Psychological/Talking Therapies

Humanistic and Cognitive Behavioural Therapy

Introduction

Information to ascertain the differences between the many types of ‘talking’ or psychological therapies is difficult to access for non-psychological professionals, carers and patients.

This document focuses on Humanistic Therapies and CBT (Cognitive Behavioural Therapy), and provides the basic differences between the therapies to enable an informed choice prior to embarking upon psychotherapy or counselling.

Humanistic Therapies

Humanistic Therapies include:

- **Gestalt**
- **Person Centred Approach (PCA)**
- **Integrative Psychotherapy**
- **Psychosynthesis**
- **Counselling Psychology**

The common element for all humanistic therapies training is mandatory **Personal Self-Development** through personal therapy**.** This essential aspect of training fosters trainees' self-reflection or self-awareness of personal attitudes in relationships. When qualified, humanistic therapists have a high degree of psychological maturity, having a sound psychological fitness to practice psychotherapy/counselling. The deep respect for patients acquired from personal therapy minimises unwitting psychological abuse in the therapeutic relationships.

Personal Self-Development

The process of personal self-development induces an increasing acceptance of personal idiosyncrasies, thereby attaining psychological self-respect. Having attained self-respect, respecting the idiosyncrasies of others becomes part of the therapists' character.

Rogerian Person Centred Conditions of **Congruence, Empathy** and **Unconditional Positive Regard** play an important part in the therapeutic relationship and during personal self-development training and are increasingly strengthened.

Humanistic Patients

Empathy and unconditional positive regard enables patients to feel valued ‘As a Person’ and therapists’ congruence gradually fosters trust in the therapist.

Because the therapist does not come over as the ‘expert’, the patient can self direct the therapy process from his/her own perspective.

As therapy proceeds patients become increasingly psychologically self-empowered due to an increase in personal self-awareness and self-knowledge. The previous conflicts that resulted in mental health difficulties become integrated and at the same time psychological distress is alleviated.

Personality Development Theory

Gestalt and **Person Centred Approach** have a **Theory for Personality Development.**

This is important, as these therapists/counsellors understand the human psychological growth process from birth and are aware that interruptions in the psychological growth process can cause mental health difficulties such as anxiety and depression.

Gestalt Theory of Personality Development

Gestalt theory incorporates all babies are born with instinctive **self-knowledge** and **self-awareness.**

Self-knowledge enables babies to survive: babies instinctively know their own needs. For example a hungry baby will cry until its essential need for food from the caregiver is satiated. This action shows the baby is being respected psychologically and self-knowledge is kept true to babies' needs.

When a crying, non - hungry baby is fed, baby becomes conditioned to eat for the sake of eating and over time baby's self-knowledge of essential needs about eating become distorted, due to baby being psychologically disrespected by the caregiver.

Babies' self-awareness in relation with themselves, the world and other people gradually develop as they physically mature.

Respect and Personal Boundaries

When caregivers show respect, babies' experiences and feelings are validated and they develop into unique beings, secure and independent, with strong personal boundaries.

When disrespected by parents/caregivers, babies gradually develop insecurities due to invalidation of babies' experiences. The inner unique self is replaced by the conditioned role dictated by caregivers resulting in fragile personal boundaries which extend into adult hood.

Fragile Personal Boundaries

People who have fragile personal boundaries experience self-disrespect and incongruence, as their body and verbal language do not tally with their emotions; they are not aware of how they are behaving with other people as their perception of self-awareness is minimised.

Examples of behaviour and attitudes for people with fragile personal boundaries, in varying degrees include:

Deceit, arrogance, manipulation, coercion, bullying, controlling, denial, covert/overt threatening behaviour, unknowing defensiveness, projection of blame onto others and lack of accountability for their behaviour/actions. Such behaviour contributes to a loss of the essence of humanity.

Fragile Personal Boundaries

All people with fragile personal boundaries have difficulties in forming mature relationships with other people whether this is a social or work situation.

Even though fragile conditioned behaviour was acquired through no personal fault, people do have a choice of gaining their self-respect, by embarking upon personal therapy with a humanistic therapist.

Strong Personal Boundaries

People with strong personal boundaries have in-depth self-knowledge and heightened self-awareness and self-insight into how their behaviour affects other people. Their body language is congruent with their emotions and verbal language.
When babies are respected and validated psychologically caregivers provide solid psychological roots for forming sound, progressive and respectful relationships with other people. With strong psychological roots people are able to cope more efficiently in personal trauma, enabling people to cope psychologically.

A tree with strong roots does not blow down in a gale.

Reading through psychology literature does not attain strong personal boundaries; this is achieved through a therapeutic relationship with a therapist/counsellor who has already strong personal boundaries.

