THE PROCESS OF PSYCHOTHERAPY FOR HELPING PROFESSIONALS: THE ROLE OF EMPIRICAL FINDINGS TO GUIDE PRACTICE

A Kagee

INTRODUCTION

Ever since it achieved respectability as a modality of healing, the practice of psychotherapy has been subjected to considerable discussion, debate and criticism. Often the therapist is attributed the status of an emotional saviour, a personal champion or a benevolent confidant. Despite the fact that counselling and psychological treatment feature prominently in modern health care, the internal mechanisms of the therapeutic process are sometimes shrouded in mystery. Hence, the professional and ethical imperative is to lay bare the inner workings of therapist-client dynamics that lead to emotional healing and client change. This paper is an articulation of a process of psychotherapy and is aimed at identifying the sometimes hidden change processes that effect mental and emotional healing.

The paper has been organised into several sections. First, a paradigm is identified within which the process of psychotherapy is located. Second, a rationale for the therapeutic process is delineated. The psychotherapy process is then described from the initial to the final stage and evidence is cited to support specific therapeutic procedures and techniques. Additional miscellaneous factors are cited that impact on the therapeutic proceedings. A process model is necessarily subject to future revision following increased personal experience, advances in theory and new empirical findings.

A CONTEXTUAL PARADIGM

Largely neglected in the discourse of psychotherapy is the essential notion that this form of exchange and healing is premised on often concealed but always undeniable ideological, political and cultural assumptions that inform our practice (Katz, 1985). Much of Euro-American psychology is seemingly oblivious to the sociogenic factors that impact on mental health. Instead, there is a tendency to locate the etiology of pathology and problematic interpersonal relationships within individuals (Mann, 1978), thus absolving the socio-political context of its role in contributing to human distress (Perkel, 1988).

The practice of psychotherapy and mental health counselling extends from the premise of Euro-American cultural and ideological values (Katz, 1985). According to Pedersen (1987), these values include an emphasis on individualism, a reliance on linear thinking and a focus on effecting individual rather than systemic change. The practice of psychotherapy is therefore implicated in endorsing a social agenda, namely that of reifying the cultural and ideological norms of those who exert hegemony in society (Katz, 1985).

As mental health practitioners, it is of great consequence for us that the clinical practice of the helping professional reflects the theoretical grounding of his or her view of human nature. Thus a personal worldview that embraces the principles of cultural pluralism (Carter, 1991), social contextualism (Cottone, 1991), and the interactional and dynamic manner in which clients engage with their social and political realities (Mann, 1978) should be reflected in therapeutic practice. Following from this important premise, a conceptual task of psychotherapy is then to resist the tendency to treat the client in isolation from his or her social framework. Instead, the imperative is for effective therapists to locate the client's psychic dilemma within the context of extra-individual

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variables such as social class, race, ethnicity and access to social power (Bulhan, 1985). Many authors stress the importance of clinicians familiarising themselves with the culture of their clientele (Hilliard, 1985; Jones, 1990; Todisco & Salomone, 1991; Wade, 1994) and thus acquiring a familiarity with and knowledge of clients' cultural context, political reality and worldview is necessary.

Caution should be exercised not to conflate the heterogeneous nature of a society's culture to a single and unvarying phenomenon. Instead, the notion of plurality within and between cultures should be acknowledged and embraced. In order to diffuse tensions that may arise in transcultural therapeutic relationships, the therapeutic task then is to directly acknowledge differences when they occur and to confront their effects on rapport (Block, 1984).

A RATIONALE FOR PSYCHOTHERAPY

Effective and congruent treatment services to clients follow two basic assumptions, namely the efficacy of psychotherapy and the ability of clients to benefit from treatment (Moursand, 1990). Regarding the first assumption, Frank, Hoehn-Saric, Imber, Lieberman and Stone (1978:30) note that "…simply by offering any form of therapy the therapist conveys his expectations that it will work, thus creating favourable expectations in the patient". Hence, the activity of rendering psychological services communicates an unspoken acceptance that this form of healing is both effective and beneficial. However, simple belief in therapeutic efficacy, while necessary, is not sufficient from either an ethical or a professional standpoint. Familiarity with the empirical evidence demonstrating the effectiveness of psychotherapy is also an implied imperative (Lambert, 1991).

