Both cognitive behavioural therapy (CBT) and client-centred counselling (CCC) offer patients help and support by addressing personal issues. The practices share the common therapeutic endeavour of improving well-being. The need for an integrated approach to CBT and CCC was highlighted by requests from clinical staff for a model that was practice driven and easy to use in the clinical setting. Clinical staff indicated they would welcome the model by practitioners. This project attempted to bring together the unique qualities of each intervention while encouraging a synergistic approach. This was undertaken by developing and delivering a three-day pilot study workshop. The experiential workshops were evaluated using two sets of structured questionnaires and six semi-structured interviews with randomly selected participants. A follow-up questionnaire was used to review the combined approach in practice.

Initially, combining CBT and CCC appears to pose problems as both practices seem to be inherently different. CCC has developed from the humanistic non-directive ethos. It is founded on the belief that the patient knows ‘where it hurts’ and progress towards resolution is most likely if the necessary and sufficient conditions can be offered (Rogers, 1957). Research indicates that the counsellor proffers a therapeutic way of being (Norcross, 2001). Describing this form of therapy, Patterson (1984) says: ‘There are few things in psychology for which evidence is so strong [and] incontrovertible.’ This way of being is grounded in the core conditions of unconditional positive regard (respect or warmth), congruence (genuineness or authenticity) and empathy (Rogers, 1957).

CBT, in contrast, is a more directive form of engagement. It uses Socratic questioning and a contractually led approach (Salkovskis and Clark, 1998). Socratic questioning encourages a patient to develop a challenging attitude towards his or her own thoughts and feelings. The patient is also invited to negotiate a contract of care. This includes commitment to the CBT agenda, homework and keeping a diary. See Box 1 for a summary of the differences between CCC and CBT.

However, both approaches value therapeutic relationship as a means of enabling, teaching and facilitating healthy coping mechanisms with patients who are experiencing psychological pain and/or disharmony. Culley (1991), Egan (1996) and Nelson-jones (1999) have given credence to the emergence of these two differing approaches suggesting that they can successfully coexist within the practice of the therapist, offering the patient greater therapeutic opportunities. The shift from a medical model to a more holistic understanding of disorders in psychiatric nursing has never been more evident and, thus, the need for effective therapeutic intervention has never been greater. It was felt that a synergistic approach would be more easily applied within the clinical setting.

**The workshop**

**Methodology**

The aims and objectives of this project were to:

- Evaluate the potential for combining CBT and CCC;
- Explore and review the areas of convergence between CBT and CCC;
- Develop an integrated workshop on a combined model of CBT and CCC based on theory, experience and practitioner need;
- Evaluate the efficacy of the educational intervention;
- Review the subsequent utilisation of the combined model by practitioners.

Following a literature review, a three-day pilot study was undertaken with volunteers at a psychiatric hospital in Scotland. A questionnaire was distributed to the 10 participants before the workshop. This was designed to provide a base-line measure of participants’ knowledge, attitudes, experience and expectations in terms of the knowledge and skills they hoped to gain. The findings of the questionnaire greatly assisted in the formulation of the experimental workshop. The themes underpinning the workshop were as follows:

- Integration model;
- Self-efficacy;
- Core attitudes in client-centred therapy;
- Introducing cognitive behavioural approaches;
- Formulating and testing beliefs;
- Increasing self-awareness;
- Communicating with patients experiencing abnormal perceptions and beliefs.
Evaluation

Preworkshop questionnaires were circulated to all participants before the workshops and these were then geared towards the identified needs. Two three-day experiential workshops were developed integrating client-centred and cognitive behavioural therapies in the formation of the therapeutic alliance (Beck, 1976). Two groups of 15 nurses were invited to attend the workshops that were evaluated using an anonymous post-workshop questionnaire and the response was positive.

The programme

The workshops were intended to reflect the value systems associated with the therapeutic alliance. It was agreed that group discussion would be treated as confidential, and to emphasise the importance of trust, participants were asked to work in small groups to formulate the overall themes of the workshops. These concepts were then reflected on and revisited. Active participation and the sharing of anecdotal experience by participants was encouraged.

PowerPoint presentations, printed handouts and participation were used to explore the concepts of empathic dialogue, unconditional positive regard and congruence.

To illustrate the link between self and self-efficacy, a psychotherapeutic model based upon clinical practice and linked to theoretical constructs was developed. This model combined client-centred and cognitive behavioural approaches and illustrated how such a combination could be a powerful therapeutic intervention. Discussion identified the four core features that enable the individual to achieve a reasonable level of self-efficacy (Bandura, 1986):

- Mastery experience – successful past experience enhances efficacy;
- Vicarious learning – seeing others succeed;
- Verbal praise – encouragement from a credible person;
- Physiological sensations – factors such as anxiety or stress can affect self-efficacy.

It was felt that ‘focusing’ (Gendlin, 1981) led to an increased self-awareness, which may contribute to increased effectiveness in the therapeutic alliance/relationship. This approach is based on the belief that experiential learning has a profound and enduring effect on the individual. Pretherapy offers a means of increasing ‘contact’ communication between those experiencing different realities and those who care for such patients. Pretherapy illustrates that, despite barriers to communication, a therapeutic contact can be fostered and maintained effectively. A postworkshop questionnaire was completed by all workshop participants. This focused on:

- Aims and content of the course;
- Organisation and environment;
- Level of interest by participants;
- Opportunities to interact with the course leaders.

