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COUNSELLING IN ACTION

Counselling psychology and the integration of theory, research and practice: A personal account

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Abstract
This paper aims to explore the factors that have contributed to the development of my understanding of integrating theory, research and practice. I will attempt to demonstrate how factors such as relevant psychotherapeutic models, psychological research, use of supervision, personal therapy and multicultural issues have impacted upon my ongoing practice as an integrative practitioner. My growing capacity to think reflectively will be illustrated by the use of clinical examples from my work as a trainee counselling psychologist. Furthermore, I will also explore how the development of reflective thinking has assisted in my ability to grow as an integrative practitioner. However, this paper will not suggest that I have become a fully integrated therapist or that my style of practice is fixed and thus not open to future development; it rather aims to demonstrate the ways in which the foundations towards this aim have been set.

Keywords: *scientist practitioner model, integration, eclecticism, therapeutic relationship*

Introduction

Counselling Psychology can be defined as ''the application of psychological knowledge to the practice of counselling'' (Woolfe, 1996, p. 4). The British Psychological Society's guidelines for the professional practice of counselling psychology state that the aim of the profession is to ''develop models of research and practice which marry the scientific demand for rigorous empirical inquiry with a firm value base grounded in the primacy of the counselling/psychotherapeutic relationship'' (BPS, 1998, p. 3).

In my view these guidelines propose the adherence to a scientist-practitioner model which, according to Meara, Schmidt, Carrington and Davis (1988), is ''an integrated approach to knowledge that recognizes the interdependence of theory, research and practice'' (p. 368). A more recent definition states that ''scientist-practitioner psychologists embody a research orientation in their practice and a practice relevance in their research. Thus, a scientist-practitioner is not defined by a job title or a role, but rather by an

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integrated approach to both science and practice'' (Belar & Perry, 1992, pp. 72–73, see Milne & Paxton, 1998). My position is that developing as an integrative practitioner one needs to draw on these three aspects (theory, research and practice) with the aim to use the knowledge derived to tailor therapy to the client's needs. The idea of integrating different psychotherapies has intrigued professionals for over a half century (Goldfried & Newman, 1992). The failure of psychotherapy outcome studies to support the efficacy of one approach over the others (Clarkson, 1994; Goldfried, Castonguay, & Safran, 1992) has provided another stimulus for interest in psychotherapy integration.

My integrative approach to psychotherapy draws from a number of theories of human functioning: client-centered, cognitive-behavioural, psychodynamic, to name but a few. I agree with Putnam (1996) who states that we need to integrate all these perspectives on human behaviour into a consistent working model, the aim being to help clients to be able to act congruently with their selves and to be in relationship at the same time.

Emphasis on the therapeutic relationship

Over the years of my training, I have been able to acquire a good understanding of three major psychotherapeutic approaches, namely client-centred therapy, psychodynamic therapy and cognitive behavioural therapy. My endeavour throughout these years has been the integration of these schools of thought as well as the incorporation and effective utilization of various other aspects such as relevant research, personal therapy, supervision, social and cultural issues, ethics and the work context in which the therapy is taking place. As a developing integrative therapist, I am increasingly learning that the most important things that I have to offer to my clients are my genuine interest in their phenomenological experiences, my presence to provide a safe environment as they explore their internal worlds, and a relationship with me based on mutual trust as they learn to bridge the gap between their internal and external worlds.

Hence, throughout my training, I have been interested in factors that unify rather than divide the aforementioned schools of thought. For example, I have been attracted by the expanding body of empirical evidence suggesting that the specific techniques associated with specific types of therapy are less important than non-specific factors such as positive qualities of the therapeutic relationship (e.g., Clarkson, 1995; Orlinsky & Howard, 1986). One cannot disregard the fact that in a comprehensive review of the research relating psychotherapy process variables to psychotherapy outcome, it was found that up to 80% of research relevant to the predictive value of the therapeutic relationship has produced significantly positive results (Orlinsky & Howard, 1986). Similarly, according to Henry, Schacht and Strupp (1986), in ''good outcome'' therapy the therapist is described as ''helping and protecting, affirming and understanding,'' whereas the patient is seen as ''disclosing and expressing.'' In ''poor outcome'' psychotherapy the therapist tends to be ''blaming and belittling,'' whereas the patient is depicted as ''walling off and avoiding.''