Considerable evidence has been amassed to support the position that psychotherapy is an efficacious endeavour (Smith & Glass, 1977; Smith, Glass & Miller, 1980) and thus familiarity with this rich empirical base is warranted. While noting the utility of positivist methods of inquiry in demonstrating therapeutic efficacy, it is also acknowledged that some qualities of the therapeutic exchange defy experimental manipulation. Thus methodological eclecticism is indicated in arriving at a more complete understanding of therapeutic dynamics (Garfield & Bergin, 1994).

The second proposition offered by Moursand (1990) rests on the assumption that the client has personal freedom to effect modifications in her or his life and thus benefit from therapeutic interventions. The practice of therapy is premised on the inherent strength of clients to act upon and alter problematic behaviours, cognitions and emotions in order to realise psychological wellness (Seedat & Nell, 1990).

On a related point, despite the seeming immensity and insurmountability of the presenting problem, it is worth noting Haley's (1976:5) assertion that "…the most useful point of view for the therapist is the idea that there is sufficient variety in any situation so that some better arrangement can be made". While clients may be immersed in dysfunctional familial and other relationships, the realisation that the individual client is responsible first for changing herself or himself offers an avenue out of the mire of hopelessness.

Luborsky (1976) notes that the client's expectation of positive change is of paramount importance in predicting successful therapeutic outcome and thus the therapist's belief in the value of psychotherapy is a powerful contributor to the client's healing. Consequently, Moursand's (1990) two underlying assumptions of the psychotherapy process provide not only an ethical rationale for the therapeutic engagement, but also serve the pragmatic function of enhancing therapeutic efficacy, namely instilling hope in the client that healing is not only possible but also likely to

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occur. Hope, therefore, is an essential ingredient of therapy and hence a foundational therapeutic task would be to instil a sense of hope in the client.

Having briefly described salient components of an effective paradigm of psychotherapy and provided a rationale for its practice, it is now appropriate to operationalise in greater detail a model for the process of psychotherapy. While the process model that follows serves as a broad template for the therapeutic exchange, it is necessary to note that consistent adherence to it is sometimes constrained due to the contextual pragmatics of specific therapy situations. Thus the model assumes a quality that oscillates between a literal blueprint and theoretical abstraction.

BEGINNING THE JOURNEY OF PSYCHOTHERAPY

The initial interview often carries a disproportionate salience in comparison with other stages of the course of therapy, since several tasks must be accomplished here. The presence of the client in the therapy room is a powerful signal of her or his hope for recovery from problematic symptoms, as well as a communication of faith in the psychotherapy process and in the clinician as a healer. The fact that in medical trials patients who receive placebo treatment generally show greater improvement compared with those who receive no treatment (Bowers & Clum, 1988; Landman & Dawes, 1982) suggests that hope is an essential determinant of positive change. It is therefore appropriate to harness this attribute in therapy for maximum benefit in facilitating the reduction of symptoms. One way of ensuring that the momentum of hope is not squandered is to schedule the first session rapidly following the client's initial application for services. The importance of such promptness is underscored by evidence that a long wait between seeking and ultimately receiving therapy is negatively related to outcome (Luborsky, Crits-Christoph, Mintz & Auerbach, 1988).

The culture of psychotherapy (Bernard, 1994), while familiar to therapists and others well-versed with the mental health profession, is often alien to many new clients. Often the erroneous expectation persists that the therapist will assume the role of a personal saviour and offer solutions that will magically supplant the client's problematic symptoms with healthy functioning. Thus, in the initial interview it is appropriate to engage the client in identifying and modifying expectations for the course of therapy, since such role induction is associated with positive outcomes (Eisenberg, 1981; Friedlander 1981). In this way, the myth that the therapist is an authoritarian dispenser of treatment, while the client assumes the position of a passive recipient, is gently negated. Instead, the client is regarded as an active participant in the therapeutic proceedings, whose task is to collaborate in defining the agenda and to engage in a bilateral dialogue in which solutions are jointly sought. In this manner a synergy is created in which symbiotic and reciprocal interpersonal influence within the therapist-client dyad is effected (Highlen & Hill, 1984).

