Compare and contrast two models of counselling and assess their relevance to a particular setting.

The models I have chosen to address the essay question are Rational Emotive Behavioural Therapy and Object Relations theory.

Introduction

In this piece of work I hope to give an overview of my two chosen approaches describing both theory and practice. My main focus shall be on the therapeutic alliance because of it's importance for the outcome of the counselling relationship. This will be quite a challenge from the outset given that CBT approaches are more concerned with the goals, aims and objectives of therapy than the relationship itself. I have tried to outline these approaches in a structured fashion considering theoretical concepts for example, the importance of transference, holding and containment, projections and the therapeutic use of self for the psychodynamic therapist in contrast to CBT with it's focus on the here and now, self disclosure and the challenging of self defeating cognitive and behavioural patterns of behaviour.

From a psychodynamic perspective the space that I hold in mind is both physical, metaphysical and psychic in origin; it is within this environment (space) that understanding and growth takes place. Understanding and enlightenment may lie at the centre of many approaches but for the therapist who works psychodynamically the focus is to understand the client, not a particular problem per se. In describing the focus of therapy Brodie stated:

(3) "Psychodynamic psychotherapies focus on understanding the client (as opposed to helping the client, teaching the client, getting the client to see, and so on)"

(Brodie 2007 p.96)

As stated above when working with young people it's the type of setting, time, space and presenting issue which inform my interventions in terms of theoretical practice, but whatever the approach, the relationship needs to be child/client centred, it's the client who is most important not the theory.

(3) (Klein 1997) described object relations theory as a modern adaptation of psychoanalytic theory that places less emphasis on the drives of aggression and sexuality as motivational forces and more emphasis on human relationships as the primary motivational force in life. Object relations theorists believe that we are relationship seeking rather than pleasure seeking as Freud suggested. Object Relations places relationship at the heart of what it is to be human. The importance of relationships in the theory translates to relationships as the main focus of psychotherapy, especially the relationship with the therapist.

(2) For me Object Relations Theory remains a rich tapestry of concepts which I have woven into my therapeutic practice and aids understanding of the client's symptoms and underlying issues. **4(b)** There are key features within this approach which facilitate a framework for listening to and understanding the story which client's bring to the session; (A) that there are real external events and images of these events established internally. (B) that these object impressions of real events indicate the experience of the individual with others and it is the communications between these object relations which manifest themselves in a range of transactions in the external world. Hough links theory and relationships:

> "Object relations theory is concerned with human relationships and the way these are imagined and represented mentally by each individual.
>
> (Hough 1998 p.84)

4(a) Using this approach the task of therapy is to explore the symbolic narrative and the ways in which past, present and future events can be linked and understood. Concepts from Kleinian theory which have had a major impact on psychodynamic practice are the Paranoid Schizoid and the Depressive positions. These concepts aid our understanding of how infants cope with intense anxiety by splitting and projecting as a defence, and later when the baby is able to move towards a higher level of integration in which it can experience ambivalence without fear of being overwhelmed. As splitting diminishes Gomez describes the baby's experience:

"With less need to distort his perceptions the baby in the depressive position experiences inner and outer reality more accurately."

(Gomez 1998 p.42)

5(c) Object relations therapists are interested in the client's defences against anxiety and the use or over use of projection to evacuate what seems unbearable outside of the self and into another (historically mother) which in this context is the therapist. It's the therapist who contains such positive and negative experiences, detoxifies them, cools them before feeding them back to the (client) child.

5 (c) Holding is a key concept from the work of Donald Winnicott which describes the kind of holding which reflects the physical and psychological holding provided by mother. The umbilical cord may well be cut but the intense psychological cord is still very active for a short time after the baby is born. Winnicott called it primary maternal pre-occupation, an intense empathic attunement to the (client's) infant's needs and an ability to understand the needs of her (client) baby. Klein cites Winnicott's description of mothers presence:

"The mother is the facilitating environment."