The use of the therapeutic relationship as an umbrella for different approaches has also been suggested by Clarkson (1994), who identified five modalities of relationship existing in every psychotherapeutic situation. They are: a) the working alliance, b) the transferential/counter-transferential relationship, c) the reparative/developmentally needed relationship, d) the I-You relationship and, e) the transpersonal relationship. I agree with Clarkson's (1994) postulation that these forms of relationship are present in every approach to psychotherapy, even if different therapists recognize that some of these are indeed more or less present than the others. The contribution of therapeutic empathy and a good working alliance to positive clinical outcome has been demonstrated in several clinical

trials of adult patients (Burns & Nolen-Hoeksema, 1992; Luborsky, McLellan, Woody, O'brien, & Auerbach, 1985). Although these effects are often referred to as "nonspecific," in reality, the cultivation of a helping alliance involves very specific tasks, including the enhancement of patient involvement, good interpersonal relationship skills, and a consistent therapeutic orientation (Lafferty, Beutler, & Crago, 1989; Luborsky et al., 1985).

Non-specific factors often refer to dimensions that are shared by most psychotherapies and include the therapeutic alliance, the therapist's competence and adherence to the treatment protocols whereas specific factors refer to the specific techniques and interventions that characterize particular psychotherapies. However, another review of the literature on "non-specific" treatment factors reveals that the therapeutic alliance and therapist competence may vary among patients and therapists, and that the therapeutic alliance also varies among treatment modalities. All three non-specific treatment factors, therapeutic alliance, therapist competence and adherence to the specific treatment modality, contribute significantly to treatment outcome and may account for more of the variance in outcome than specific treatment approach (Chatoor & Krupnick, 2001).

Furthermore, in a recent study, Howgego, Yellowlees, Owen, Meldrum and Dark (2003) examined the level of evidence supporting the assumed link between a positive therapeutic alliance among patients and case managers and effective outcome for patients with a mental illness who are managed in community mental health services; they also found that a definite correlation exists in the psychotherapy literature between the therapeutic relationship and improved outcomes, with its potential as a prognostic indicator highly acknowledged.

It seems to me that this emphasis on the therapeutic relationship is what basically distinguishes the practice of counselling psychology from the existing medical model of practice. The counselling psychologist's aim is to establish a collaborative relationship with the client and to focus on accordingly on the subjective experience of their inner world and their idiosyncratic meaning making process. There is consequently a move away from the medical model of illness and a move toward a way of being with the client in such a way so as to facilitate the client's personal growth and potential (Woolfe, 1996).

Multicultural issues

Developing as an integrative therapist also entails the need of taking into consideration as many different aspects as possible, which may have an impact on the therapeutic relationship.

One of my main concerns when I started my training in Counselling Psychology was the way I would be perceived by other professionals and most importantly by clients, given the fact that I was coming from a different cultural background. I recall that one of my fantasies was that I might be perceived as being insensitive to clients' issues or that I might overlook important aspects of their narratives and hence be perceived as incompetent or deskilled.

Transcultural practice has therefore been for me a continual issue in my clinical practice. Transcultural therapy may be defined as a relationship and a process in which the therapist and the client belong to different cultures, in which multiple value systems and diverse assumptions of normality and psychopathology come into play, and in which procedure, goals and parameters of the process have to be adopted to suit the cultural context of the client (Sharma, 1996). In that matter I was informed by D'Ardenne and Mahtani (1989), which suggested that it is essential that counselling psychologists are aware of their own cultural views and biases before dealing with clients'

