, the family script of not getting into debt had, for this young mother, changed into a myth that because she had credit cards, she was a negligent mother. These ideas had caused her to doubt her every action as regards her son, and as a result, she felt unable to stick to clear boundaries that were rooted in a strong sense of value.

One of the key advances in thinking made by the Milan team was that they recognised that paradoxes exist within family systems, paradoxes regarding family ‘rules’ that actually prevent positive change, and can actually maintain difficulties. This was linked to the work of Watzlawick, Weakland and Fisch (1974), and Fisch, Weakland and Seagal (1982), and the MRI therapeutic model, who suggested that, ‘problem formation and maintenance’ are actually a ‘vicious circle’, one in which ‘solution’ focused behaviours can actually maintain a problem (Fisch, Weakland and Segal, 1982). These ideas are also linked to Bateson’s work on double binds. How to break this cycle of problem maintaining behaviour has been a guiding goal for many approaches to therapy.

For example, the original Milan group would use 'counter-paradox', the effects of this being to alleviate blame, and to allow the family and team to look at the construction of less damaging systems and patterns of communication. An example may be if a therapist inwardly acknowledges that a certain pattern of interaction may in fact be

maintaining a certain position, but realises that to dwell upon this interaction and highlight it further defines the family in terms of being a problem. The family may be using methods to deal with a problem that are actually exacerbating it (paradox), whereas the therapist may positively connote (Selvini-Palazzoli et.al., 1978) the processes used to arrive at such interactions, such as unity and concern, rather than the interactions themselves (counter-paradox). This may help the family to open up new lines of interaction.

The Milan group re-interpreted the MRI model, and other models, and looked at the therapeutic use of language and information. They looked at how information is passed down from generation to generation, and how this information quickly becomes accepted as 'truth' (Gorell Barnes, 2004). This work was an important pre-cursor to the work of White and Byng-Hall, mentioned above. It could also be argued that the early Milan model was very much in the strategic arena, linked to therapists such as Haley (1963). Strategic family therapists highlight 'strategies' that families have in place in order to address difficulties, the problem often being that such strategies are problem maintaining. The aim is to offer counter strategies that disrupt this pattern. For example, I have encountered many families with a 'difficult' child who has become the focus of everything that is negative within the family's frame of reference. The family sub-consciously maintain the child's difficulties, as it often serves to deflect blame and prevents them from changing their patterns of interaction. Tomm's (1987ab, 1988) 'strategic questioning' is influenced by this work, the intention being to allow families to confront problematic patterns of interaction, e.g., 'what prevents you from talking in a civil manner'?

Minuchin (1974) looked at family therapy in terms of the structures within family groups preventing change. This structural family therapy would focus on forming collaboration between the therapist and the family with a view to 'unbalancing' these systems, and devising new boundaries.

Like the original Milan team's approach, it could be argued that structural and strategic family therapy relied upon the therapist to initiate change, almost in a prescriptive way. For me, this does not address the challenges I have set out earlier regarding imposing a hypothesis onto a situation. The danger is that by remaining in the 'expert' arena, the therapist is not allowing the family to truly embrace their own resources.

The Milan group modified the approach however, introducing concepts such as hypothesising, circularity, and neutrality (Selvini Palazzoli et. al.,1980), allowing therapists and families more scope to view interactions from a number of different viewpoints (Reimers, 2000). However, there was still an emphasis upon the team's interpretation of interactions.

The work of Karl Tomm is linked to that of Boscolo and Cecchin, who developed the Milan approach towards a more social constructionist stand-point. They placed more emphasis upon collaboration and the use of language and while hypothesis, circular questioning and neutrality were still important, they recognised that these elements were potentially restrictive.

Irreverence

Cecchin (1987) suggests that neutrality, circularity and hypothesising were 'recursively interlinked', and in tandem with curiosity, could facilitate the testing of different viewpoints, and therefore, different realities. Another important facet of this work is the idea of irreverence. Similar to Tomm's ideas, and indeed very influential towards them, is the idea that hypotheses exist and are indeed a valid and constructive tool for the

therapist. The main difference is that by being 'curious' about emerging patterns within the session, the therapist and family would be able to explore a variety of different 'realities', each one being valid. This idea of collaboration and irreverence meant that both the family and the team would be able to move on from being organised by a particular hypothesis, thus increasing the family's sense of empowerment.

Tomm describes this irreverence as 'a pattern of creative teamwork that clearly separates the cognitive constructions of the therapist in contrast to the belief systems of the family' (Tomm, 1984). It is this element of collaboration, and the notion that hypothesising is a process that is a part of therapy rather than a potentially restrictive occurrence that appeals to me.

With regard to the challenges mentioned above, Tomm's idea of using hypothesis in a way that will help the therapist to strategise rather than be over organised, has allowed me to use my natural instincts of formulating a hypothesis in a more robust way, ensuring that any hypothesis I have is robustly tested.

Similarly, Gergen (2002) suggested that perceptions of the world are not only affected by language and communication, but by the particular culture within which we live. The use of language becomes increasingly important, because language used reflects 'the current values and outlooks of that culture' (Goldenberg and Goldenberg, 2004).

This for me is linked with Tomm's ideas of teamwork, and the therapist being part of a team that includes the family. An example is that of a Zambian family with whom my team were working. It became apparent that having recently moved to Britain, they found some aspects of our culture difficult to understand, and indeed, quite threatening. It was quite possible that many of the family's perceived problems were affected by each family member's attempts to 'fit in'. The therapist was able to help them to explore these issues, and they felt that the difference in each family member's 'pace' of adaptation was a cause of conflict.

The wider field

Other styles of therapy that are closely linked to that of Karl Tomm include 'conversational' styles of social constructionist therapy (Lowe 2004), ones that 'invite a sense of ambiguity and multiple viewpoints'. These include the collaborative language approach of Goolishian and Anderson (1988), and the work of Hoffman (2002) and Andersen (1991, 2001). Andersen used a reflecting team approach where the team offers reflections upon a session, with the hope that multiple viewpoints will be heard.

These reflections are offered as part of a conversation, as opposed to a prescriptive, interpretive approach. Andersen has recently likened this process to that of physiotherapy, where instead of muscle groups being stretched and loosened, viewpoints are loosened, thus allowing 'multiple voices' to be heard. Goolishian and Anderson (1988) call the process of therapy 'the creation of a context or space for dialogical communication'. They suggest that as human beings, we naturally attribute meaning to communication and language as a way of contextualising such processes. The 'space' mentioned above allows new meanings to develop.

Case Discussion

I shall use a case from my own experience as a way of outlining Karl Tomm's ideas in more detail. I shall also use this case to illustrate how Tomm's ideas have helped me to at least address some of the challenges outlined in my introduction.

The case in question is that of a 15 year old girl and her mother who had been attending therapy for 13 sessions. The daughter had experienced problems with self-

image that had led to depressive episodes. For the previous two sessions, we as a team had been considering how to end the sequence, as both mother and daughter had reported positive changes.
Prior to this session, we had decided as a team to use some of Karl Tomm's ideas around strategising. Tomm (1987a) suggests strategising as a 'fourth guideline' for interviewing, and builds upon the original Milan team's ideas of hypothesising, circularity and neutrality. He describes strategising as a type of interviewing with 'particular intentions in mind', and describes four types of intent: investigative, exploratory, corrective and facilitative. Our reasons for using these ideas in this case arose from our feelings as a team that there may be an 'elephant in the room' i.e. the clients may have felt that therapy was ending, we certainly felt this, but nobody was actually talking about this possibility.
The dangers of using a simple hypothesis such as 'they have told us that they have seen improvements, we have seen evidence of this, therefore therapy needs to finish' were that we may have been reacting more to our own need to see closure, than the needs of the clients. Also, there was the danger that the clients would take our lead, rather than their own.

Finding cornerstones

For me, this is where Karl Tomm's ideas form a cornerstone of family therapy. By following Tomm's ideas regarding strategising, we were still mindful of our own instincts, but were also giving the clients more opportunity to lead the session, and to 'own' the ending. The therapist was able to use investigative and exploratory questions in order to gauge where the clients stood in terms of their perceived progress. Tomm terms these questions as 'orienting', and suggests that they are intended to elicit change from the team, as opposed to the client, and this was the case: we felt more certain of the progress that had been made because both the mother and daughter were talking of progress.
The therapist then used facilitative questions in order to help the clients to look at new possibilities. Tomm terms these as 'influencing' questions, as they are intended to elicit change for the clients. Examples were, 'What strengths do you feel you now have as a family?' and 'How have you used these strengths to arrive here?'
Tomm (1987b, 1988) describes four levels of questioning: lineal (information seeking), circular (enquiring about patterns), strategic (allowing families to directly confront problematic interactions), and facilitative (allowing families to think about new possibilities).
These specific questions are linked to the four strategising intentions mentioned above. The use of facilitative questions opened up several possibilities for the clients, and for me, illustrated the benefits of using Tomm's approach clearly. Firstly, they were able to recognise their own part in the process of change, as opposed to feeling 'cured' by a group of professionals. This hopefully had the effect of empowering them, and also of allowing them to approach a position of 'safe uncertainty' (Mason, 1993), a position where they feel safe with their own resources, thus allowing them to face the uncertainties of the future with more confidence. Secondly, it was felt that this recognition was part of a process of growth and change that they now viewed as a positive experience, not as one to be feared.

The therapist then used a future orientated question (de Shazer, 1985, 1988) to allow the clients the opportunity to transpose this progress, and the strengths they had identified, to future possibilities. The danger in using this approach, for me, is that

clients may feel a sense of being overwhelmed, and that the pace of change may be too fast i.e. by asking them to think of the future, we as therapists are in effect transporting them to a place that is potentially frightening. However, in this case, using Tomm's approach, we felt a sense of 'safe uncertainty' in that we felt as sure as we could that the family now possessed the resources to address this question positively. The question was 'How can you use these strengths in the future?' Although future orientated, this was still a facilitative question. The mother replied "I don't quite know, I guess we'll muddle through like any other family, but that's better than not having a clue and getting into a state, which is what we usually do"!