Setting the parameters described above is indicated following the findings that client involvement in the process of therapy (Kolb, Beutler, Davis, Crago & Shanfield, 1985), and a collaborative rather than authoritarian therapeutic style (Rudy, 1983), are related to a positive outcome. Indeed, a process that facilitates the client's verbal engagement in the therapeutic exchange should be developed, since this has also been associated with positive end results (Sloane, Staples, Cristol, Yorkston & Whipple, 1975).

Demystifying the process of psychotherapy, explaining to the client how and why it works, estimating the approximate length of time of treatment and offering an optimistic prognosis are powerful interventions in countering the client's sense of demoralisation (Frank, 1981). Moreover, by making the process transparent, client empowerment is encouraged (Mann, 1978) and in this manner hope is instilled that positive change is a likely outcome of treatment (Smith & Glass, 1977). Depending on the specific context, it may also be useful to provide him or her with objective evidence of therapeutic efficacy (e.g. Lambert & Bergin, 1994).

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During the intake interview it is appropriate to defer judgment and refrain from forming a binding pact to work together. Instead, the first three sessions may be devoted to mutual assessment, after which both the client and the therapist may arrive at a realistic appraisal of the healing possibilities and of their desire to work together.

The client's regular attendance during the first six months of therapy requires emphasis as it has been demonstrated that the most change occurs in this period (Howard, Kopta, Krause & Orlinsky, 1986). Particularly, the importance of the client attending the first few sessions should be underscored, following findings that clients who miss one of their first four scheduled sessions are more likely to experience negative outcomes (Peiser, 1982, cited in Whiston & Sexton, 1993).

The payment of a fee for service signals the client's personal investment in the therapy process, which is considered to enhance therapeutic outcome. This contention is supported by evidence linking fee-payment to the success of therapy (Meinberg & Yager, 1985; Stanton, 1976). Moreover, the expectation that missed sessions will be paid for places the responsibility of regular attendance on the client.

While ensuring that the client's experience is validated, it is also beneficial to contextualise the client's subjective tribulations within the broader frame of human experience by acknowledging that others too endure similar difficulties (Highlen & Hill, 1984). Hence, a new meaning may be generated if the client locates his or her individual predicament alongside that of others who have or have had similar experiences (Waldegrave, 1990).

It is appropriate for the tasks of assessment and diagnosis, which should be continually revisited throughout the course of treatment, to commence in the initial interview. A crucial and sometimes overlooked aspect of the assessment process is determining whether the client is likely to benefit from participating in therapy (Seligman, 1986), since suitability for treatment has been linked to positive outcome (Colson, Cornsweet, Murphy, O'Malley, Hyland, McParland & Coyne, 1991). If, after the initial assessment, a client is clearly an unsuitable candidate for psychotherapy, an appropriate referral should be made, e.g. for medication management (Buelow & Hebert, 1995).

While for many therapists the diagnosis represents an attempt to unnecessarily label the client and the presenting problem (Sarason & Sarason, 1989), the case in favour of this process is strong, since it permits rapid and effective communication between clinicians, treatment planning and record-keeping (Seligman, 1986). The limitations of diagnosis are, however, acknowledged since "…there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder" (American Psychological Association, 1994: xxii). Consequently, the concept of diagnosis is approached with some flexibility and the process is employed as a guide to formulating a treatment plan.

As an aid to the diagnostic and treatment planning process, psychometric testing offers an additional means to construct an integrated assessment of the client (Anastasi, 1988). However, the utility of tests is enhanced when augmented by clinical data derived from personal interviews with the client and from the recorded case history. As Anastasi (1988) cautions, data provided by test scores should be regarded as part of a set of hypotheses about the client that await confirmation or refutation as other information is gathered. Consequently, when considered as one of several sources of information, the results of psychometric testing provide valuable insights into the intrapsychic dynamics of clients and offer a springboard to further therapeutic conversation.

Most theoretical orientations concur that an essential ingredient for effective therapy is the clinician-client relationship (Highlen & Hill, 1984). Indeed, it is worth noting Rogers's (1967:73)

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assertion that "significant positive personality change does not occur except in a relationship". The importance of therapeutic rapport is underscored by Gelso and Carter's (1985) observation that a positive relationship provides the basis for the application of therapeutic procedures and techniques that effect client change. These propositions are not only of heuristic import, but are buttressed by considerable empirical evidence that a strong therapeutic relationship is related to a positive therapeutic outcome (Bachelor, 1991; Luborsky *et al.*, 1988).