points of view. Clarkson and Nippoda (1998) also stated that cultural factors are very important to counselling psychologists, adding that they have the responsibility of learning all they can about the cultural background of their clients. In that sense, I had to work both on my views and attitudes towards the British culture as well as on acquiring awareness of any distinguishing cultural factors that might influence the therapeutic work with clients. In this endeavour I found very insightful the suggestions made by Kitayama and Markus (1994), who indicate that societies can be placed on a spectrum that ranges from 'individualistic' to 'collectivistic' and that in the same way individuals can be characterized as laying on a spectrum ranging from 'independent' or 'interdependent', each having a specific and different definition of what is good and moral. For example, for the client from a society where the definition of the good, moral person is based on the individualistic model, the client will give high priority to the promotion of the individual, placing less emphasis on maintaining relationships. On the other hand, if these definitions are based on the collectivistic model, then the goals of the client's behaviours will be focused more on the place of the individual within the group; moreover, relationships with others, especially family, will be at the top of the priority list.

Further research has shown that most cultures in Asia, South America and South Europe follow the collectivistic model, whereas Northern America and Northern and Western Europe societies belong to the individualistic model (Smith & Bond, 1994).

In my therapeutic practice I had indeed to be sensitive to all those factors, especially when the treatment goals and the clients' expectations from therapy were considered. Moreover, I recall that in the beginning of my therapeutic work I was alert to any paralinguistic features such as emphasis, volume and pace, as well as other cultural features such as ways of indicating agreement or being polite. Part of this was coming from my reading on transcultural therapy (e.g., D'Ardenne & Mahtani 1989; Henley & Schott, 1999) which suggested that although we usually use and interpret such devices unconsciously, they are a crucial part of the message we give and constitute a very important clue in therapists' attempt to understand and explain people's physical and emotional needs. In that sense, I wanted to eliminate any instances of misinterpretation or misunderstanding of such clues. Here, my mixing with people from the predominant culture on a social level certainly enabled me to understand better the cultural context I was entering.

On reflection, I realize that as I was gaining more experience and was becoming more aware of any cultural aspects of therapy, I was able to incorporate these issues and make them an integral part of my therapeutic work.

Furthermore, I need to mention here that at the early stage of my training, my personal therapy played a very important role on many levels. Although there is some debate in the literature concerning the impact of trainee counselling psychologists' personal therapy on their work with clients (Macaskill, 1988), I personally feel that it has helped me to become more aware of my own issues (at least some of them) that could possibly impinge upon the therapeutic process. Furthermore, it has been an invaluable learning experience, where I had the opportunity to learn about therapy through the process of modelling. This was particularly insightful at the beginning of my training as it often acted as a frame of reference in my early work with clients. Being a client also increased my awareness of the potential power imbalances that may exist in a therapeutic encounter, and the possible impact this may have on the therapeutic process. Indeed, these benefits are in accordance with the findings of Williams, Coyle and Lyons (1999) that personal therapy

contributes to counselling psychology trainees' well-being and acts as a model for professional learning.

Integration and eclecticism

Psychotherapy integration is an umbrella concept that includes technical eclecticism, theoretical integration, common factors, and assimilative integration (Asay, Lambert, Gregerson, & Goates, 2002). At this point it needs to be mentioned that the two most commonly discussed forms of integration are the *technical eclecticism* and the *theoretical integration* (Norcross & Newman, 1992). It is true that there is much debate centred around the definitions, differences, and relative merits of eclecticism and integration (Arkowitz, 2002; Arnkoff, 2000). Stricker and Gold (1996) maintain that technical eclecticism is the most clinical and technically oriented form of psychotherapy integration. In this form, techniques and interventions drawn from two or more psychotherapeutic systems are applied systematically and sequentially. Techniques are chosen on the basis of the best clinical match to the needs of the client, as informed by both clinical knowledge and research findings. On the other hand, theoretical integration has been described as the most sophisticated and important form of integration, but has also been criticised as overly ambitious and essentially impossible (Lazarus, 1992), mainly because of the scientific incompatibilities and philosophical differences among the various traditions of psychotherapy. Theoretical integration involves the synthesis of novel models of personality functioning, psychopathology, and psychological change out of the concepts of two or more schools of thoughts. However, the 'integrative' approach may stimulate various epistemological issues. For example, there are indeed difficulties in unifying both the empiricist and the interpretative underpinnings of different theoretical schools. As a therapist attempting to integrate such wide ranging approaches (e.g. humanistic, psychodynamic, cognitive-behavioural) there is a danger of falling into the trap of being excessively eclectic, or drawing on 'bits' of therapies without a consistent theoretical knowledge base for doing so.