The therapist felt able to broach the subject of ending the sessions, and asked two circular questions, 'what would happen if you no longer came to these sessions'? The mother replied that in the past, they had used the sessions as 'a crutch', but at present, this was no longer the case, and she had not mentioned ending therapy before now because she did not want to appear ungrateful! The daughter's reply was similar, she stated that she now felt 'normal', and had realised that she was 'ok'. Both felt that they no longer needed to attend, but were very grateful for our help, and this allowed us as a team to officially end the process by giving positive feedback to both the mother and the daughter.

Conclusions

I feel that I have placed Tomm's work within a historical framework. Having looked in some detail at how some of his ideas can be used in the therapeutic setting, I feel that there are several advantages that have helped me to address the challenges that I outlined earlier. I feel that Tomm's work allows myself and my team to move out of our 'comfort zones' in a safe way, a way that echoes the 'safe uncertainty' (Mason, 1993) outlined above.

Firstly, rather than feeling under pressure to not be led by your own feelings and instincts as a therapist, I believe that Tomm's work allows the team to place such instincts into a therapeutic context, one that recognises the importance of where these instincts have arisen from, and how they can be addressed in a therapeutic way.

Secondly, by recognising that some questions are intended to change the therapist, this allows for that process to be part of the therapeutic process. I feel that Tomm's work has allowed me to accept that at times, it is indeed prudent to ask orienting questions, but the key seems to be that the therapist and team *recognise* that this process is occurring.

Finally, the processes outlined above allow the team to treat hypotheses with irreverence. Without the processes outlined in Tomm's work, I feel that there is a danger either to completely negate the importance of hypothesising as a therapeutic process, or to be over-organised by it.

<u>References</u>

ANDERSON, H and GOOLISHIAN, H. (1988**).** *'Human systems as linguistic systems: preliminary and evolving ideas about the implications for clinical theory'.* <u>Family Process,</u> **27**, 371-394.

ANDERSEN, T. (1987). *'The Reflecting Team: dialogue and meta-dialogue in clinical work'.* <u>Family Process</u>, **26**, 415-428

ANDERSEN, T. (1991). <u>*'The Reflecting Team: Dialogues and Dialogues about the Dialogues'*</u>. New York: Norton.

ANDERSEN, T. (2001**).** *'Reflecting Family Therapy: an interview with Tom Andersen',* in DENBOROUGH, D (ed), <u>*'Family Therapy: Exploring the Field's Past, Present and Possible Futures'.*</u> Adelaide: Dulwich Centre Publications.

BATESON, G. (1972). <u>*'Steps to an Ecology of Mind'.*</u> New York: Ballantines.

BATESON, G. (1979). <u>*'Mind and Nature: a necessary unity'.*</u> New York: Dutton.

BATESON, G. and RUESCH, J. (1951). *'Communication: the Social Matrix of Psychiatry'.* New York: Norton.

BURNHAM, J. (1986). <u>*'Family Therapy'.*</u> London: Routledge.

BYNG-HALL, J. (1995). <u>*'Rewriting Family Scripts. Improvisation and Change'.*</u> New York: Guilford.

CARR, A. (2000). <u>*'Family Therapy: Concepts, Processes and Practice'.*</u> Chichester: Wiley.

CECCHIN, G. (1987). *'Hypothesizing, circularity and neutrality re-visited: an invitation to curiosity'.* <u>Family Process</u>, **26,** 405-413

DeSHAZER, S. (1985). <u>*'Keys to Solutions in Brief Therapy'.*</u> New York: Norton.

DeSHAZER, S. (1988). <u>*'Clues: Investigating Solutions in Brief Therapy'.*</u> New York: Norton.

FISCH, R., WEAKLAND, J, and SEGAL, L. (1982). <u>*'The Tactics of Change: Doing Therapy Briefly'.*</u> San Francisco: Jossey-Bass.

GERGEN, K.J. (2002). *'Psychological Science: to Conserve or Create?'.* <u>American Psychologist,</u> **56**, 803-813.

GOLDENBERG, H and GOLDENBERG, I. (2004). *'Family <u>Therapy: an Overview'.</u> Pacific Grove: Thomson.*

GOOLISHIAN, H. and ANDERSON, H. (1987). *'Language Systems and Therapy: an*

evolving idea'. Psychotherapy, 24, 529-538.

GORELL-BARNES, G. (2004). *'Family Therapy in Changing Times'.* Basingstoke: Palgrave MacMillan.

HALEY, J. (1963). *'Strategies of Psychotherapy'.* New York: Grune and Stratton.

HOFFMAN, L. (2002). *'Family Therapy: an Intimate History'.* New York: Norton.

LOWE, R. (2004). *'Family Therapy: a Constructive Framework'.* London: Sage

MASON, B. (1993). *'Towards Positions of Safe Uncertainty'.* The Journal of Systemic Consultation and Management, 4, 189-200.

MINUCHIN, S. (1974). *'Family's and Family Therapy'.* Cambridge, MA: Harvard University Press.

REIMERS, S. (2000). *'Triple mindedness'.* Journal of Family Therapy, 22, 24-28.

REISS, D. (1981). *'The Family's Construction of Reality'.* Cambridge, MA: Harvard University Press.

SELVINI-PALAZZOLI, M. et. al., (1978). *'Paradox and Counter-paradox'.* New-York: Aronson.

SELVINI-PALAZZOLI, M. et. al., (1980). *'Hypothesizing-circularity-neutrality: three guidelines for the conductor of the session'.* Family Process, 19, 3-12.

TOMM, K. (1984). *'Externalising the Problem and Internalising Personal Agency'.* Journal of Strategic and Systemic Therapies, 8, 1.

TOMM, K. (1987a). *'Interventive interviewing(I): strategizing as a fourth guideline for the therapist'.* Family Process, 25, 4-13.

TOMM, K. (1987b). *'Interventive interviewing(II): reflexive questioning as a means to enable self-healing'.* Family Process, 26, 167-183.

TOMM, K. (1988). *'Interventive interviewing(III): intending to ask linear, circular, strategic or reflexive questions'.* Family Process, 27, 1-15.

WATZLAWICK, P. WEAKLAND, J. & FISCH, R. (1974). *'Change:Principles of Problem Formation and Problem Resolution'.* New York: Norton.

WHITE, M. (1989). *'Selected Papers'.* Adelaide: Dulwich Centre Publications.

WHITE, M. and EPSTON, D. *'Literate Means to Therapeutic Ends'.* Adelaide: Dulwich Centre Publications.

Once Upon-A-Time in History: The historical development of the narrative approach to family therapy.

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Introduction

This essay explores the historical development of narrative therapy and highlights the following topics as central to current thinking: language, power, narrative, family resilience, externalising and the shifting focus from the idea that it is the individual or family who maintains the 'problem', towards the powerful influences of the cultural narratives that influence our lives. The work of White and Epston (1990) have been selected as fundamental text for discussion, supplemented by theoretical concepts underlying the narrative approach, of others drawing from or working parallel to them.

The field of family therapy like everything else has been significantly shaped within its historical timeline. It has over fifty years of history, where its theorists began to challenge the conventions of psychiatry by including whole families in the therapy of individuals. By exploring unconventional ideas, questioning commonly held viewpoints they developed new and creative practices. The ideas of what constituted a family and family life in the 1950's were also very different from what they are today, and were influenced similarly on the historical ideologies and discourses inherent in the society in which we lived then and of our society today. These early family therapists recognised the powerfully shaping influence families have on the development of children and adults and sought to find ways to connect that power in the service of therapeutic treatment.

Historical lens

The history of family therapy theory and practice, offers a broad spectrum in terms of methods for working with families with various difficulties. Within this broad term, there are a wide variety of views on what types of problems are appropriately addressed by family therapy, who defines them, what constitutes family therapy practices and what type of theoretical rational and research underpins and validates these practices.
Family therapy derived its theoretical foundations from the emergent, cross disciplinary body of knowledge called 'systems theory'. Systems theory proposes that all occurrences are interconnected and cannot be known without reference to their context. Simply put, there is nothing—no person, no thing—that stands apart from its networks of relationships. Individuals cannot be understood without reference to their past and present relationships, especially their families. This thought had real importance for early family therapists who were seeking new and more effective ways of helping. As family therapy developed, attention was paid to the effect of other significant influences on families, including such areas as culture, ethnicity, religion, and socioeconomic class (Gergen, 1991; White, 1993).

Contemporary practices

The present day field of family therapy is characterised by a number of concepts including focusing on the role of the family in predisposing people to developing problems or in precipitating their difficulties. Some others focus on the role of the family in problem maintenance, but all acknowledge that a consideration of people's understandings and how these are related to the culture in which they live is an important contextual factor. There is also considerable variability in the degree to which theories privilege the role of family patterns or interaction, family belief systems and narratives, and historical contextual and constitutional factors in the origins and maintenance of problems.

With respect to family therapist's practices, some invite all family members to all therapy sessions, or conduct family therapy with individuals by empowering them to manage relationships with family members in more satisfactory ways. Whilst others have broadened their practices so it includes members of wider professional and social network around the family, and may refer to this approach as systemic practice. Family therapy is really a way of thinking, an epistemology rather than about how many people sit in the room with the therapist. Family therapists are relational therapists; they are interested in what goes between people rather than in people (Tomm, 1987; 1988; Gergen, 1991).

There are a number of different concepts that have guided family therapy through time, from the earlier 1950's ideas of psychoanalytic family therapist Nathan Ackerman, to the first order perspective of the structural approach as offered by Salvador Minuchin and associates. The strategic-related therapy offered by the Palo Alto institute and then later in the 1970's with the further expansion of these ideas by the Milan group. This evolved further in the 1980's with a paradigm shift, which came out of the new ideas of Ginfranco Cecchin and Luigi Boscolo, who split away from the Milan group and moved family therapy into what is known today as the Post-Milan or second order perspective, therapy position of systemic therapy.

Wider influences

Other influences around this time were coming from the collaborative language systems approach (of Goolishian and Anderson), and the solution focused approach (of De Shazer and Berg). The Post-Milan approach is an amalgam of the original concepts and new techniques in the family therapy field that have evolved over time (Dallos & Draper, 2000). This was also a time when other ideas and approaches were emanating from different parts of the globe other than United States and Europe. Ideas about language, power and culture, which were joined with original concepts and a combination of these ideas, evolved to underlie the most recent post-modern/post-structural position or third perspective.
This awareness came from social constructionist theorists influenced by feminist writings, who were increasingly interested in the role of language and how it shaped our interactions with each other. Out of these new concepts in the 1990's, the latest narrative paradigm of knowledge emerged, from theorists' such as Michael White and David Epston and their development of the Narrative approach to therapy. It is their approach to narrative therapy that I have selected as fundamental text for discussion.