The initial phase of therapy carries the inordinate responsibility of setting the tone for initiating and maintaining a strong therapeutic relationship, although this process is of course ongoing and its effects cumulative. By using such techniques as questioning, paraphrasing, reflecting and commenting, the therapist engages the client in a therapeutic conversation in which information is shared, tentative hypotheses are generated and tested and rapport is developed (Moursand, 1990). These activities, when engaged in respectfully, convey the therapist's sense of congruence, genuineness and positive regard (Rogers, 1967). However, contrary to Rogers' assertion that these therapist attributes constitute "necessary and sufficient" conditions to facilitate positive change, it is believed that further interventions that effect change are strongly indicated. However, these may only be rendered within the context of a positive relationship.

Rogerian concepts have been demonstrated to show effectiveness in therapeutic outcome. For example, positive regard and therapist warmth toward the client have been found to be related to improved outcome (Feitel, 1968, cited in Whiston & Sexton, 1993). The therapist's level of engagement in the therapeutic relationship is also related to positive outcome (Friedlander, 1981). The client-therapist relationship is a continuous theme of the therapeutic process, since it is inextricably related to other essential components of facilitating change. Rapport thus has relevance and application throughout the process, although its salience is enhanced in the initial phase.

The process of goal-setting and of identifying the pertinent matters that require work signals both parties' serious commitment to a collaborative arrangement. In addition, the therapist's routine checking that the therapeutic conversation addresses important issues to the client conveys genuineness and respect for his or her contribution to the process.

THE CORE OF THE THERAPEUTIC EXCHANGE

The therapeutic process defies an orderly transition from the initial to the middle phase and these constructs are used mainly for purposes of organisation. Indeed, many of the tasks identified thus far are woven into the course of the client-therapist interaction throughout the process. Once rapport has been established and therapeutic induction has commenced, the task of developing the client's expectations for positive change now has to be altered to maintaining these expectations, since this has been related to positive outcome (Luborsky *et al.*, 1988). One way of maintaining such expectations would be to routinely redirect the therapeutic dialogue to the presenting problem rather than engaging in discussion about tangential or peripheral matters. The value of such direction is enhanced by evidence that it results in positive outcome (McCullough, Winston, Farber, Porter, Pollack, Laikan, Vingiano & Trujillo, 1991). The use of questions in further investigating and focusing on the client's problem is also indicated (O'Malley, Suh & Strupp, 1983). Simultaneously and somewhat paradoxically, a stance that conveys respect and regard for the client's sense of self requires that the therapist permit him or her to define the agenda for the therapeutic conversation (Moursand, 1990). Such a practice not only fashions a collaborative interaction, but is also instrumental in fostering the client's sense of empowerment (Mann, 1978). A sound practice as each session commences therefore is to inquire of the client how he or she would like to make use of the time together. As the session draws to a close, it is again appropriate

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to ask the client to offer a synopsis of the therapeutic discussion as a means to provide closure to the hour of contact. Thus, when the client is assigned responsibilities in the therapeutic proceedings, his or her sense of self-efficacy is validated.

Three aspects of psychological change are invoked in effecting healing and symptom reduction, namely affective deepening, cognitive restructuring and an alteration in behaviour patterns. Differentiation within this triangle of psychological change is often unnecessary, since its synergy culminates in a holistic conceptualisation of psychological distress and healing. However, it is simultaneously possible to tease out and focus on specific dimensions at a time. Given the emphasis placed on affect in many theoretical orientations and for the purposes of convenience, it is appropriate to focus first on this dimension.

An often stereotyped theme of the core therapy process is the therapist's facilitation of the affective engagement of the client. While it may be an exaggeration to assert that no therapeutic change would occur without engaging affective processes, it is presumed that experiencing in-session affect will promote opportunities for client change. This position is not only theoretically endorsed (Greenberg & Safran, 1987), but also empirically validated since a focus on patient affect has been associated with positive change (Jones, Parke & Pulos, 1992).

Various affective change processes are involved in the client's accessing of his or her in-session emotional experience. These include a conscious acknowledgement of the primary affective response, an arousal of the affective response usually in the form of a cathartic release, and a consequent expression of feelings within the context of the therapeutic relationship (Greenberg & Safran, 1987). Moreover, the client's personal ownership of emotions and the acknowledgement that responsibility for these emotions resides with herself or himself are considered necessary factors. However, such an acknowledgement is not necessarily equated with locating the etiology of the problem within the individual client.