In my clinical practice, I have found myself utilizing both forms of integration. On the one hand, I try to be flexible in the kind of intervention that I might use with a particular client at a particular moment of therapy, depending on his/her needs at that moment. However, the (technical) choice is influenced (most of the time) by a holistic conceptualization of the client's current difficulties, by exploring any underlying issues that may have served as contributing factors to his/her present situation.

It is also due to my belief that very often different approaches are concerned with similar issues (e.g. increase client's awareness) but may use different language when it comes to describe these issues. Moreover, I would ascribe a very important role to the therapeutic relationship, as mentioned earlier, which I would use as an umbrella for integrating different therapeutic modalities.

Throughout my therapeutic work over the last years I have felt more confident to reflect on my diverse experiences and thus begin to practise more integratively. A very important factor that has facilitated this process is the adherence to Motivational Interviewing, an approach designed basically for working with people with addictive problems (Miller & Rollnick, 1991), based on the transtheoretical model of psychotherapy proposed by Prochaska and DiClemente (1984).

Motivational Interviewing is an approach which aims to help clients build commitment and reach a decision to change. It draws on strategies from various psychotherapy systems such as client-centered therapy, psychodynamic therapy and cognitive therapy.

More specifically, it involves listening to, acknowledging and practising acceptance of clients concerns, opinions and preferences (some of the core conditions in client-centered counselling). In addition, it takes into account the underlying issues that may have contributed to the current difficulties and at the same time deals with clients' resistance by carefully confronting their behaviour, trying to avoid argumentation (psychodynamic approach). Furthermore, the therapist maintains a strong sense of purpose and direction and actively chooses the right moment to intervene in incisive ways (cognitive-behavioural approach) (Miller & Rollnick, 1991).

In that sense, I feel that I have been very fortunate to work within this transtheoretical model of therapy, since it provides an excellent opportunity to actively integrate aspects of the three major psychotherapeutic traditions. The therapeutic work with Mr T. will demonstrate this clearly.

Mr T., aged 56, was referred by his general practitioner concerning his alcohol misuse. On admission Mr T. acknowledged that over the last two years his alcohol consumption had increased to the point where he was drinking about two bottles of spirits daily. He stated that his difficulties with alcohol started when he lost his job as a successful lawyer. He reported that since that time he had been trying to find another job unsuccessfully, attributing this to the fact that he is ''over-qualified'' for most of the jobs available.

Mr T. was the only child in his family; he reported that he spent all his school years (from 5 to 18 years old) in a boarding school, having very little contact during this period with his parents, whom he described as quite ''distant'' and poor in emotional expressiveness.

As I was listening to his personal history and background, it seemed to me that Mr T. grew up in an environment where professional achievement was perceived as the only means to success and self-worth. It also seemed that he had been defining his self-identity largely through his role as a high-powered professional. These core beliefs have been carried into the present time, where he believed that he was worthless if he did not maintain the high-powered image he used to have until the recent past. In that sense, his excessive alcohol consumption was conceptualized as an attempt to block his feelings of worthlessness and low confidence and neutralize his anxiety about the future, the levels of which seemed to be very high.

During the assessment, it occurred to me that one important factor in the development of Mr T's current difficulties had been his inability to express his feelings about various situations in his life, including his painful feelings about the loss of his job. Therefore, I decided in the initial stage of therapy to allow the time and space to Mr T to 'offload' his distressing feelings and give me his personal account of his situation. In order to do that I tried to listen to his narrative in an accepting, non-judgmental way and at the same time to communicate to him my empathy and understanding. My efforts were also directed to creating a safe environment where Mr T would be encouraged to talk about any underlying issues that may had contributed to his present difficulties (experience of boarding school, competitive relationship with his father, emotionally distant mother).