Narrative therapists early thinking came out of first order cybernetics, the later more recent approach has incorporated combined ideas from other fields such as second order cybernetics, post-modernism/structuralism and interpretative anthropology. Narrative therapy as formulated by White and Epston, owes much too several poststructuralist theorists such as the anthropologists Gregory Bateson, Barbara Myerhoff and Clifford Geertz, ethnographer Edward Bruner, social constructionist Kenneth Gergen, sociologist Erving Hoffman, philosopher Jacques Derriada (White, 1997; Goldenberg & Goldenberg, 2004) and to earlier Foucauldian themes that focused on notions of genealogy and power and knowledge (Foucalt, 1980). They later integrated Foucalt's further ideas of power, knowledge and the ethics of self regulation (Foucalt, 1997). Narrative therapy can be considered to be positioned within the social constructionist domain of social psychology (Gergen, 1991; White, 2000; Morgan, 2002).

Setting the foundations

In establishing narrative therapy, Michael White and his friend and colleague David Epston, became interested in the cybernetic thinking of Gregory Bateson, and his use of metaphor 'maps'. These were offered as carrying various mental maps, which held all our knowledge of the world, our personal narrative that extends through time. Mental maps of *"external"* or *"objective"* reality and those different maps lead to differing interpretations of *"reality".* No map includes every detail of the territory that it represents, and events that do not make it onto a map, do not exist in the map's world of meaning (Freedman & Combs, 1996: 15). Bateson's idea where interpretation is about object reality is important to narrative therapy, as this notion of interpretation argues that *"since we cannot know object reality, all knowing requires an act of interpretation" that is determined by how things fit "into the known pattern of events"* (White & Epson, 1990: 2).

In other words, the interpretation of events depends on the context in which they are received and events that cannot be located in a context cannot be chosen and so would not exist, or we would not note them as facts. Later influences came from the anthropological and ethnographic concepts of Bruner and Geertz (Goldenberg & Goldenberg, 2004). These insights influenced White and Epston's therapeutic work away from 'maps', to the use of the narrative or story (Monk, 1996; Monk, & Winslade, 2001; Goldenberg & Goldenberg, 2004).

White and Epston went on to develop an interest in the way people construct meaning to their lives, rather than, just with ways they behave (Gergen, 1991). They argued that people's relationships are 'shaped' by the stories that people tell and engage in, to give meaning to their experiences and are open to interpretation and multiple meanings (Epston & White, 1992; Monk, 1996; Morgan, 2002). They suggest we construct certain habits and relationships that make up ways of life by staying true to these internalised stories. A narrative therapist assists people to resolve problems by enabling them to deconstruct the meaning of the reality of their lives and relationships, and to show the difference between the reality and the internalised stories of self. The narrative therapist encourages people to re-author their own lives according to alternative and preferred stories of self-identity, and according to preferred ways of life (White & Epston, 1990).

Basic Premises

The basic premise of narrative therapy is that, the person is not the 'problem'; the problem is the problem (White, 1989; White & Epston, 1990). Narrative therapy is built on the concept that people are not the problem, but that the relation a person has to a set of resources for making sense of their situation, can position people 'in' problems. It allows people to confront the essentialisms in their stories. Essentialism is most commonly understood for this purpose as a belief in the real, true essence of things, the invariable and fixed properties which defines a given entity.

The narrative approach developed by White and Epston (1990) is applicable for work with families, groups, individuals and communities. It holds that the knowledge and stories (narratives) emanating from their culture, families and experiences, shape people. In developing this concept they came to believe that *"stories do not mirror life they shape it",* (White, 1992: 123) that's why people have a remarkable tendency of becoming the stories they tell about their experiences.

This is based on the idea that our daily lives are full of small and big events, which we interweave together over time and eventually form a story that narrative therapists believe are linked in sequence, across time and according to a plot (White & Epston 1990; Morgan, 2000). It could be said this is how we come to understand and live our life story, by the ones we tell about ourselves. Of course there are many simultaneous and conflicting stories we have about our lives and our relationships, the good and the bad. How we link these stories together and which ones we believe to be more true than others, depends very much on how we have linked events together and what meaning has been ascribed to them.

Every type of therapy designates a different aspect of life as the base root of experience. As systems therapy focuses on family interaction as the base root, so does narrative therapy see the story as a person's base root of experience (White & Espton, 1990).

It is with this concept, that narrative therapy views the way people experience themselves and their situations. White and Epston (1990), suggest that our experiences are constructed through culturally mediated social interactions. Through stories and language, culture sends powerful messages to their members about the meaning of important concepts that sustain that culture; including gender, sexuality, health, race and class (Foucault, 1980, 1997). Narrative therapy focuses on how people's stories can get written and rewritten. It focuses not only on words and language but relies solely on language for its existence (White & Epston, 1990).

Deconstruction

One of the interesting areas of Narrative Therapy is the use of deconstruction. This term was first introduced in 1970's by the French philosopher Jacques Derrida in his use of examining literary works, indicating that text has no *"single meaning, emphasizes the meaning imposed by the reader as much as the author"* (Goldengerg & Goldengerg, 2004: 345). White and Epston (1990) harnessed this notion of *"deconstruction"* to externalize the *"dominant problem-saturated"* stories of a person's life, to listen to spaces and gaps, hidden meanings or conflicting stories and to explore or map the influence that problems have in a person's life (White, 1993: 37). White and Epston

(1990) challenged earlier social constructionist ideas, arguing that what is socially constructed can be de-constructed by the person creating a new story. The narrative therapist is actively involved from the outset in delving into the meanings of the client's life and views this exploration of the narrative the therapy.

Narrative therapy, involves the application of newer social constructionist ideas that enable us to become more aware of our self-narratives, dominant cultural knowledge about self and relationships, and our discursive cultural practices (Gergen 1991). Narrative therapy assumes each story is *"ideological and representation of reality is ideological"* (White, 1989: 148). While the stories are co-authored within a society, and within the context of family structures, there is much in life that is inconsistent, discrepant, incoherent, disharmonious, muddled and irrational. It is this excluded material that can be re-storied, after deconstructive exploration. Deconstruction plays a role in loosening the grip of a dominant story.

In Western culture, there is a dominant story about what it means to be a person of honourable worth. This story emphasises self-possession, self-containment, self-actualisation and so on. It stresses individuality at the expense of community and independence at the expense of connection. These are culturally specific values which are presented as *"universal"*, human attributes to be striven for. The attempt to live up to these *"dominant"* prescriptions can have profoundly negative consequences for people (Gergen, 2006: 19).

Deconstructions allow the dominant stories to be named and externalised, its hierarchy effects to be explored. Narrative therapy reverses the claims, and allows for the story to be re-authored and resituated in preferred stories. Narrative therapy then has to do with learning to tell different stories about your self, different stories are possible, even about the same events. How we talk about what happens to us depends on our starting point, and how we explain what happens to us, depends on the questions we ask. Dialogue interpreted this way, can be understood as having fluidity to its meaning and is a *"social construction"* (Anderson & Goolishan, 1988: 377).

Saturated narratives

The Narrative approach suggests that everyone has *"dominant stories"* (Morgan, 2000: 14) about their lives, but sometimes these are not helpful, particularly if they are *"problem saturated stories"* (White & Epston, 1990:13). Our lives are multi-storied, (Morgan, 2002) some of which are imposed on us by others with definitional power, whether that is a parent, teacher or religious figure, consultant, etc. those that observe our lives and interpret its personal meaning. Understanding within this notion, is based on the belief, that events do not inherently contain meaning to be assessed and deciphered by the observer. Rather, that people create their own meaning about the events in their lives based on past understandings of education, socialisation and the internalisation of ideas about the world. This notion affords an understanding of reality as multi-storied, rather than a base of 'truth' because every person may interpret an event or series of events in a unique and equally valid manner (White & Epston, 1990; Gergen, 1991, 2000)

The narrative therapist refers to 'thin' interpretations (Geertz 1973, in White, 2002) which are often likely to lead to superficial conclusions that label a person, leaving out an understanding of the complexities of that person's life. Unfortunately these labels or stories are the -"*taken-for-granted realities"* we often take to be *"so-called truths"* about ourselves (White, 1995: 122). The practitioner's role is to help replace dominant problem stories that the person has, with other more useful stories. Therefore, problem stories can be deconstructed, with the aim of reconstructing stories that lead to better outcomes; these are called 'preferred stories'. As the person interprets each life experience, their stories, which grew out of similar past experiences, will be reinforced and thus strengthen new experiences, *"thickening"* or more *"richly"* describing the story allowing a connection to be more available to them (Morgan, 2000: 74). The narrative therapist is a collaborator with the client in the process of discovering richer thicker stories, but discouraged from commitment to any particular *"truth of self*" (Gergen, 2006: 98).

White and Epston (1989, 1990) point out, that truth in the traditional notions of knowledge, position one form of knowledge over another, they suggest there are multiple (truths) realities and these can be found in our relationships with others. It takes this concept from social constructionist dialogues *"what we take to be knowledge of the world and self finds its origins in human relationships"* (Gergen, 2006: 18). This is not to say that traditional theories are redundant or insignificant, but that it offers us different views that invite our curiosity for further understandings.

Knowledge and Power

The narrative approach also suggests that *"power and knowledge are inseparable"* (White & Epston 1990: 29). White (1992) argues *"a domain of knowledge is a domain of power and that a domain of power is a domain of knowledge"* (White, 1992: 122). It is here perhaps, that we can see the biggest shift away from the traditional concepts of first order perspectives, within family therapy. White and Epston address the use of power in relation to self, and power in relation to others, in local settings. White (1993) suggests that power can be seen within:

"The technologies of the self--the subjugation of self through the discipline of bodies, souls, thoughts, and conduct according to specified ways of being (including the various operations that are shaping of bodies according to gender-specific know ledges)...[and]...*The technologies of power--the subjugation of others through techniques such as isolation and surveillance, and through perpetual evaluation and comparison*" (White, 1993: 54).