The task of the therapist in facilitating affective experiencing is to accurately reflect the client's affect with the expectation that this will result in emotional expression and release. Again, the salience of a strong relationship cannot be overstressed as emotional release within a poor relationship is considered unproductive at best and detrimental at worst. The client's experience of receiving sensitive care and positive regard from the therapist despite expressing negative emotions is likely to result in an experience of validation. This sense of validation permits the client an entitlement to his or her subjective experience and consequently promotes the experience of a new way of being (Greenberg & Safran, 1987). In this manner the client may "re-experience that relationship emotionally and learn at an emotional level that it is possible to respond differently" (Moursand, 1990:65).

An important therapeutic task during emotional arousal is the direction of the client's attention to the present or "the Now" (Perls, 1969, cited in Corey, 1986). Hence, during affective arousal it is appropriate to help the client make contact with the present moment by offering support and by encouraging a dialogue in the present tense (Corey, 1986). A focus on here-and-now involvement during therapy has been found to be related to positive outcome (Jones, Cummings & Horowitz, 1988; Orlinsky & Howard, 1975).

Such a focus invariably invokes the transference aspects of the relationship, since in the context of emotional arousal in therapy the clinician is the primary provider of support and care. Thus, she or he becomes the object of the client's affective energy and the therapeutic rapport is consequently intensified. Since transference entails either a positive or a negative misinterpretation of the therapist by the client (Gelso & Carter, 1985), it considered necessary to take this process into account throughout the therapeutic exchange, but especially during periods of the client's

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emotional arousal. However, the deliberate cultivation, intensification and analysis of transference may not necessarily constitute a therapeutic imperative unless it assumes a problematic dimension and hinders therapeutic work. On the other hand, the therapist-client relationship often provides rich data that may be utilised to extrapolate and infer the dynamics of other extra-therapeutic relationships in which the client may be engaged. Some evidence has been found linking a focus on personal relationships and transference to positive outcome (McCullough *et al*., 1991).

A possible marker that distinguishes the middle phase from the earlier stage of therapy is the focus on affect, as opposed to a more superficial description of the problem which characterises the earlier stage (Moursand, 1990). Again, the clients' progress through the therapeutic journey defies neat compartmentalisation into impermeable stages. Indeed, the progress of many clients is often staggered, oscillatory and circular.

No deeply ingrained emotion is willingly forsaken, since symptoms often serve a secondary function of providing the client a homeostatic, albeit uneasy, affective plateau. The abandonment of a troublesome symptom, emotion or cognition is usually accompanied by a marked level of discomfort. It is here that the therapist-client relationship is of crucial importance, since the therapist must provide the client a haven of safety and simultaneously encourage her or him to remain with the pain experienced in the moment. This process is considered instrumental in emotional unblocking and in paving the way for further growth (Perls, 1969, cited in Corey, 1986). Staying with the client is not only theoretically sound but has empirical support. For example, the therapist's focus on here-and-now involvement was found to be related to positive outcomes (Jones *et al*., 1988), as was the client's focus on the same (Orlinsky & Howard, 1975). Similarly, the therapist's supportive communication has also been associated with a positive outcome (Jones *et al*., 1992).

For many clients an abreactive release ushers in new ways of relating and may be accompanied by some hesitance often born from guilt, shame or even a sense of emotional self-indulgence. Here the therapist's task is to encourage the client to suspend personal judgment, to offer permission to feel and to reassure him or her of the validity of the experience. Fundamental to the therapist's credibility as a permission-giver is the client's perception of him or her as having expertise and trustworthiness (Strong, 1968).

Focusing on the client's affect provides the therapist with an opportunity to stay with the client while continuing to offer support, and repeatedly directing her or him to focus on the here-and-now experience. In this way the therapist assists the client in amplifying and developing significant or poignant statements (Greenberg & Safran, 1987). The employment of such detailing is supported by empirical data. For example, therapeutic interventions associated with a positive outcome include focusing on patient affect (Jones *et al*., 1992; Hoyt, Xenakis, Marmar & Horowitz, 1983) and here-and-now involvement (Orlinsky & Howard, 1975).