(Klein 1997 p.233)

A facilitating environment is the pre-condition for the safe development of what Winnicott called a “true self” and if all is well the mother acts as the environment supplying the care the infant needs. My affinity for the Object Relations approach is centred around these ideas and concepts of introjection, projection, splitting and the holding environment as the task of the therapist.

1(a) As I reflect on my own professional experience it’s the move from theory to practice which highlights the therapeutic relationship itself and informs and guides therapeutic interventions. The therapeutic relationship could be described as an entity or living experience where the client can express fears and anxieties while being held by the therapist. I have found this approach to be very helpful when working in a youth club setting with young people who are in mid or late adolescence and who have experienced trauma and a fragmented maternal environment.

5 (a) The world of the adolescent is one of fluctuation between biological, psychological and social changes in the space between childhood and adulthood. The youth who finds him/herself in a developmental impasse which can’t be articulated or described in terms of goals, aims or objectives may not be a candidate for CBT given that the approach is time limited and problem focused. In contrast and from a psychodynamic perspective this kind of developmental impasse is grist for the therapeutic mill, where the therapist’s task is to engage the youth in a process of self discovery which may shed some light on how the impasse came to be.

4 (a) It is the therapeutic alliance which holds and contains the projected and split off positive and negative aspects of a youth who acts out in an effort to communicate what is needed. **(3)** Brodie describes the process of understanding communications within the client/counsellor relationship as psychotherapy:

> "Psychotherapy is the process in which one person works to understand another person, and to communicate that understanding to that other person."
>
> (Brodie 2007 p.8)

1(a) The building of a therapeutic alliance is a vital component in the monitoring and building of trust, especially adolescents who are striving for a sense of autonomy in an adult world. As the therapist/parent the young person can make psychological use of me in this new relationship through projection and transference, where I survive the negative attacks without retaliation. This leads to the regulation of emotion and the building of trust.

1(a) I found the building of a therapeutic alliance to be of central importance when working with young adolescents in a local youth centre. A core theme to the work was the issue of trauma and violent conflict where the youth's early experience was one of environmental failure. **1(b)** From a psychodynamic perspective I was able to provide regular weekly sessions which represented a consistency of environmental care through the holding and containment of the therapeutic relationship.

5 (c) In my experience this young person would not have benefited from short term focused work given that his history was one of power battles with parental authority figures and where his ability to form a relationship with an adult was of paramount importance for internal stability. His goal was to block or destroy the relationship thus proving that he was useless and unworthy of kindness, love or respect.

Machel describes the impact of conflict on families and communities:

> " Armed conflict destroys homes, splinters communities and breaks down trust among people, undermining the very foundations of children's lives. The impact of being let down and betrayed by adults is measureless in that it shatters the child's world view.
>
> (Machel 1996 p.39)

(2) The therapeutic alliance cannot be established if the child/client has little or no trust in the process. The psychodynamic approach provides a therapeutic environment which protects, holds and contains the young person while growing and developing psychologically. The task is the provision of a secure base from which the client can explore internal and external relationships. **(3)** Bowlby emphases the importance of the secure base:

> "giving a central place, not only in practice but also in theory, to the role of providing a patient with a secure base from which he can explore and then reach his own conclusions and take his own decisions".
>
> (Bowlby 1998 p.146)

5(a) (REBT) developed by Albert Ellis in 1955 could be described as the earliest form of Cognitive-Behavioural Therapy. Ellis who was originally a trained psychoanalyst became dissatisfied with the length of time it took to produce therapeutic results which at best were ineffective. He continued to explore and experiment with various approaches until he arrived at what we now call REBT. (Dryden 1996)

REBT is and is one of a number of cognitive behavioural therapies which although developed separately have many similarities such as Cognitive Therapy developed by psychiatrist Aaron Beck in the 1960s.