All subjects responded positively to the postworkshop questionnaire. This was followed three months later by a follow-up questionnaire to see how the theory was being put into practice.

Results

Of the 30 follow-up questionnaires that were distributed to participants, 19 were returned. Interviews, which were audio-taped, were also conducted using a semi-structured interview schedule. The results showed that all 19 respondents were familiar with attitudes reflected in the use of empathy and Socratic dialogue.

Most participants said that they were able to offer patients unconditional positive regard and valued its therapeutic effectiveness. This is particularly interesting because of the comments of those who closely linked unconditional positive regard to psychosis and pretherapy. This may be due, in part, to the course leaders expressing the importance and experience of being offered unconditional positive regard during the workshop. The use of unconditional positive regard was supported by findings from other sources.

Congruence was explored in relation to the formulation of beliefs and feelings. In the past, congruence has proved a difficult concept to translate. However, it was evident during the workshop that participants were able not only to engage in this process but also wished to use it within the clinical setting.

Self-efficacy can create harmony between CBT and CCC. The individual interviews suggested that participants felt that they valued and used self-efficacy in developing a therapeutic alliance.

It would also appear that respondents were able to apply the concept of ‘continua’ in challenging irrational beliefs. Continua makes use of a Likert Scale to identify where a person is between two opposing beliefs.

The applications of focusing and pretherapy were also evaluated. Findings indicate that respondents had a conceptual difficulty with themes. This could be because of the way the concepts were addressed during the workshop or because of their lack of experience. These findings, however, were not supported by the recorded interviews. Of the six attendees interviewed, four indicated that they applied pretherapy in their clinical practice effectively.

The findings were favourable and demonstrated the use of empathic responses and Socratic dialogue. The

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participants indicated the benefits of an understanding of self-efficacy in relation to forming a therapeutic alliance. This was encouraging as it was a major component in linking the two approaches. Pretherapy was also positively evaluated and was implemented within the clinical setting.

Discussion

The concepts discussed during the workshop were incorporated into the respondents’ clinical practice. The concept of self-efficacy enabled person-centred and cognitive behavioural approaches to be merged. The concepts of self and self-efficacy helped form the bond between person-centred and cognitive behavioural interventions. Before participants were able to embark on therapeutic dialogue they first had to possess some insight and awareness of their own feelings, emotions and thoughts. This enabled them to reflect on their own awareness and explore aspects of themselves that they had not considered before. In turn, this helped participants to identify and respond to the needs of others in a much more empathic and accepting way.

Bandura’s work on self-efficacy underpins the basic concepts of CBT (Bandura, 1997). Dialogue in cognitive therapy often reflects the patient’s previous successes. One of the main components of self-efficacy is ‘mastery experience’ that emphasises the patient’s past successes. Vicarious learning, another major component of self-efficacy, whereby the patient experiences someone undertaking a particular behaviour with a positive response, is not dissimilar to the modelling sometimes associated with CBT. Verbal praise and physiological sensations, both integral parts in the development and maintenance of self-efficacy, are also major players in the delivery of CBT.

The links between self and self-efficacy are apparent (Bandura, 1997). Low self-esteem results in patients perceiving themselves as being in a state of negativity, leading to a situation of learnt helplessness. As Bandura states: ‘Self-belief does not necessarily ensure success, but self-disbelief assuredly spawns failure.’

Self-actualisation

Maslow’s (1954) theory of self-actualisation may be defined as the reorganisation and integration of new learning with established experience or, as Zimmerman (2003) suggests, as the process of creating new neural pathways. This integration fosters the potential for creative ways of working.

This attempt to understand some neural activity appears to reflect qualities of the connectionism model of the brain. McClelland and Rumelhart (1986) propose that knowledge is stored in the brain in a network of connections, not in a system of rules or as individual pieces of information.

This view of experience gives rise to the idea that learning is achieved by strengthening certain connections that are functional and weakening those that are not. Such a model appears consistent with the findings of current research on the brain. This suggests that information is distributed in many locations and is connected by intricate neural pathways (Blakemore and Frith, 2000; Hendry and King, 1994).

Rogers’ (1957) concept of ‘self’ supports the view that low self-esteem has a significant impact on the functioning of an individual – leading characteristically to the experience of incongruence, which may act as a barrier to the opportunity to change. Thus, without the opportunity to explore its nature and impact the individual is limited to move from the ‘edge of awareness’ to a greater level of self-acceptance and understanding.

The evaluation questionnaire indicated that the dialogue elements of the workshop were relatively easily transferred into the respective clinical areas. Transfer of the concepts reflected in response to questions 6, 7 and 8 were disappointing (Box 2). Consequently, the programme has been modified and restructured.

Conclusion

The small size of the study sample means that the results are not necessarily representative and further development with a larger sample coupled with a wider skills mix would support a more realistic perception of the combined interventions. The limitations inherent in the use of a self-reporting questionnaire as a means of data collection are also recognised.

This article is a reflection of some of the experiences gained by clinical practitioners on the adaptation of CBT and CCC. It is recognised that much more research and application is necessary in order to understand and perfect this approach.

However, feedback suggests that the integrated model may play an important role in the application and delivery of a therapeutic intervention within the mental health field.