Training Institutes and Accreditation

The Humanistic and Integrative Psychotherapy College (HIPC) of The UK Council for Psychotherapy (UKCP), the British Association for Counselling and Psychotherapy (BACP) and independent organisations i.e. Metanoia set the training standards for personal self-development.

HIPC require:
"...a minimum of 40 hours per year for four years, and normally be in psychotherapy throughout their training. Personal psychotherapy must normally be undergone with a UKCP registered psychotherapist, or equivalent."
Training Standards of the Humanistic and Integrative Psychotherapy College (HIPC) of UKCP. *http://www.hipcollege.co.uk/page/training+standards*

Training Institutes and Accreditation

BACP, through Reflective Practice Criteria, incorporates trainees' development in self-awareness, in practice with clients and the impact on the therapeutic relationship. University course requirements for personal therapy for Counselling Psychologists range from 40-90 hours and can be taken within four different therapy modalities. ***BACP Counsellor/Psychotherapist Accreditation Scheme – Standard for accreditation.*** *http://www.bacp.co.uk/admin/structure/files/pdf/2520_criteria%20oct%2011.pdf*

Metanoia require 40 hours per year for four years.
PCA trainees' aptitude for Rogerian' congruence, empathy and unconditional positive are assessed using Counsellor Rating Scales.
Counselling Psychologists trainees' self-awareness is assessed during course experiential work.

Cognitive Behaviour Therapy

Cognitive Behaviour Therapy (**CBT**) does not have a **Theory for Personality Development.** This results in many **CBT** psychologists failing to understand how patients' mental health psychological difficulties result from interruptions of the psychological growth process.

CBT training does not require the mandatory commitment to undertake **Personal Self-Development.**

Out of a total survey of clinical psychologists working in the NHS…only 20% of the 41% who were **CBT** therapists undertook any **Personal Therapy,** and out of these only two (11%) chose personal therapy within the CBT model. The majority chose modalities other than **CBT** for **Personal Therapy.**

Source: Darongkamas J. et al,(1994) "The use of personal therapy by clinical psychologists working in the NHS in the United Kingdom"
http://onlinelibrary.wiley.com/doi/10.1002/cpp.5640010304/abstract

Cognitive Behaviour Therapy

Trainee psychologists who took personal therapy within **CBT**, or in a modality without a **Theory of Personality Development** are unlikely to have experienced therapeutic personality growth.

Consequently **CBT** psychologists may have a limited degree of self-awareness/insight into their own behaviour, together with 'how' they are interacting with patients. This situation may potentially lead to qualified psychologists disrespecting patients unwittingly. It is debateable whether psychologists have the appropriate psychological maturity, for fitness to practice, when **Personal Self-Development** is not undertaken.

Cognitive Behaviour Therapy

"The focus is on the patient's thinking as the cause and solution of the problem."

"Emotional upset is seen as the consequence of holding unrealistic or negative beliefs."

"*The patient's* beliefs and patterns of thinking are challenged. The therapist shows what is 'normal' and clients have to 'comply' in accordance with the therapist's worldview."

"Is there such a thing as genuine collaboration/dialogue in CBT? The therapeutic alliance requires the client to accept the therapist's authority and expertise."

"…the 'problem' is firmly located in the individual, following the medical model."

Source: "The Dynamics of Power in Counselling and Psychotherapy: Ethics, Politics and practice" by Gillian Proctor (2002) PCCS Books

Behaviour Therapy

The UK Improving Access to Psychological Therapies (**IAPT**) has detailed training information for Psychological Wellbeing Practitioners (PWP) who deliver Low Intensity Interventions for common mental health illnesses. IAPT Reach Out Educator Training Manual. 2nd edition *http://www.iapt.nhs.uk/silo/files/reach-out-educator-manual.pdf*

Since CBT psychologists compiled the PWP training, Low intensity Interventions therefore are fundamentally **CBT** based.

In the training manual, on pages 25-6 and 67-8, 'empathy dots' are used by practitioners as memory joggers to remind them to **use** verbal empathic statements at regular times in the interview with the objective of getting patients to achieve the psychologist's goal of changing patients' behaviour i.e. to think differently.

Behaviour Therapy

Points to consider:

When practitioners need to be reminded to be empathetic, and this is used as a technique to achieve patients' compliance with the practitioner's viewpoint, the quality of the therapeutic relationship becomes questionable, since the technique is *manipulative* and not conducive to a trusting therapeutic relationship.

Cognitive Behaviour Therapy

CBT takes control and directs patients in what should be done about the problem. This results in patients' experience becoming invalidated, with the loss of their locus of control, self-direction and self-empowerment.

The original common mental health problem might be alleviated initially but because the patient is not self-directed and empowered to sort the problem out himself or herself, the problem may resurface.