Once I had established a trusting relationship with him, I thought that I could start tackling a significant feature of his clinical picture, his ambivalence about change. Ambivalence is defined as a state of mind in which a person has coexisting but conflicting feelings about a situation and is considered to be a very common characteristic among people with addictive difficulties (Orford, 1985). In doing this, I was informed by a basic principle of Motivational Interviewing, which is working with clients' ambivalence. One technique that is used to facilitate this is the 'balance sheet', which is used to specify what a person perceives to be the benefits and costs associated with his/her behaviour (Miller & Rollnick, 1991). Indeed, by using this technique, Mr T was able to identify and see diagrammatically the

pros and cons of his current pattern of behaviour; by creating and amplifying a discrepancy between Mr T's current behaviour and broader goals, he did start contemplating some active steps towards change.

Conclusion

In this paper I have attempted to demonstrate the processes by which I have conceptualized and developed the integration of research, theory and practice. My aim was also to indicate the ways in which my training has contributed to the development of a critical and reflective stance to my therapeutic practice. As I am evolving as an integrative practitioner, I feel more confident to draw on a wider range of therapeutic techniques, research and theoretical models to inform my therapeutic work than I did at the early stages of my clinical practice. After the invaluable experience that I had over the years of my training, I feel that the foundations have been set, on which I ceaselessly continue to build a practical model based on a combination of theory and technique that fits my own values and assumptions.

I acknowledge the fact that, due to time and space limitations, I have not been able to fully address areas such as political factors that may impact on the therapeutic practice. However, I hope that I have been able to demonstrate some of the skills that I have acquired in my endeavour to practice integratively. This by no means suggests that I have fully succeeded in the latter effort; I perceive the development as an integrative therapist to be an ongoing and endless process, one that may reflect my own developmental and individuation processes.

References

Arkowitz, H. (2002). Toward an integrative perspective on resistance to change. *Journal of Clinical Psychology*, *58*, 219–227.

Arnkoff, D. B. (2000). Two examples of strains in the therapeutic alliance in an integrative cognitive therapy. *Journal of Clinical Psychology*, *56*, 187–200.

Asay, T. P., Lambert, M. J., Gregerson, A. T., & Goates, M. K. (2002). Using patient-focused research in evaluating treatment outcome in private practice. *Journal of Clinical Psychology*, *58*(10), 1213–1225.

Beck, A. T., Emery, G., & Greenberg, R. L. (1985). *Anxiety disorders and phobias: A cognitive perspective*. New York: Basic Books.

British Psychological Society. (1998). Division of Counselling Psychology. *Guidelines for the professional practice of counselling psychology* (p. 3). Leicester: British Psychological Society.

Burns, D. D., & Nolen-Hoeksema, S. (1992). Therapeutic empathy and recovery from depression in cognitive-behavioral therapy: A structural equation model. *Journal of Consulting and Clinical Psychology*, *60*, 441–449.

Chatoor, I., & Krupnick, J. (2001). The role of non-specific factors in treatment outcome of psychotherapy studies. *European Child and Adolescence Psychiatry*, *10*, 119–125.

Clarkson, P. (1994). The psychotherapeutic relationship. In P. Clarkson & M. Pokorny (Eds.), *The handbook of psychotherapy*. London and New York: Routledge.

Clarkson, P. (1995). *The therapeutic relationship*. London: Whurr.

Clarkson, P., & Nippoda, Y. (1998). Cross-cultural issues in counselling psychology. In P. Clarkson (Ed.), *Counselling psychology: Integrating theory, research and supervised practice* (pp. 95–119). London: Routledge.

D'ardenne, P., & Mahtani, A. (1989). *Transcultural counselling in action*. London: Sage.

Garner, D. M., & Garfinkel, P. E. (1988). *Handbook of psychotherapy for anorexia nervosa and bulimia*. New York: The Guildford Press.

Goldfried, M. R., & Newman, C. F. (1992). A history of psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration*. New York: Basic Books.

Goldfried, M. R., Castonguay, L. G., & Safran, J.D. (1992). Core issues and future directions in psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration*. New York: Basic Books.