Narrative therapy also highlights that the:

"Personal story of self-narrative is not radically invented inside our heads. We don't individually make up or invent these stories. Rather these stories are negotiated and distributed within various communities of persons and also in the institutions of our culture" (Nicholson, 2003: 25).

Viewed from the perspective of the social constructionist movement even *"the mind becomes a form of social myth;* [and]... *the self-concept is removed from the head and placed within the sphere of social discourse"* (Gergen, 1985: 271).

The narrative therapists aim is to help *"separate the person's identity from the problem for which they seek assistance"* (Morgan: 2000: 17). Externalising the problem is a way of de-centering the dominant discourses and is central to this process; it is powerful in deconstructing the problem. The therapist stresses an importance on the language used, which is more an attitude in *"orientation"* in conversations or *"philosophy"* of therapy, rather than a technique (Dallos & Draper, 2000: 109), (White & Epston, 1990).

The basic premise is that you can have difficulty fighting a problem if it is part of you, but if you are fighting something else, this can be really effective. The person is being helped to position themselves apart from the actions that are causing them and others concern. The use of the person's own language is seen as critical. That is, the therapist is asked to listen to what the person is saying and use the person's words where possible, this allows for the client to hear that the therapist is critical of the problem and not the person. By means of questions, the therapist brings *"forth creative thinking within the constraints of otherwise fixed realities, such as time and proximity"* (Hedtke, 2000: 14). Over the years the narrative approach to therapy has come up with some labels that have been used to describe and externalise the problems, which have included, the famous *"Sneaky Poo"* (White & Epston, 1990: 46). It is important to the therapy, that regardless of the label that is applied to the problem, it must come from the person or be taken up eagerly by the person once it has been suggested.

Subjugation

White and Epston (1990) suggest that therapists are also *"inevitably engaged in a political activity"*, in the sense that they must continually challenge the *"techniques that subjugate persons to a dominant ideology"* (White & Epson, 1990: 29). In this sense narrative therapists must always assume that they are participating in domains of power and knowledge and are often involved in questions of social control. Rather than placing themselves in the traditional position of the 'expert all knowing therapist' or on the opposite side and the 'not knowing therapist', the narrative therapist acknowledges both social constraints on subjective life and individual agency, and power within these constraints. The narrative approach argues that there should be a shift away from searching for pathology within individuals or families, and towards an appreciation of our understanding of cultural influences and their toxic effects (White, 1995).

Situating itself in social constructivism, the narrative approach differentiates itself from traditional perspectives, in which the practitioner takes an objective position, from where exists a body of knowledge that can be applied as means of remedying any given situation. As implies the person in need of therapy, is viewed from this perspective to lack the necessary skills in order to create any meaningful change and movement, in their own lives, which can have the effect of the client assimilating the therapist's values and belief system (Walsh, 1998)

Narrative therapy represents a radical departure from this scenario, in contrast second and post order approaches maintain that objectivity is not feasible, and endeavours to

establish collaboration with the person seeking therapy. With awareness, comes an understanding that professionals are also vulnerable to cultural power discourses, which are instrumental in forming the way we see the world. These cannot be arbitrarily taken off and put back on again, therefore the only way to be non-biased from these positions is to admit to the bias and be as transparent as possible with the bias (Anderson & Goolishan; 1988; 1990). Karl Tomm suggests *"as part of this cultural process we are now seeing ourselves as professionals, as vulnerable of getting caught in power dynamics that are pathologising"* (Tomm, in Denborough, 2001:118).

In other words, therapists confront the question of how their own beliefs and behaviours, influence people who seek therapy. In doing so, they also confront their own position regarding their practices: are they following techniques of identification, which disqualify speculation, or are they willing to examine their own pre-suppositions and the grounds of their questions

In collaboration with the person the narrative therapist encourages them to re-author their stories, by discussing how the person would prefer to be and what they would like to be happening in their lives. This is done through careful and respectful questioning. The language used is purposefully ethnically neutral, non-sexist and avoids medical model terminology or methods, and therapy is viewed as therapeutic conversations (White, 1997, 2000). This is seen as encouraging the person to take a position about the problem. In re-authoring, the shining moments are explored more thoroughly, as is the meaning of the preferred story. Change is sustained, by thickening the preferred story and identifying who in the person's family/friendship culture will support them in the process. This process is termed re-membering conversations, a meaning given to preferred memories that people *"prefer to revise or revoke"* (Morgan, 2000: 77). This allows people to reconnect with important relationships, made invisible or minimised by their dominant story.

Other processes created in narrative therapy may be used at this stage, such as therapeutic letters (Epston, 1998) or definitional ceremonies and outsider-witness rituals. The latter are processes drawn from the work of cultural anthropologist Barbara Myerhoff, (White, 2002). These ritual metaphors provide structural ways of offering a "*therapeutic arena",* in which a person's story can be retold and witnessed by a group (e.g. professionals, colleagues, friends, family or members of the community) they then swap places. The initial therapeutic conversation, is witnessed by the group who listen and later re-tells what they have heard, similar offered by Tom Anderson's reflective teams (White, 1995). The definitional ceremony and outsider-witness responses serve to help reinforce the preferred story, and *"contribute to options for action in peoples lives that would not otherwise be available to them"* (White, 2002: 14).

Challanges

One of the challenges facing this narrative field at present is a move away from the notion that problems are inherent in individuals or in families. Instead it questions the toxic effects culture has on relationships, because *"people are induced by our culture into subscribing to narrow self-defeating views of themselves and the world"* (Schwartz, 1999: 266). It argues that the deficit discourses tends to act in a totalising way, that result in personal self-enfeeblement and leads to a greater reliance on professional authority and expertise, at the same time as it erodes the local, commonsense

knowledge of how to handle problems. In her paper 'Dancing with Death', Lorraine Hedtke explains this so eloquently "*These models, based in deficit ideas, only inhibit our coping abilities and undermine our confidence"* (Hedtke, 2000: 12).

In their search to further their approach to narrative therapy, White and Epston, raise the field of family therapy's consciousness regarding the exploration of the *"power of cultural discourses and the importance of discussing those in therapy"* (Schwartz, 1999: 266). Hopefully this will further conversations about the standardising normality of diagnosing and labelling, which they suggest are usually so hidden that the in-built cultural and social biases of such accepted standards, are seldom open to, or able to be questioned.

Conclusions

In conclusion, narrative therapy in the broadest sense has its theoretical framework, within Family Therapy and those therapies, which have a common ethos of respect and acknowledgement for the importance of context, interaction, language, discourse and the social construction of meaning. White and Epston's innovative thinking, helped shape the basic tenets of narrative therapy, which considers the broader historical, cultural and political framework of the family. Within the narrative approach, therapists try to understand how people's personal beliefs and perceptions, or narratives, shape their self-concept and personal relationships. In this relational world there is no single centre of knowing; nor is there a knower, nor even a body of knowledge. They took Foucault's work concerning the instruments of power and control in societies invisible discourses, (i.e. gender, racial, patriarchal, health) as well as ideas and beliefs which subterfuge as the 'truth' (i.e. status, power, science) and developed a therapeutic approach, that aims to help people free themselves from learned oppressive ways of being. Individuals and families are encouraged to reconstruct their narratives, to facilitate more adaptive views of themselves and more effective interpersonal interactions. The narrative therapist, from a curious standpoint, which carefully considers the use of language, collaboratively exposes the problem. This is considered from the perspective that discourses can originate from multiple sources (i.e. family, religion, culture).

Narrative therapy holds an obvious promise, both theoretically and practically to open up new developments in family therapy. Their understanding and challenge of the dominant discourses within society, allows for more transparency within interactions. This brings forth how focusing on the family as maintaining problems, can obscure our view of the cultural inequities, by shifting the focus on dominant discourses that are politically driven. These discourses are almost always a source of control, for those who benefit from their dominant understanding in society. It also highlights the ethical political problem of speaking for others and promotes a means of knowledge that acknowledges and accommodates diverse cultures. However it must be careful not to place too much emphasis on culture alone, as this constrains the fluidity of movement for people to explore different parts of themselves. Under this paradigm, people are not seen as flawed but as self-subjugating, according to a belief that may not be in their best interest, and it is they who control the direction they would most like to attend to in their lives.

References:

Anderson, Harlene and Goolishian, Harold (1988) Human Systems as Linguistic Systems: Preliminary and Evolving Ideas about the Implications for Clinical Theory. *Family Process* (27): 4.

Dallos, Rudi, and Draper, Ros (2000). *An introduction to Family Therapy: systemic theory and practice.* Buckingham: Open University Press.

Freedman, J. and Combs, G. (1996). *Narrative Therapy*: the social of preferred realities. New York: Norton.

Gergen, Kenneth. (1985), The social constructionist movement in modern *Psychology. American Psychologist,* 40:266-275.

Gergen, Kenneth (1991) *The Saturated Self: Dilemmas of Identity in Contemporary Life.* New York: HarperCollins.

Gergen, Kenneth (2001) *Social construction in context.* London: Sage Publications.

Gergen, Kenneth (2006) *Therapeutic Realities: Collaboration, Oppression and Relational Flow.* Ohio: Taos Institute Publications.

Goldenberg, Irene and Goldenberg, Herbert (2004) *Family Therapy: An Overview* (6th ed.) Pacific Grove: Brooks/Cole.

Hedtke, Lorraine (2002) Dancing with Death. [online] Available at: http://www.dulwichcentre.com.au/lorrainearticle.html. [Accessed 14 March 2007].

Morgan, Alice (2000) *What is Narrative Therapy?* Adelaide: Dulwich Centre Publications.
Morgan, Alice (2002) Beginning to use a narrative approach in therapy. International *Journal of Narrative Therapy and Community Work*, 1: 85-90.

Nicholson, Susan (1999) *The Narrative Dance – A Practice Map for White's Therapy* Adelaide: Dulwich Centre Publications

Tomm, Karl (2001) Addressing our own practices of power. In D. Denborough (Eds) *Family Therapy: Exploring the field's past, present & possible futures.* Adelaide: Dulwich Centre Publications.

Schwartz, Richard (1999) Narative therapy expands and contracts family therapy;s horizons. *Journal of Marital and Family Therapy. (25) 2: 263-267*

White, Michael, Epston, David & (1990) *Narrative Means to Therapeutic Ends*. New York: W.W. Norton & Co.