5 (c) (Dryden1996) describes REBT as a brief, direct, and solution-oriented therapy which focuses on resolving specific problems facing a troubled individual. Fundamental to REBT is the concept that our emotions result solely from our beliefs, not by the events that occur in our lives. Therefore, it is of utmost importance for our beliefs to be healthy and rational, because the consequences of these beliefs will be emotional growth and happiness. If our beliefs are irrational and self-defeating, our emotional life suffers from neuroses such as self-blame, depression, and anxiety. REBT is an educational process in which the therapist teaches the client how to identify irrational beliefs, dispute them, and replace them with rational ones. Once the client is equipped with healthy beliefs, emotional difficulties and problematic behaviour are reduced.

At the core of REBT is the A-B-C theory of personality. The A stands for an activating event, usually some type of challenging life situation. An example activating event might be a teenage boy being “dumped” by his girlfriend. The B represents a belief that takes over and causes the emotional consequence, represented

by the C. If the belief is irrational (for example, the boy believes “Everyone must always like me and treat me well”), the consequence is likely to be depression or anger. Alternatively, if the belief is rational (e.g. “Sometimes people will not like me and will mistreat me”) the consequence would be only a temporary sadness that the relationship is over. Key to REBT thought is that the belief, not the activating event, causes the emotional consequence. Therefore, if a person has a number of irrational beliefs, then he or she is likely to experience much emotional pain throughout life as various challenges are encountered. On the other hand, if a person’s beliefs are rational, then he or she can handle the disappointing events of life with confidence. In other words, how one feels is primarily determined by how one thinks.

REBT Therapy

5(b) Recalling the A-B-C theory of personality **5(c)** (Dryden1996)b, stated that successful REBT therapy adds steps D, E, and F. The D stands for disputing: the therapist helps the client to challenge the irrational belief (B). REBT teaching suggests that the therapist ask the client if there is any evidence for the belief, or what would be the worst possible outcome if the client were to give up that belief. In therapy the counsellor may point out faulty beliefs, but he or she also teaches the client how to dispute them in day-to-day life outside of therapy.

4(a) The result of disputing the self-defeating belief and replacing it with a rational one yields an effective philosophy (E), and also a new set of feelings (F) which are not debilitating. Although REBT teaches that the counsellor should demonstrate unconditional full acceptance, the therapist is not encouraged to build a warm and caring relationship with the client. The counsellor’s only task is to aid the client in identifying and confronting irrational beliefs and replacing them with rational ones. The therapist is not usually interested in the past events which are the source of the irrational belief; all that matters is getting rid of that belief in the present.

4(b) While considering the differences and similarities between the two approaches I am aware that from a REBT perspective the focus is on our irrational beliefs, these are not thought of as unconscious irrational beliefs but conscious evaluations in the present. While the therapist aids the client in understanding his/her thoughts, feelings and actions by working with the ABC model, in contrast the psychodynamic therapist utilises the therapeutic environment and self awareness to understand the client's underlying issues which underpin and reinforce the irrational beliefs and behaviour.

1(b) The use of either approach would depend on external and internal factors when deciding it's suitability. The external factors might include the type of setting, for example a school environment may not be suitable for long term psychodynamic therapy, the young person needs to be assessed to discover his/her ability to reflect and make use of interventions and interpretations.

(2) REBT interventions have proven quite useful when working with current symptoms of anger, addictions, eating disorders, phobias, exam anxiety, obsessive-compulsive disorder and anti-social behaviour. Therapy tends to last from one to fifteen sessions but this again depends on the individual therapist and the setting. **1(a)** I have been able to make use of REBT when working with young people who attended counselling as part of an agreed programme. The programme was time limited and my focus was on building a rapid therapeutic relationship using empathy and unconditional acceptance and respect. Unlike psychodynamic therapy the relationship existed to facilitate the work rather than forming part of the therapy.

1(b) A psychodynamic approach would not have proved affective given the time frame and may even have been detrimental leaving the youth with weakened ego defences and unresolved material.