One possible way of augmenting permission to feel is the technique of silence. For many, silence during social conversation represents a moment of awkwardness. In the therapeutic exchange, however, silence offers the opportunity for reflection, pacing, focused introspection and an analysis of the meaning of the silence (Corey, 1986). Since the therapeutic dialogue is premised on an alternative set of assumptions to those of social conversation, silence may signal the development of important processes within the client and the client-therapist dyad. Hence, it may provide rich material for a further exploration of affect (Moursand, 1990).

Reflection and interpretation of the client's affective statements or of silence is a method of increasing awareness and reshaping her or his construction of reality. These techniques should ideally grapple with the underlying meaning of the client's utterances and not merely echo their

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content. Timely interpretations may assist clients in comprehending the relationship between previous cognitions, affect or behaviour, and those occurring in the present. In this manner fresh insights into future possibilities may be gained (Corey, 1986).

Interpretations are not without pitfalls as they may be incorrect. Hence, they may be presented in the form of tentative hypotheses with the expectation that they be confirmed or rejected by the client. Further, by offering rampant interpretations the therapist may impose meaning on the client's statements instead of permitting her or him to make personal discoveries that generate a personally-owned meaning. Consequently, an appropriate task is to assist the client in making unique interpretations and to jointly explore possible meanings with her or him. The empirical support for the use of interpretation and reflection is strong, and these techniques have been overwhelmingly related to a positive outcome (Cadbury, Childs-Clark & Sandhu, 1990; Jones *et al*., 1992; Jones *et al*., 1988). Furthermore, the process of facilitating the client's self-exploration has been associated with a positive outcome (Orlinsky & Howard, 1975; Hill, Beutler & Daldrup, 1989).

The timing of encouraging high affective arousal is a critical therapeutic and ethical point. It is often detrimental to induce high emotional expression with the client just prior to the end of the therapeutic hour. Instead, if an emotionally-charged point arises close to the end of the session, a responsible practice would be to postpone its clarification until the following encounter (Moursand, 1990).

The notion of client insight in the therapeutic proceedings is bestowed differential status by various therapeutic orientations (Corey, 1986). However, insight has significant implications in linking an affective arousal to cognitive change. When latent emotions are brought to conscious awareness, a realisation often occurs as to the underlying etiology of dysfunctional symptoms. Among the therapeutic techniques associated with effecting shifts in awareness is the Gestalt two-chair technique as behaviour change and the resolution of intrapsychic conflict has been shown to follow this form of treatment (Greenberg & Dompierre, 1981).

Whether cognitive change precedes or follows affective arousal requires no prolonged debate. However, while affective change may be effected, it is also appropriate and even necessary to attend to cognitions by identifying those that are self-defeating for the client and those that facilitate their restructuring or discardment (Ellis, 1979). A conventional conceptualisation of "irrational beliefs" (Corey, 1986:216) is resisted, since this notion rests on the assumption of an external objective reality that must be aspired to by clients. Instead, a constructivist view of ontology is favoured in which reality is defined from the perspective of the client and problematic cognitions are viewed as reflections of "formerly adaptive strategies" (Mahoney & Lyddon, 1988:219) that are now presently maladaptive.

Nonetheless, beliefs that lack utility for the client in terms of psychological wellness may be challenged with the aim of recognising the purpose they serve in buttressing the client's appraisal of her or his life situation or of the problem. Various techniques may be employed to offset the undue hegemony that these non-utilitarian beliefs and automatic thoughts exert on the client. Socratic questioning, for example, has the aim of disputing beliefs that have a negative impact on the client's affective set. In a collaborative spirit automatic thoughts and beliefs may be approached jointly and every cognition may be conceptualised as a hypothetical assertion to be tested against external evidence (Young, Beck & Weinberger, 1993).

Employing this methodology of "collaborative empiricism" (Young *et al*., 1993) signals regard for the client's belief structure and is consonant with a constructivist conceptualisation of the client's reality (Mahoney & Lyddon, 1988). In almost all cases irrational or faulty cognitions can be

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refuted by objective evidence garnered from past events, present circumstances and future possibilities. Rather than vigorously persuading the client to alter cognitions by exposing their illogicality, an alternative approach may be to invite the client to discover beliefs that are inconsistent with reality on their own. In this way the therapist serves as a guide in the client's process of self-discovery, rather than robustly debating, disputing and challenging her or him as is common in some cognitive therapies (Corey, 1986).