White, Michael (1992) Deconstruction and therapy. In D. Epston and M. White (Eds) *Experience, Contradiction, Narrative and Imagination.* Adelaide: Dulwich Centre Publications.

White, Michael (1993) Deconstruction and therapy. In S. Gillian & R. Price (Eds) *Therapeutic conversations*. New York: W. W. Norton.

White, Michael (1995) *Re-authoring lives: Interviews and essays*. Adelaide: Dulwich Centre Publications.

The historical development of hypothesizing in family therapy: to hypothesize or not to hypothesize, that is the question.

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Introduction

Hypothesizing and formulation have an important history within psychotherapy and more specifically in family therapy. Palazzoli et al. (1980) use The Oxford Dictionary definition of hypothesis as 'a supposition made as a basis for reasoning without reference to its truth as a starting point for an investigation '. They go on to define it, 'in the terminology of experimental science, an hypothesis is an unproved supposition tentatively accepted to provide a basis for further investigation, from which a verification or refutation can be obtained'. Similarly, Fleuridas, Nelson and Rosenthal (1986) consider hypotheses to be 'suppositions, hunches, maps, explanations or alternative explanations about the family and the problem in its relational context'.

Within therapy, tentative formulation can be used as a starting point for the process of gathering information or as a guide for subsequent action, technique or intervention. Bertrando and colleagues (and Arcelloni, 2006: and Toffaneti, 2003) cite C. S. Piers's comment that everyone confronted by the unknown that is not understood creates a hypothesis in order to make sense of it. The wisdom people acquire through the passage of time helps to refine their learning from subsequent experiences.' Hypotheses must always be tentative and can only be adopted provisionally. While clients tell their story, the therapist will select some facts and not others to help form a hypothesis. This selection will happen according to the therapist's own personal filter which is based on his or her own beliefs and theoretical foundation. Once a hypothesis is formed, therapists are guided by feedback from clients as to whether their hypothesis has a good fit with the situation before them.

Bertrando and Toffaneti (2003) draw a distinction between scientific hypothesizing and hypothesizing in therapy. Both should remain open to the possibility that events will not conform to their hypotheses. However, unlike scientists, therapists cannot be detached from their hypotheses and would never consider the clinical situation to be a neutral object to be studied. The authors draw on the work of Schon (1983) in highlighting circularity in the hypothesizing process, the therapist 'moulds the situation while conversing with it, so that his models and evaluations are in turn moulded by the situation'.

The use of hypothesizing in systemic (Milan) therapy

Although hypothesizing has long been used in a range of psychotherapeutic approaches (see Johnstone and Dallos, 2006), it is most closely associated with systemic family therapy. So central is hypothesizing to systemic therapy that Bertrando and Arcelloni (2006) see the evolution of family therapy as the evolution of the role of hypothesis.

In their seminal paper, Palazzoli et al. (1980) outline the three principles that they feel are 'highly productive' when interviewing a family. These are hypothesizing, circularity and neutrality. For the Milan team the hypothesis is considered to be 'the formulation

by the therapist based upon the information he possesses regarding the family he is interviewing'. According to therapists of the Milan school of systemic therapy, it is never possible to know the reality of an individual or family's situation. Therapists must therefore formulate hypotheses regarding the difficulties that have lead to clients seeking therapy. In turn, these hypotheses could never be considered to be factual. A hypothesis 'is neither true nor false, but rather more or less useful'. According to Ugazio (1985) the hypothesis answers the 'why' of symptomatic behaviour by suggesting reasons for it but never attempts to define its cause.

Traditions

In the Milan tradition, hypothesizing occurs during the pre-session, before therapists meet the clients, as well as during the sessions. During the pre-session the team discuss ideas about the family they are going to see and their own relationships with it. Members of the team generate different hypotheses about what may be happening for the family and the therapist chooses one of these to bear in mind at the outset of the session. Cecchin (1992) sees the hypothesis as the 'base for starting a conversation'. Jones (1993) suggests that the pre-session hypothesizing acts to allow the team members to set out to themselves and one another their own values, assumptions, prejudices, stereotypes and pet theories that are likely to affect the work. She sees this as a positive move as it allows them to 'become available as creative resources to our work, rather than functioning as invisible organisers of our perceptions and actions'. In addition, Jones suggests that the very act of more than one person offering hypotheses ensures 'flexibility and guards against the likelihood of becoming convinced of the absolute truth of one's own view.' Thus working together as a team and being open to other's ideas can help to prevent therapists becoming too attached to their own particular hypothesis. Milan therapists are aware of this danger and warn against 'falling in love' with or even 'marrying' one's hypotheses.

As Palazzoli et al (1980) state, what is important about a hypothesis is how useful it is to those involved in the therapy. According to Cecchin (1992) it is not the quality of a hypothesis that makes it useful, instead it is the contrast or relationship between the team's hypothesis and that of the family, or of the one that emerges during the session. A useful hypothesis enables therapists to take an active stance in a session, ensuring that they seek information that will confirm or refute it. Cecchin (1987) discusses the crucial importance of curiosity in systemic therapy. He states that while curiosity is a stance, hypothesizing is what therapists do to try to maintain this stance. Thus the hypothesizing process allows the therapist to remain curious.

According to the Milan system, once the team have generated the multiple hypotheses and selected one in particular, the therapist takes it into the session and uses it to organise the information received from the family. This allows the therapist to focus on what may be pertinent and prevents him or her from becoming overloaded by the wealth of information on offer. During the session, information is them sought to support or counter the hypothesis. Palazzoli et al (1980) discuss the hypothesizing their team carried out before meeting with a mother and her son. They used information about the family from a preliminary telephone call made by the mother to formulate a hypothesis about the son's difficult behaviour being his way of getting his father to return to the family. On the basis of this they decided to focus questioning on the mother and son's relationship with the father. Throughout the session the hypothesis

was 'disproved' and they moved on to consider a second one that 'hit the target'. The authors see this hypothesizing process as positive in that the questioning provoked by the hypotheses led to the information 'essential for a choice of a therapeutic intervention'.

According to Palazzoli et al (1980), the value of hypothesizing is not simply the way that it organises the therapist, but is in itself pivotal to the therapeutic encounter. In their early work (Palazziolí et al. 1978) the authors discussed a model of therapy in which a session would culminate in a final intervention that frequently was designed to promote change. However, critics pointed out that it was sometimes difficult to see on what basis the intervention had been made and so it could appear to arrive without an obvious and logical precedent (see Ugazio, 1985 for discussion).
An intervention could therefore be perceived by clients as 'a cryptic message' and only valued if delivered by 'a therapist with a peculiar charismatic power'. Using a hypothesis to allow the therapist to remain actively curious while asking questions not only acts to reduce disorder, but also to encourage 'negentropy' (the acquisition of information). For the Milan team, a hypothesis allowed them to introduce the 'unexpected' and the improbable' into the family system.
This idea is reminiscent of Bateson's famous concept of 'a difference that makes a difference' (1972) that it is this difference that promotes change. Indeed, Palazzoli et al (1980) and Ugazio (1985) suggest that the generation of, selection of and questioning provoked by a hypothesis can have such a powerful negentropic effect, that it leads to change, rendering a final intervention unnecessary. Bertrando and Arcelloni (2006), point out that clients react to an intervention (the dialogue) based on a hypothesis, and not directly to the hypothesis itself. The hypothesis is never shared directly with the clients as it 'belongs solely to the therapeutic team.'

Hypotheses are considered to be most likely to promote change if they are different, but not too different. Numerous hypotheses may be on offer to the therapist. However, in order for a hypothesis to be useful for families it needs to offer different reasons for the behaviour, but reasons that are plausible to the family. The therapist must make a selection based on the degree of 'incoherence', or dissimilarity of the hypothesis from the family's own explicative schemas (Ugazio, 1985). This idea is similar to that of Andersen (1987) who talks about families responding to different types of difference, only one of which makes a difference.

The use of hypothesizing in reflective teams and conversational therapy

While Milan therapists focus heavily on hypothesizing, therapists from other, more conversational or reflective schools explicitly try not to hypothesize. The major function of a hypothesis is to prevent therapists from becoming overwhelmed by the enormous amount of data available to them, allowing them to deliberately attend to specific information and to focus in on a particular theme or idea. This could be seen to be the reverse of what Anderson and Goolishian are attempting in their therapeutic conversations. Anderson and Goolishian (1988, 1992) see the goal of therapy as being to 'participate in a conversation that continuously loosens and opens up, rather than constricts and closes down'.

Therapists' questions are not focused on discovering information and are not designed to confirm or refute a hypothesis. Instead, they are intended to open the conversation up so that new meanings can be created. The authors refer to and attempt to guard

against, Bateson's challenge that in observations, 'it is more familiar and comfortable to select that which confirms our already existing beliefs'. During these therapeutic conversations, no one interpretation is discovered and there is no single solution or 'either/or', but instead a recognition that there are multiple truths 'both/and'. Instead by making room for 'the not-yet-said', new meanings and understanding are achieved and the problem 'dis-solves' (Anderson and Goolishian, 1988).

Not only are hypotheses considered to close down conversations, but they are also thought to distance therapists from clients. One of the fundamental tenet's of this conversational approach to systemic therapy is that therapists attend to the power within the therapeutic relationship and attempt to work in collaboration (Strong 2000) with clients. Within therapy, expertise creates power. One way to circumvent this is to be a respectful listener who does not understand too quickly (if ever) and who adopts a stance of 'not knowing', allowing a more collaborative relationship to develop (Anderson and Goolishian, 1988, 1992).

'Not knowing' enables a therapist to enter the therapy room free from already formed ideas about the clients, their problems and potential solutions. However, it does not refer to the therapist's mind being a blank slate. Anderson and Goolishian acknowledge the existence of pre-understandings, opinions and prejudices, but offer these during sessions in such a way that they act to continue the conversation rather than close it down.