Henry, W. P., Schacht, T. E., & Strupp, H. H. (1986). Structural analysis of social behavior: Application to a study of interpersonal process in differential psychotherapeutic outcome. *Journal of Consulting and Clinical Psychology*, *54*, 27–31.

Howgego, I. M., Yellowlees, P., Owen, C., Meldrum, L., & Dark, F. (2003). The therapeutic alliance: The key to effective patient outcome? A descriptive review of the evidence in community mental health case management. *Australian and New Zealand Journal of Psychiatry*, *37*, 169–183.

Kitayama, S., & Markus, H. (1994). *Emotion and culture: Empirical studies of mutual influence*. Washington DC: American Psychological Association.

Kahn, M. (1997). *Between therapist and client: The new relationship* (revised edition). New York: W. H. Freeman and Company.

Lafferty, P., Beutler, L.E., & Crago, M. (1989). Differences between more and less effective psychotherapists: A study of select therapist variables. *Journal of Consulting and Clinical Psychology*, *57*, 76–80.

Lazarus, A. A. (1992). Multimodal therapy: Technical eclecticism with minimal integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 231–263). New York: Basic Books.

Lewis, S. & Bor, R. (1998). How counselling psychologists are perceived by NHS clinical psychologists. *Counselling Psychology Quarterly*, *11*, 427–437.

Luborsky, L., McLellan, A.T., Woody, G.E., O'brien, C. P., & Auerbach, A. (1985). Therapist success and its determinants. *Archives of General Psychiatry*, *42*, 602–611.

Macaskill, N. D. (1988). Personal therapy in the training of the psychotherapist: Is it effective? *British Journal of Psychotherapy*, *4*, 219–226.

Meara, N. M., Schmidt, L. D., Carrington, C. H., & Davis, K. L. (1988). Training and accreditation in counselling psychology. *The Counselling Psychologist*, *16*(3), 366–384.

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing*. New York: The Guildford Press.

Milne, D., & Paxton, R. (1998). A psychological re-analysis of the scientist-practitioner model. *Clinical Psychology and Psychotherapy*, *5*, 216–230.

Norcross, J. C., & Newman, C. (1992). Psychotherapy integration: Setting the context. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 3–46). New York: Basic Books.

Orford, J. (1985). *Excessive appetites: A psychological view of addictions*. New York: Wiley.

Orlinsky, D. E., & Howard, K. I. (1986). Process and outcome in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behaviour change* (3rd ed., pp. 344–347). New York: Wiley.

Papadopoulos, L., & Bor, R. (1998). Psychological counselling in primary health care. In P. Clarkson (Ed.), *Counselling psychology: Integrating theory, research and supervised practice* (pp. 119–133). London: Routledge.

Prochaska, J. O., & Diclemente, C. C. (1984). *The transtheoretical approach: Crossing traditional boundaries of change*. Homewood, IL: Dorsey Press.

Putnam, J. (1996). Reflections of an integrative psychotherapist. *Transactional Analysis Journal*, *26*, 289–292.

Scott, D. (1988). *Anorexia & bulimia nervosa: Practical approaches*. London: Croom Helm.

Sharma, S. K. (1996). Transcultural psychotherapy. In A. A. Sheikh, & K.S. Sheikh (Eds.), *Healing east and west: ancient wisdom and modern psychology* (2nd ed., pp. 516–541). New York: John Wiley & Sons.

Smith, P. B., & Bond, M. H. (1994). *Social psychology across cultures: Analysis and perspective*. Boston: Allyn & Bacon.

Strawbridge, S. & Woolfe, R. (1996). Counselling psychology: A sociological perspective. In R. Woolfe & W. Dryden (Eds.), *Handbook of counselling psychology* (pp. 605–629). London: Sage.

Williams, F., Coyle, A. & Lyons, E. (1999). How counselling psychologists view their personal therapy. *British Journal of Medical Psychology*, *72*, 545–555.

Woolfe, R. (1996). The nature of counselling psychology. In R. Woolfe & W. Dryden (Eds.), *Handbook of counselling psychology* (p. 4). London: Sage.