Semantic adjustment is another avenue to cognitive restructuring, since from the rational-emotive standpoint "…imprecise language is one of the causes of distorted thinking processes" (Corey, 1986:221). Since the relationship between language and cognition is often symbiotically and dynamically influential (Chomsky, 1993), the client's language patterns should receive close attention. Hence, language patterns that reflect helplessness and self-condemnation may be unlearned and fresh, positive self-statements may be substituted in their place.

As a final component of psychological change, the therapeutic conversation may be directed to fashioning alternative behaviours to previously maladaptive ones. Techniques such as behavioural rehearsal in assertiveness training (Emmelkamp, Van der Hout & De Vries, 1983), in vivo exposure (Marshal, 1988), role-play of alternative response patterns, social skills training (Paul & Lentz, 1977), and progressive and applied relaxation in cases where anxiety reduction or stress management are indicated (Ost, 1988) have shown considerable promise as therapeutic interventions. Certainly, behavioural rehearsal within the therapeutic context as well as between-session homework assignments will permit clients to perform new and difficult tasks. In this manner they may translate affective and cognitive insights in the form of concrete action. Inevitably, the idea that engaging in activities directed at altering one's personal circumstances is preferable to non-action is communicated.

Another method of altering problematic behaviours is the technique of the paradoxical directive, which has been associated with considerable therapeutic success (Conoley & Garber, 1985; Horvath & Goheen, 1990), especially with clients who are resistant to change. However, criticisms that have been levelled against paradoxical techniques include the fact that they are premised on manipulating and deceiving the client (Hill, 1992). Consequently, their implementation is considered ethically dubious unless, as suggested by Hill (1992), clients are provided with information about the intention of the technique and the technique itself is jointly designed by the therapist and client.

Behavioural interventions of any variety are concrete markers for measuring client change. When a new behaviour has been successfully implemented and practised in or outside of therapy, a probable consequence is an enhanced sense of self-efficacy (Bandura, 1977). Interventions directed at altering behaviour should ideally be designed to produce maximal success in client performance, thus inspiring confidence, which in turn would generate further successes in behaviour. As a measure of the utility of therapeutic interventions, continuous checking of her or his perception of progress is indicated. In this way ineffective interventions may be swiftly replaced with alternative ones.

The triple mode of psychological change (affect, cognition and behaviour) may be invoked to effect symptom reduction at an immediate level. Simultaneously, deeper healing to cement therapeutic gains in a long-term manner may be effected with the use of various techniques and approaches such as in vivo treatments, reinforcing functional behaviour and enhancing self-efficacy (Galassi & Galassi, 1984). In summary, the core of the psychotherapeutic engagement involves modifications in all three modalities of psychological response and these culminate in holistic client change.

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THE END OF THERAPY

Considered rather as a process than a single act, termination procedures ideally commence from the onset of therapy. As a component of therapeutic induction, the onus is on the clinician to define the therapeutic relationship as a finite engagement and the client should be routinely but sensitively reminded throughout the course of therapy of this fact. Although the empirical data on the superiority of time-limited versus unlimited contractual terms of therapy are mixed (Zola, Howard & Orlinsky, 1987, cited in Orlinsky, Grawe & Parks, 1994; Gelso, Spiegel & Mills, 1983), it is considered a sound ethical practice to offer a time estimate for the duration of therapy). Such an estimate may be based both on personal experience and empirical data.

While the temptation to convey an impression of termination as a temporary phenomenon may be great, the reality of its permanence must be confronted. Termination procedures, then, when implemented sensitively and empathically, would provide a sense of closure to the unique interpersonal experience in the therapeutic dyad. Much of the empirical literature supports the use of termination procedures (Clementel-Jones, Malan & Trauer 1990; McNeill, May & Lee, 1987; Quintana & Holahan, 1992) and relate "proper termination" (Orlinsky *et al.*, 1994:291) to a positive outcome. Consonant with the theme of egalitarianism and collaboration in the therapeutic relationship, it is preferable for the timing and method of termination to be arrived at mutually, rather than unilaterally decided upon by either the therapist or the client. This strategy is empirically supported as termination by mutual agreement has been associated with more successful rather than less successful cases (Clementel-Jones *et al*., 1990). Similarly, clients who terminated against the advice of their therapists were found to experience poorer treatment outcomes to those who completed treatment (McNeill *et al*., 1987).