In developing their reflecting team method, Tom Andersen and his colleagues have adopted a similar approach to hypothesizing as that used during the therapeutic conversation. Before meeting clients, the team try not to hypothesise about them. Andersen (1991) points out that the team's understanding of the 'before-hand' information would inevitably be within team members own context and not within that of family/ system members. Thus the hypothesis could be seen to distance the team from the families with whom they meet, rather than bringing them closer. Instead, the reflecting team decided to try not having any ideas before-hand and instead 'use as a starting point what the system itself defined as most relevant.' Conversations begin 'where' the client is and not 'where' the therapist is. Indeed when the team does have prior information, they try not to let it be 'too much a part of us'.

For Andersen and his colleagues, not only is it a problem that a hypothesis is coloured by its creator, but also hypotheses are seen as intrinsically unhelpful in therapy. Andersen (1991) states that a hypothesis is either found or not found. Thus, like Anderson and Goolishian, he suggests that it therefore acts to constrain the therapeutic conversation by limiting the therapist's openness to anything outside of that particular supposition. Andersen (1991) cites Bateson (1978) p42.

"The ordinary processes of scientific advance in a lineal world, a world of lineal thought, are, after all, experiment, quantification, and, if you are anywhere within the realm of medicine, you will be expected to take a "clinical posture". I want to suggest to you that experiment is sometimes a method of torturing nature to give an answer in terms of *your* epistemology, not in terms of some epistemology already immanent in nature. Quantification will always be a device for avoiding the perception of pattern. And clinical posture will always be a means of avoiding the openness of mind or perception which would bring before you the totality of the circumstances surrounding that which you are interested in."

Bateson appears to be suggesting that taking an experimental approach (or as he terms it 'clinical posture') limits our ability to perceive (and perhaps understand) the patterns around us that are the reason for our scrutiny. Forming a hypothesis therefore prevents us from having an openness of mind. We decide what our hypothesis will be based on our own world view and from that point we focus our attention on whether we accept or reject our own hypothesis, rather than on the process of perceiving the patterns that are evident around us.

Bertrando and Arcelloni (2006) do not agree that hypotheses are limiting for clients. They comment that they believe that there are two reasons why reflecting teams and conversational therapists are opposed to hypothesizing. Firstly, they are opposed, because they see it as a way to 'drive the client in a pre-established direction' and secondly, because it may be considered to be a definitive definition of 'reality'. However, Bertrano and Arcelloni comment that while it can be used in this way, it does not always have to be used in this way. They suggest that hypotheses which are about processes do not close down conversations by finding a cause and a problem-solving strategy but instead open up the dialogue, albeit within some limits as certain ideas or discourse fields are selected while others are not picked up.

You can never not-hypothesize

There are however those who suggest that even if a therapists theoretical and ethical standpoint is that it would be desirable not to form hypotheses about the clinical situation, it is impossible not to do so. Bertrando & Toffanetti (2003) go so far as to suggest that such therapists may not be able to prevent themselves from hypothesizing, 'we might ask ourselves, though, whether therapists who maintain that they form no hypotheses really do so. In our opinion, not even the most respectful and 'not knowing' conversational therapist can work without hypothesising at all.' Later, Bertrando and Arcelloni (2006) question whether it would be possible for therapists to sustain an open, therapeutic conversation without hypothesizing, 'we could say that the therapist needs to build a sort of inner mirror in order not to see the ideas and hypotheses she is unwittingly constructing.'

The pragmatic hypothesizer

While many therapists have taken definitive positions over whether or not to hypothesize before and during sessions, others take a more pragmatic approach. Rober (2002) proposes the notion of constructive hypothesizing. He suggests that the Milan idea of a hypothesis could be seen as a tool to try to 'open space for the not-yet-said in the conversation.' He points out that in family therapy the amount of information being offered to the therapist is so huge that a tentative hypothesis is required to select what to hold on to so as not to be 'overwhelmed by a chaotic stream of information'. As such the hypothesis' narrows the focus and brings unity and order to the polyphony of voices in the inner conversation'. However, when the hypothesis is no longer useful – does not contribute to the 'therapist's responsive understanding of the family' she or he lets go of it and permits him or herself a broader focus on the information presented. According to Rober, hypothesizing is a continuous movement between knowing and not-knowing.

My own view of hypothesizing

Hypothesizing appears to have two distinct fundamental uses. The first is as a starting point in therapy to help the therapist home in on meaningful information and not

become overwhelmed by that which is less relevant. The second is to provide the therapist and clients with new understanding about their current situation.

Palazzoli et al (1980) state that ”the hypothesis establishes a starting point for his investigation as well as his verification of the validity of this hypothesis based upon specific methods and skills”. If the hypothesis is proven false, the therapist must form a second hypothesis based upon the information gathered during the testing of the first.' This is what happens in the example they give of the mother and son.
The first hypothesis, that the son's behaviour was a way of trying to get the father to return to the family was rapidly disproved. However, before realising that this tentative idea was not relevant for the family, the therapist and team had already decided to 'spend little time listening to the mother's complaints of the boy's behaviour and instead focus our questions on their relationship with the absent father.' Thus, on the basis of very little evidence, the therapist and team have decided to close themselves off to information that may have been instrumental in reaching a better understanding of the difficulties the family were experiencing.
The pre-session hypothesis was soon discarded and a second proposed which 'hit the target'. It seems to me that the initial hypothesis acted simply to close off one potentially meaningful area of discussion, rather than promoting any deeper understanding of the clients' difficulties. In the case discussed in the Palazzoli et al paper, it appears that the therapy was useful to the clients. However, it would be interesting to find out whether the clients of therapists with a strong tradition of pre-session hypothesizing feel as well 'listened to' as do the clients of therapists who enter the therapy room in a more open manner.

I feel more comfortable with the second reason for hypothesizing. That is, to provide the therapist and clients with new understanding of their situation. This does not always involve hypothesizing at the outset of therapy, before meeting with clients. Rather it involves the process of arriving at a formulation or hypothesis through engaging in a therapeutic conversation. As clinical psychologists, we are taught to formulate and re-formulate and to do so on the basis of all the information with which we have been provided.
Our formulations are always tentative, as like Milan family therapists we are aware that there is never a conclusive reality to uncover. However, unlike Milan therapists formulations are frequently (but not always) used to drive an intervention. Wherever possible the formulation is arrived at in collaboration with clients and is almost always shared and refined openly with them. Usually this is done verbally during a session and is sometimes backed up through a process of letter writing

Sharing a hypothesis with clients is not considered to be desirable by all family therapists. Some therapists (e.g. Roffman, 2005; Weakland, 1993) argue that this can lead to clients feeling blamed for the difficulties they have presented and even blamed for the therapy not working. However, even therapists currently working in Milan now see the value of sharing hypotheses with clients.
Bertrando and Arcelloni (2006) discuss their reasons for sharing hypotheses with their clients. 'The idea was that unveiling the whole hypothesizing process to clients could make the power balance between therapists and clients more ethical, solving, at the same time, some stuck situations'. Bertrando and Arcelloni (2006) discus the co-evolution of a hypothesis with both therapist and clients involved in the process which they term, a dialogical hypothesis. The therapist suggests a hypothesis based on what

she has been told by the clients. Together with the clients this is discussed and improved until a final hypothesis emerges which is of 'common heritage' to all involved. It is still however a hypothesis rather than a truth.

Bertrando and Arcelloni suggest that the Milan tradition has developed from having a team with the therapist, to having an internalized team, to teaming up with the clients. For them, sharing hypotheses with clients appears to be a revelation and a huge development in their approach which was brought about through becoming stuck while working with a specific client. However this is a way that many mental health workers, including clinical psychologists, have long been taught to work (see Vetere, 2006).

I always attempt to work collaboratively. Vetere (2006) points out that 'a collaborative approach to formulation may go some way towards protecting against the imposition of ideas that do not fit or work for the people concerned.' For me the collaborative approach to formulation or hypothesizing helps to draw me closer to clients and makes it less likely that I will take on an expert stance.

While I try not to hypothesise before a session, from the moment I meet with clients I am actively working towards a hypothesis or formulation with them. This is not dissimilar to Bertrando and Arcelloni's approach of questioning; presenting a tentative formulation and then checking and clarifying with clients until together we have reached a working hypothesis. Sometimes this leads onto an intervention, but sometimes the journey there was enough. In my own mind, I try to hold onto the notion that while a formulation may seem to have become firmed up within the session, it is just one of any number of other formulations that may have been reached by other people, or even by the same people but on another day.

In conclusion

Family therapy has developed numerous different methodologies based upon a wide variety of theoretical underpinnings. Hypothesizing, its presence and absence and the diverse ways in which it is used, has been instrumental in this development. Some practitioners see it as the only effective way to work for and with clients, while others view it as being distinctly unethical. However, the process of considering whether or not to engage in hypothesizing has enabled therapists to think deeply about how they personally want to work with families in order that they find new and helpful ways of thinking about the difficulties they bring with them into the therapy room.

References

Andersen, T. (1987). The reflecting team: Dialogue and meta-dialogue in clinical work. Family Process, 26, 415-428

Andersen, T. (1991) The Reflecting Team; dialogues and dialogues about the dialogues. Norton, New York.

Anderson, H. and Goolishen, H. (1988). Human systems as linguistic systems. Family Process, 27. 371-393.

Anderson, H. and Goolishen, H. (1992). The client is the expert: A not-knowing approach to therapy. In S. McNamee & K. J. Gergen (Eds.) Therapy as social construction (p25-39). London: Sage.

Bateson, G. (1972). Steps to an ecology of mind. New York: Balantine.

Bertrando, P. and Arcelloni, T. (2006). Hypotheses are dialogues: sharing hypotheses with clients. Journal of Family Therapy, 28, 370-387

Bertrando, P. and Toffaneti, D. (2003). Persons and hypotheses: The use of the therapist in the hypothesising process. Australian and New Zealand Journal of Family Therapy, 24 (1), p 7-13.

Cecchin, G. (1987). Hypothesizing, circularity and neutrality revisited: an invitation to curiosity. Family Process, 26 (4).

Cecchin, G. (1992). Constructing therapeutic possibilities. In S. McNamee and K. Gergen eds.) Therapy as Social Construction. London: Sage.

Fleuridas, C., Nelson, T. and Rosenthal, D. (1986). The evolution of circular questions: Training family therapists. Journal of Marital and Family Therapy, 12, (2) 113-117

Johnstone, L. and Dallos, R. (2006). Formulation in psychology and psychotherapy: making sense of people's problems. Hove: Routledge.