4(b) During assessment the therapist will try to ascertain the client's ability to stay with anxiety, rage and anger and not act out in the therapy sessions. A good psychodynamic assessment will consider the client from a bio psychosocial perspective to ensure that the client is not re-traumatised and has the ability to form a working alliance. REBT therapists would similarly conduct an assessment but the focus would be on the gathering of specific information about the client and the nature of the problem(s) using the ABC model.

5 (c) While the REBT counselling relationship (Dryden1996) does not specify any particular kind of relationship counsellors are flexible in their approach seeking to provide an egalitarian relationship based on unconditional acceptance yet challenges self defeating attitudes and belief systems. The therapist is encouraged to be open, honest and were appropriate make therapeutic use of self disclosure which indicates to clients that the therapist too is human and therefore fallible.

5(b) In comparison, and because object relations holds that it's the overall relationship with the parents which is important **5(c)** (Hough 1998) describes Bowlby's view that therapy could provide a secure and corrective experience which client's lacked in childhood. A psychodynamic approach would seek to discover (through the therapeutic relationship) the original environmental failures in the transference relationship with the therapist. The therapist's use of self (counter transference) and exploration of the client's themes and projections enable the therapist to provide the young person with an opportunity to express ambivalent thoughts and feelings of anger and rage.

1(b) REBT will not be interested in transference but will focus on the symptoms arising from ambivalent or split off projections witch protect the client from experiencing to much guilt and anxiety. (Dryden 1996) describes a standard goal of REBT is to encourage client's to identify their emotional and behavioural problems and to make philosophical changes. Client's are also encouraged to get over their emotional and behavioural problems and to live a more meaningful and happier existence. Goals as outlined above are challenging enough for adults but would certainly need modification to suit the developmental level of children and young people.

Clients who present with a life crises are unlikely to benefit from either cognitive or psychodynamic therapy at least until the crises has abated.**1(a)** I have found that clients who present with addictions find it difficult to engage and commit to a therapeutic process which requires them to reflect and act on new insights gained from therapy. (Hough 1998) stresses the importance of dedication when working with problems and issues which are routed in the past.

Conclusion

While cognitive behavioural approaches work well for clients who present with (symptoms) phobias, panic attacks, exam anxiety, self defeating thoughts and behaviour the approach does not focus on the deeper underlying issues which can be uncovered over time as they are reflected within the therapeutic environment between client and therapist. From a cognitive behavioural perspective the relationship between client and therapist is important but it is seen as existing to facilitate the work rather than forming therapy itself as in psychodynamic approaches.

5(c) Froggatt describes the basic aim of REBT:

> "to leave clients at the completion of therapy with freedom to choose their emotions, behaviours and lifestyle; and with a method of self-observation and personal change that will help them maintain their gains"
>
> (Froggatt 2008 p.12)

(2) The above statement from Froggatt might well encompass the theoretical objectives from cognitive behavioural therapies but could sound a little outlandish if one wonders about the dependant child's ability to choose their emotions, behaviours and lifestyle while being able to reflect and observe internally. (Geldard 2007) reminds us that the child has a limited ability for reflection which is based on it's developmental level. In contrast, client's who work well in psychodynamic therapy tend to have an enhanced ability for self reflection and self awareness and are able to utilise language and metaphor.

1(b) Perhaps one approach or theory is never enough and learning from this piece of work points out that there is a missing element, the client. Regardless of the approach used I have focused on the therapeutic relationship because of it's central importance; a breakdown in this area means no work can be done. This is where the holding, containing and trust building allow the adolescent to just be, to just be in the moment and to have that moment reflected back so that the youth through whatever medium begins to see, and if all goes well make adjustments.

(2) Learning from this piece of work allows me to consider myself as a therapist in adolescence. That just as the youth is struggling with biological and psychological change I too need to struggle with the formation of a therapeutic identity which lends itself to being fully present, consistent and authentic. I don't believe this is possible working solely from one perspective to meet the adolescent's needs, after all the adolescent is expected to "get on" with so much change and in so doing emerges as a young adult.