Comparative Analysis of CBT and Humanistic Therapies

CBT	Humanistic Therapies
Training does not require mandatory personal self-development.	Training does require commitment to undertake Personal Self-Development with a humanistic therapist.
Mainly concerned with coercion with the medical model.	Humanistic Therapies are NOT coercive.
Adheres to rational problem solving; therapy is directed from the psychologist perspective, aiming to unwire 'undesirable' behaviour/feeling into more desirable behaviour, changing one specific behaviour pattern into another.	Adhere to the Rogerian conditions of Congruence, Empathy and Unconditional Positive Regard, provide authentic human contact and facilitate patients to lead the therapeutic process at their own pace from the patient perspective.

Comparative Analysis of CBT and Humanistic Therapies

CBT	Humanistic Therapies
CBT psychologists neither focus on the dialogue for therapeutic recovery nor do they have the fundamental belief that patients are the expert in knowing what 'hurts'.	Humanistic Therapists focus on the relationship as the medium for recovery and have the fundamental belief patients are the experts in knowing what 'hurts'.
CBT Psychologists are the 'expert' on the patient problem, presenting the powerful nature of the psychologist within the relationship.	Humanistic Therapists have a therapeutic relationship with clients which is mutual and balanced, because the therapist does not portray as the 'expert'.

Comparative Analysis of CBT and Humanistic Therapies

CBT	Humanistic Therapies
CBT thwarts patient self-direction and self- empowerment essential for personality growth development and authentic recovery. Consequently patient recovery may be temporary, leaving patients to life-long dependency on mental health services.	Humanistic Therapies foster patient self-direction and self-empowerment which is essential for personality growth development. Because of the inner psychological growth and healing, lasting patient improvement occurs.

"To exploit the desperation of people by giving them inauthentic human contact is inexcusable"

Source: Sanders2006. Chapter titled: "The Counsellor is ready to Help" in Sanders P.(2006) "Person-Centred Counselling" PCCS BOOKS: Ross on Wye

Mental Health Social Strategy

Currently there is no NHS information that depicts the major difference between **CBT** psychologists and **Humanistic Therapists** about **Personal Self-Development.**

Many UK Mental Health (MH) organisations such as Skills for Health, the Royal College of Psychiatrists, **NICE** Guidelines and **IAPT** are dominated by medical model/**CBT** orientated practitioners.

"CBT superiority questioned at conference" University of East Anglia. July 7, 2008. Retrieved September 1st 2012.
http://www.uea.ac.uk/mac/comm/media/press/2008/july/CBT+superiority+questioned+at+conference

UKCP response to Andy Burnham's speech on Mental Health 1st February 2012
http://www.psychotherapy.org.uk/article1488.html

Mental Health Social Strategy

During the development of IAPT, there was a greater representation of leading **CBT** psychologists at meetings compared with **Humanistic Therapists/Counsellors.** When the issue of **Personal Self-Development** was raised, dominant and influential **CBT** psychologists did not understand the concept, which led to the dismissal of **Personal Self-Development.**

Because the DH is underpinned by major professional bodies who have no concept of **Personal Self-Development** this omission leaves the public at a disadvantage, as patient choice about different kinds of therapy in relation with **Personal Self-Development** is unknown.

Mental Health Social Strategy

Mental Health patients and carers frequently experience attitudes and behaviour from MH practitioners, which are typical of fragile personal boundaries.

Clarke C., A Carers Perspective of the Mental Health System. In S. Joseph and R. Worsley (2005) Person-Centred Psychopathology: A Positive Psychology of Mental Health. PCCS BOOKS: Ross on Wye.

Clarke C., (2006) Relating With Professionals Journal of Psychiatric and Mental Health Nursing, Vol13, 522–526

Mandatory **Personal Self-Development** during training for all disciplines in mental health would provide practitioners with the psychological maturity to practice. Although this would not be a cheap option, it needs to be recognised mental heath patients are vulnerable psychologically and this therapist training requirement would ensure patients are protected from potential unwitting psychological abuse.

Mental Health Social Strategy

The Government relies upon the integrity of influential mental heath leaders to promote policies and treatments. However when the large majority of **CBT** professionals compromise policies, then the integrity and reliability of the government endorsed policies is speculative.

The importance of the commitment undertaken by the Government for a mature and psychologically healthy practitioner workforce for the formulation of mental health policies and practice is paramount.

Otherwise it is like the blind leading the blind.

Useful websites for further information:

British Association for Behavioural & Cognitive Psychotherapies (BABCP)
http://www.babcp.com/Accreditation/Accreditation.aspx

Metanoia Institute
http://www.metanoia.ac.uk/

UK Council for Psychotherapy (UKCP)
http://www.psychotherapy.org.uk/

British Association for Counselling & Psychotherapy (BACP)
http://www.bacp.co.uk/

Contributors:

Catherine Clarke SRN, SCM, MSSCH, MBChA
Jan Evans MCSP. Grad Dip Phys

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