Jones, E. (1993). Family Systems Therapy: Developments in the Milan-systemic therapies. Wiley: Chichester

Palazzoli Selvini, M., Boscolo, L., Cecchin, G. & Prata, G. (1978). Paradox and Counterparadox. Aronson: New York

Palazzoli Selvini, M., Boscolo, L., Cecchin, G. & Prata, G. (1980). Hypothesising, circularity, neutrality: Three guidelines for the conductor of the session. Family Process, 19 (1), p3-12.

Rober, P. (2002). Constructive hypothesizing, dialogic understanding and the therapist's inner conversation: Some ideas about knowing and not knowing in the family therapy session. Journal of Marital and Family Therapy. 28, (4), 467-479.

Roffman, A. E. (2005). Function at the junction: revisiting the idea of functionality in family therapy. Journal of Marital and Family Therapy, Vol 31 (2), p 259-268.

Schon, D. A. (1983). The Reflective Practitioner. How professionals think in action. New York: Basic

Strong, T. (2000). Collaborative influence. Australian and New Zealand Journal of Family Therapy, 21, 144-150.

Ugazio, V. (1985). Hypothesis making: the Milan approach revisited. In D. Campbell and R. Draper (Eds.) Applications of systemic family therapy: the Milan method. London: Grune & Stratton.

Vetere, A. (2006). The role of formulation in psychotherapy practice. Journal of Family Therapy, 28, 388-391.

Weakland, J. (1993). Commentary. In S. Gilligan and R. Price (Eds.) Therapeutic Conversations (pp18-21) New York: Norton

A Critical Evaluation and Discussion of Cognitive Behavioural Therapy (CBT).

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Preface

This assignment will critically evaluate a preferred model of psychotherapy and counselling making references to relevant others. The model will be discussed and shall include critical analysis and evaluation of its core concepts. Links will be shown to the philosophical, cultural and social constructs that give rise to those concepts. The links will be made through experience of practice in the explication of the preferred model.

There appear to be well over 250 assorted theories of counselling and therapy, all seemingly vying to be 'the best' available in the counselling arena. One could possibly find it easy to 'dismiss' many as 'idealistic, unrealistic, un-researched, and without theory. However, taking a more positive viewpoint, it does leave one thinking what it is that remains of the assorted therapies that *has* been researched and *has* core concepts and theories that can be effectively utilized within the counselling field in today's ever changing world.

At this stage of my counselling career I am being increasingly drawn to the scientifically evidence based Cognitive Behavioural Therapy as standing out and making a lot of sense. However, although being drawn to this orientation as my primary preferred model of counselling, I am moving toward an 'integrative' approach to my work.

Taking this a step further, I am not alone in thinking that certain theories which are *understood and respected* can be integrated and systematically formed into part of one's own ' particular counselling model.' In addition, I believe this integrative model can be effectively used alongside a single primarily used preferred theoretical orientation. In my work as a bereavement volunteer I integrate several models into my counselling work. These models include Person Centred Therapy (Carl Rogers) and aspects of Gestalt Therapy (Fritz Perls) with my primary preferred theoretical orientation model being Cognitive Behavioural Therapy (CBT).

It is Cognitive Behavioural Therapy that I have chosen to lay open to the reader, in a way that may be clearly understood. It is intended to be a general overview and is by no means exhaustive. The 'warts and all' evaluation shall also include what it has in common with other theories.

Introduction

CBT was developed during the 1960's by Professor Aaron Beck, born in 1921 (Rhode Island), the third son of Russian Jewish immigrants. Although Beck's family appeared to be part of white middle class America, it was against a backdrop of the 1920's and 30's where areas of poverty, 'Prohibition' and the 'Depression years' were the 'norm.' Beck's mother suffered from depression for much of her life. Beck disliked his mother's moods and behavioural inconsistency, his father, however, nurtured his

scientific interests in nature. Later in life Beck went on to develop certain anxieties and phobias including a fear of abandonment. After university graduation in 1942, the following academic years led Beck to gaining an MD from Yale University and a subsequent fellowship of psychiatry at Pennsylvania University. Beck became increasingly disillusioned with the psychodynamic approach to counselling, preferring instead to study possible links between cognitions and behaviours of his patients. This led to the birth of CBT, '... a structured, short term, present oriented psychotherapy for depression, directed toward solving current problems and modifying dysfunctional thinking and behaviour' (Beck 1964 cited in Beck 1995:1).
Many practicing British therapists choose Beck's cognitive-therapy as '... probably being the most intensively researched form of cognitive- behaviour therapy' (Beck *et al* 1979; Beck and Emery 1985 cited in Dryden 1995:227). Moreover, as a result of recent findings of successive patient surveys in mental health services ' ... together with evidence of the effectiveness of cognitive- behavioural therapy ...' (which include depression and anxiety), the government has plans to open many new CBT based treatment centres (Hurford and Seward 2007: 8).

Beck has not been alone in CBT's development, theorists such as Meichembaum (Cognitive – behavioural modification) and Lazarus (Multi-modal Therapy) have made significant contributions to this field. The work of Albert Ellis (Rational Emotive Therapy) has also been influential. One could say CBT owes much to the non confrontational style of Carl Rogers (Person Centred Therapy*)*. Further contributions come from Behaviour Therapy (seen as goal setting, hypotheses testing and homework to name but a few). Also of note is that Frankl's (Logotherapy) has placed '... emphasis on thought and action, characteristic of the cognitive behavioural approaches' (Ivey et al 1987:290).
Woolfe and Dryden (1996: 174) state that: 'There is now no disorder to which cognitive behaviour therapy has not been applied ...' but add, '...this is not to say that CBT is of demonstrated efficacy for all disorders.' What *is* important is the fact that they also refer to the well researched areas of depression, anxiety, post traumatic stress disorder, panic attacks and agoraphobia as having significant efficacy figures. I find it is not uncommon to come across aspects of the above disorders which can sometimes play a significant part in the 'grieving' client.

Theory

Aaron Beck states: 'In the theory of cognitive therapy, the nature and function of information processing (i.e. the assignment of meaning) constitute the key to understanding maladaptive behaviour and positive therapeutic processes' (Nelson-Jones 2001: 331). The theory holds that incorrect processing on the interpretation of incoming information can occur in clients during their cognitive development. CBT counsellors endeavour to 'unscramble' client's distortions at the same time teaching them to view things differently to process and 'reality test' information in more realistic ways.
Beck and Weishaar (2000, cited in Nelson- Jones 2001: 329) believe CBT theory is underpinned by the phenomenological approach to psychology positing that the individual's view of self and personal world are central to how they behave, also Freud's theory was helpful in influencing Beck when structuring cognition into primary and secondary processes, in addition, George Kelly, a modern cognitive psychologist and his concept of personal constructs had an impact on Beck. Beck's schemas are very

akin to Kelly's personal constructs (Beck, Freeman *et al.*, 1990 cited in Nelson- Jones 2001: 329).

Beck's schema concept can be briefly described as a collection of cognitions which form part of larger collections of cognitions that when activated, "… directly influences the content of a person's perceptions, interpretations and memories …" (Mark *et al* 1993: 100).

Theoretical Assumptions:

1 The person is seen as an active agent who interacts with his or her world.
2 This interaction takes place through the interpretations, inferences and evaluations the person makes about his or her environment.
3 The results of these 'cognitive' processes are thought to be accessible to consciousness in the form of thoughts and images, and so the person has the potential to change them. (Dryden 1995: 228)

It could be argued that the above theoretical assumptions are not always in place in all clients. It is possible that some people are unable to interact or even become part of their world, particularly people who have a history of mental disturbance. In addition, it is possible that not everyone may be assumed to possess the knowledge to interpret and evaluate environmental events. Further, Young (1994) points out that '… many patients with personality disorders cannot report what their automatic thoughts are or they claim not to have images' (cited in Scott *et al* 1995: 3).

Therapeutic Goals

"To relieve symptoms and to resolve problems, to help the client to acquire coping strategies and to help the client to modify underlying cognitive structures in order to prevent relapse" (Dryden 1995: 233).

Arguably, most therapies would include these three goals; however, it is the third goal that sets the cognitive behaviourists apart from other therapies. Culley (cited in Dryden 1992: 131) states: 'The aim of the cognitive approach is to help clients become aware of how they judge themselves and others and to substitute more realistic thinking.'

Possibly, practicing therapists of different approaches 'tailor' their therapy to suit a particular client. CBT is no exception, however, there are certain principles which must be followed (taken from Beck 1995: 5-8);

1. Cognitive therapy is based on an ever-evolving formulation of the patient and her problems in cognitive terms: Probably true of all cognitive therapies. CBT therapists will continually build up a cognitive conceptualization (an understanding of the client), whilst vitally offering 'Warmth, genuineness and empathy …' (Dryden 1995: 236).
2. Cognitive therapy emphasizes collaboration and active participation: This is vital to the CBT process. Questions are often asked on the effectiveness of client /counsellor communications during therapy "… *metacommunication* – communicating and reflecting on the process of communication and the state

of the relationship ... is a crucial aspect of collaborative working" (McCleod 2007: 120).

3. Cognitive therapy is goal oriented and problem focused: Much akin to Egan's model of counselling, however, all therapies have some kind of goal.
4. Cognitive therapy initially emphasizes the present: The 'here and now' approach is common to many therapies outside of the psychodynamic approach to counselling. However CBT will take the client back in time particularly when the client shows a strong desire to do so. This may help in identifying the client's 'underlying assumptions' (taken from their schemas) in order to deal with them in the 'present.' This is strongly reminiscent of the work of Fritz Perls (Gestalt Therapy). Perls appears adamant that the client's past problems are dealt with as if they are happening right now, moment to moment which '... emphasize the primacy of the world of immediate experience' (Clarkson 1989:13).
5. Cognitive therapy is educative, aims to teach the patient to be her own therapist, and emphasizes relapse prevention: This is common to the cognitive based therapies bearing more than a passing resemblance to Miller's Motivational Interviewing educative style of change.
6. Cognitive therapy aims to be time limited. Lasting from between 4 and 14 weekly sessions which are collaboratively decided: This may be seen as a great plus for CBT as opposed to other long drawn out psychodynamic therapies which can last for years.
7. Cognitive therapy sessions are structured: Often beginning with agenda setting followed by mood checks, tools for checking and monitoring moods would typically be self questionnaires in the form of Beck's Depression Index, Anxiety Inventory and hopelessness scales. Homework assignments, responding to clients' thoughts, continual feedback are part of the structured session.
8. Cognitive therapy teaches patients to identify, evaluate, and respond to their dysfunctional thoughts and beliefs: Much work comes under this principle. Thoughts are examined for validation and accuracy whilst searching for 'evidence' of thoughts and beliefs. A tool typically used for this is 'The Daily Thought Record Sheet' (see Appendix B), which helps the client track and modify their thoughts.
9. Cognitive therapy uses a wide range of techniques to change thinking, mood and behaviour: Many of these techniques are in fact borrowed from and common to behavioural and other therapies, they may include; Socratic questioning, worksheets, role playing, behavioural experimentation, relaxation techniques, graded exposure (phobias and fears).