Mutual sharing of affective reactions to the termination process is also indicated in order to facilitate healthy closure. The client's externalisation of these feelings should be especially facilitated and processed. Many affective responses accompany the termination process. These include sadness at the prospect of separation, anger at a possible sense of abandonment, fear of the loss of an important anchor and of the possible recurrence of symptoms, or guilt about a sense of dependency on the therapist. Many clients may even experience pleasant affect brought on by the satisfaction that therapy was successful (Moursand, 1990). Processing of affect has been associated with a positive outcome, as has discussion of the termination process, review of the course of therapy and other activities directed at gaining closure on the relationship (Quintana & Holahan, 1992).

It is considered both therapeutically detrimental and hence ethically unsound to terminate abruptly without an opportunity to process the implications of termination for the client. Sometimes, due to a variety of circumstances, clients unilaterally decide to discontinue their attendance in therapy. When discontinuation occurs, the therapeutic and ethical imperative is to invite the client back into treatment to commence termination procedures and to communicate the availability of further treatment at a later stage. Indeed, even when termination is mutually agreed upon, it is appropriate to offer an open invitation to the client to return whenever the need arises or when symptoms resurface. Such an invitation may be extended in a manner that does not encourage dependence on the therapist, but simultaneously communicates that future psychological suffering may be alleviated with additional therapeutic work. As a final gesture, a sound practice in cases where recidivism is likely is to make contact some time after the final session to inquire about the maintenance of therapeutic change (Nicholson & Berman, 1983).

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MISCELLANEOUS FACTORS

Several additional factors impact on one's effectiveness as a clinician. It is generally a safe practice to consult with other professionals about one's clinical judgment, case conceptualisation and treatment interventions as a means of ensuring that high-quality care is rendered. Hence, in any practice of psychotherapy, regular supervision or consultation, depending on the specific context, are integral components of therapeutic work (Bernard & Goodyear, 1992).

Reflecting a multi-disciplinary approach to mental health care, the therapist may be partnered with other professionals in offering psychological and other treatment. In an effort to approach treatment holistically, communication between members of the team is often necessary. Consequently, consultation and other communication should be conducted with an emphasis on sound professional ethics. Indeed, any interaction with clients and other professionals should reflect the ethical principles outlined by the various professional bodies governing psychology, social work, nursing and medicine. As a final point, regular and efficient record-keeping and charting of important therapeutic data often buttress the clinician's ability to offer swift clinical opinions, to render effective interventions and to refer timeously.

CONCLUSION

The process of psychotherapy has been presented in this paper as a linear, consequential series of activities. However, it is necessary to note the often circular and oscillatory processes that occur with psychological healing. If the impression is conveyed that client change follows a rational and clearly identifiable trajectory, then this is due to the theoretical nature of the present model. Often the therapeutic road is rocky and uneven, presenting unique therapeutic challenges with each client. Specific clients within specific contexts will require more specific interventions than have been outlined here.

Despite the fact that the model is presented as a series of progressive stages, the dichotomy of these stages is essentially arbitrary and somewhat artificial. However, a stage approach provides a convenient infrastructure within which to conceptualise and articulate a process model.

While the model represents an approach to conducting psychotherapy and should thus be regarded as a concrete description of personal practice, it simultaneously assumes dynamic and fluid characteristics. It is necessarily subject to further revisions following increased personal experience, since this will impact on future therapeutic pragmatics. As has been noted, a practical imperative for any effective therapist is to keep abreast of the theoretical and empirical literature. Thus advances in theory and new empirical findings will inevitably affect the revision of the model as it is continually revisited.

This paper has sketched a paradigm within which psychotherapy is conceptualised, offered a rationale for the therapeutic process and described a model for the process of facilitating psychological healing. Further miscellaneous factors were then identified that affect the process and an emphasis was placed on ethical considerations in professional practice. The model is an articulation of a conceptualisation of psychotherapy and client change that is based on the best available evidence. Its constant reformulation is thus both of professional and heuristic import.

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Prof Ashraf Kagee, Department of Psychology, Stellenbosch University, Stellenbosch, South Africa.