Young (1994 cited in Scott *et al* 1995: 3) has pointed out several possible limitations to the above principles. Clients may not always have access to their thoughts and feelings, particularly true of clients with long term disorders who may be out of touch with their feelings. It should not be a foregone conclusion that clients can identify 'triggers.' Client self control strategies and homework assignment motivation cannot be guaranteed. Clients may not be able to engage fully within a collaborative relationship within a few sessions.

Despite CBT's limitations, Craddy (2006: 29) is of the opinion that thought patterns and beliefs impacting on a client's emotions need to be considered and "integrated into whatever model is being practiced ..."

Schemas

A major theme running through CBT is a person's schema (cognitive structures developed early in life) described as a stored collection of past knowledge composed of many different events and life experiences almost like a collection of stories. From schemas (stored in long term memory) we can recall how we interpreted given situations which would include our emotional, and behavioural states, how we coped and what meaning did the experience leave us with. Schema theory posits that when we re-encounter a similar situation of a past experience, we can retrieve a similar schema, altering it to fit one's current experience.

CBT holds that client disturbance occurs as a result of processing incoming information unrealistically which becomes a distorted interpretation of events leading to inflexible and rigid schemas. This leaves a client with maladaptive core beliefs and underlying assumptions that lead to dysfunctional thinking and behaviour. However, Ellis would argue that it is 'irrational beliefs' that lead to maladaptive emotional states (Dryden 1995: 227). Clients often spontaneously selectively choose negative thoughts *and* images about oneself with seemingly no deliberate effort, often termed '... automatic thoughts' (Scott *et al* 1995: x) which lead to emotional disorders.

CBT assumes that a depressed person in some way may have easy and rapid access to schemas and automatic thoughts, Mark *et al* (1993: 101) disputes this, arguing it is only people in a depressed state that are subject to the appropriate observations. They posit that, '... there is little evidence that such individuals could have been distinguished from others not vulnerable to emotional disorders prior to its onset.' Egan (2002:4) describes clients in a similar situation as being 'tortured by unreasonable fears'. It is possible to imagine such a statement from Beck. One of the tasks of CBT is to 'chip away' at maladaptive schemas in order to modify one's core beliefs and behaviour.

Schemas, however, are not the preserve of CBT, as mentioned earlier George Kelly (Personal Construct Therapy) used the term 'personal constructs' to give meaning to the way we construe the world and our own view of reality. In Transactional Analysis, the concept of Eric Berne's 'scripts' were not unlike schemas. Other theorists describe schemata as 'Frames' or 'Frames of reference.'

Cognitive vulnerability and distortions

People who are predisposed to cognitive weakness have personal vulnerabilities and sensitivities exhibiting itself as psychological disturbance in which people often have internal dialogue with themselves. It leads Nelson-Jones (2003: 332) to state, '... their dysfunctional schemas and beliefs lead them systematically to bias information in unhelpful ways.' Some cognitive distortions taken from Beck (1995:119) that help maintain one's schemas and psychological distress may include;

Polarized thinking – I am the best or I am the worst.
Catastrophizing – (a negative prediction of the future).
Emotional reasoning – Thinking something is true whilst ignoring contrary evidence.
Magnification/minimization - Magnify negative aspects, minimize positive aspects.
Selective abstraction – Choosing one negative over many positives in a situation.
Mind reading – The therapist teaches the client that it is impossible to know what is in each other's minds.

A 'rationale' is given for the therapy and the client's disturbance explained, being based on the 'cognitive model' (Beck 1995: 18), see appendix A. This model holds that cognitions, emotions, behaviour and physiology interact with one another to produce emotional disorders, forming a 'cycle of worry' and emotional disorder. These cycles are common to depressives, seen also in the bereaved. CBT traditionally favours bringing about client change acting through the elements of cognitions (challenging automatic thoughts, teaching the client to seek 'evidence' for his thinking), and behaviour (by enacting role play or by taking exercise, lifting ones mood).
However, Scott *et al* (2001: 46) say that "… it is perfectly acceptable to break negative cycles via the emotional port …" for example, playing music or watching a 'feel good' film. During therapy, change can be brought about to one's mind or character Woolfe (1996: 272) refers to this as a 'restructuring of personality.' Idealists posit that the body is split from the mind (disagreeing with Beck's cognitive model) finding they are 'faced with the dilemma of how the mental can communicate with the physical' (Valle and King 1978: 158).

Relapse Prevention

Once the required number of sessions have been reached and all the education, teaching, training, homework, behavioural experimentation, worksheets, techniques, modified thinking and behaviour, explanations have been carried out alongside change in one's underlying assumptions, it is vitally important that the client presses on in life with what he has learned. Scott *et al* (1995: 32) give an excellent account of how the client can manage future distress by the client asking himself;

1. Triggers: What set off my reactions?
2. Emotions: What was I feeling?
3. Thoughts: What was I thinking?
4. Behaviours: What did I actually do?
5. Basic assumptions: What irrational beliefs of mine might be related?
6. Realistic concerns: In what way were my actions justified?
7. Overreactions: In what ways did I exaggerate or misinterpret?

CBT and Egan's approach to helping have much in common when it comes to relapse prevention. Recognizing that clients are at risk of relapse after completing initial therapy, CBT would typically offer three monthly 'booster sessions' whilst Egan would offer 'stop and check' sessions. However, both models stress the importance of clients retaining what has been learned during the educative nature of their therapies for future lifelong use. In true CBT fashion, Egan (2002: 360) posits that the counselling process, '… equips them with the working knowledge and skills needed to manage situations more effectively on their own.'

Transcultural issues within CBT appear to be an under researched area. Most major modern theorists including Beck are European or American, white males. Their schools of thought embedded in or a mixture of Psychodynamics, Humanistic or Behaviourism. d'Ardenne and Mahtani (1993: 74) make the point that western cultural values are not those of all 'peoples' and that 'The applicability of these theories to multicultural populations and women is questionable' (Katz 1985:619 cited in d'Ardenne and Mahtani 1993: 74).

Conclusion and the Review

This assignment has critically evaluated Cognitive Behavioural Therapy (CBT) making references to relevant others. The CBT model has been discussed which has included a critical analysis and evaluation of it's core concepts. Links have been shown to the philosophical, cultural and social constructs that gave rise to those concepts. The links have been made through experience of practice in the explication of the preferred model of CBT.

No attempt has been made to totally cover the vast field of CBT or to explain its individual therapeutic methods, tools and techniques to an array of disorders that it currently applies itself to. However, an attempt *has* been made to give the reader an 'insight' into the inner workings of CBT. A brief history of its originator has been given together with reasons of its formulation. Theorists who have been significantly influential to Beck have been mentioned, their reasons of why they made an impact on Beck's continuing formulation of CBT have been shown.

CBT's plus points and limitations have been 'weaved' throughout the assignment in a way that it has also shown what it has in common with other counselling models.

Although my current practice is in the bereavement arena and I work integratively, it is hoped that I have shown the reader the reasons why I have chosen CBT as my preferred model of counselling and psychotherapy.

Like many other models of counselling therapy, differences in world cultures still appears to be under researched. It is not difficult to imagine the many problems it can create within the counselling setting.

In my view, CBT appears to be forever gaining in popularity as a credible, well researched counselling model, the sources of it's content coming from the very top echelons of eminent theorists of psychotherapy.

REFERENCES

Beck, J.S. (1995) *Cognitive Therapy: Basics and Beyond*. New York: The Guildford Press.

Clarkson, P. (1989) *Gestalt Counselling in Action*. London: Sage Publications Ltd..

Craddy, C. (2006) 'A Place for CBT… and CBT in it's Place,' in *Therapy Today*, 17 (10): 28-29

d'Ardenne, P. & Mahtani, A. *Transcultural Counselling in Action*. London: Sage Publications Ltd..

Dryden, W. (ed.) (1992) *Integrative and Eclective Therapy: A Handbook.* Buckingham: Open University Press.

Dryden, W. (ed). (1995) *Individual Therapy: A Handbook*. Buckingham: University Press.

Egan, G. (2002) *The Skilled Helper 7th ed.* Pacific Grove, CA: Brookes/ Cole Publishing.

Hurford, H. & Seward, D. (2007) 'Putting counselors in the frame,' in *Therapy Today*, 18 (4): 7-11.

Ivey, A. E., Ivey, M. B., Simek- Downing, L. (1987) *Counselling and Psychotherapy, Integrating Skills, Theory and Practice*. London: Prentice Hall International.

Mark, J., Williams, G., Watts, F. N., Macleod, C., Mathews, A. (1993*) Cognitive Psychology and Emotional Disorders*. Chichester: John Wiley and Sons.

McCleod, J. (2007) *Counselling Skill.* New York: Open University Press.

Nelson- Jones, R. (2003) *Theory and Practice of Counselling & Therapy 3rd ed.*. London: Sage Publications Ltd..

Scott, M. J., Stradling, S. J. (2001) *Counselling for Post Traumatic Stress Disorder 2nd ed.* London: Sage Publications Ltd..

Scott, M. J., Stradling, S. G., Dryden, W. (1995) *Developing Cognitive Behavioral Counselling*. London: Sage Publications Ltd..

Valle, R. S., & King, M. (1978) *Existential – Phenomenological Alternatives for Psychology.* New York: Oxford University Press.

Woolfe, R. & Dryden, W. (eds) (1996*) Handbook of Counselling Psychology*. London: Sage Publications Ltd..