Italian Journal of Geriatrics and Gerontology

2016;1(2): 41-47

Articolo Originale

EFFICACY, FAIRNESS AND THE PRE-EMINENCE OF NON-SPECIFIC FACTORS IN PSYCHOTHERAPY AND THE HELPING PROFESSIONS

G. Buffardi

Ph. D; psychiatrist, psychotherapist, psychologist, bioethicist, degree in philosophy,
Director of Mental Health Unit d.s. 13 ASL Caserta (I); adjunct professor A.P.R.A. Rome, S.U.N. Naples.
President of Istituto di Scienze Umane ed Esistenziali (ISUE), Naples.

Many authors don't consider psychotherapy a valid method for helping older people; they consider a restructuring of the personality is impossible in the older people. Nevertheless, old people benefit for psychological interviews, counseling and any other type of aid methodology; the non-specific psychotherapeutic factors would help to facilitate this result; they are considered more valid for old people than the methods related to complex psychological models.
That's why we find it useful to propose in a geriatric journal this work that stresses the importance of non-specific aspects in psychotherapy and in the helping professions.

Abstract

The article considers the role of non-specific factors in psychotherapy and argues that:

- *non-specific factors in psychotherapy are more ethically sound than specific factors (linked to the model).*
- *non-specific factors in psychotherapy have an intrinsic therapeutic content.*
- *non-specific factors in psychotherapy are also active in most helping professions.*

Keywords: Counseling, non-specific factors, open-mindedness, psychotherapies, epoché, yes and not-set

"The psychoanalytical interpretation of a psychic illness may be incorrect but the fact that patients receive constant attention and an interpretation of the illness that appears clear to them can still soothe disorders."

(R. Ferber)

The success of psychiatric pharmacotherapy, together with a significant reduction in the side effects of the medicines themselves, led to a reduced interest in psychotherapies in the latter decades of the 20th century. There has been much criticism of the scientific claims put forward by a number of psychological models for the aetiopathogenesis of psychic conditions, and this has undermined the core tenets of many psychological models of the aetiopathogenesis of psychic illnesses (Nathan T., Zajde N. 2012, p. XVII). Simultaneously there has been a constant and gradual development of other methodologies for helping professionals of which the most important, in terms of training, target users and general interest, is counselling. This trend has extended the range of people using helping professions, including patients who do not have a psychic disorder but suffer from existential distress or are faced with making difficult choices.

The evaluation of the effectiveness of psychotherapy has also gradually undergone profound changes. There has been a transition from the simple description of individual clinical cases, following in the footsteps of Freud (1989), to the recording of psychotherapy sessions by Carl Rogers and the meta-analysis of Smith, Glass and Miller (1980). There are now various institutions that are constantly up-to-date with new ideas and discoveries in psychotherapy, such as the San Francisco Psychotherapy Research Group, Clinic and Training Center[1]. As early as 1986, a study by group members Weiss and Simpson showed that psychotherapy was actually less effective than psychoactive drugs in treating various psychiatric disorders (Weiss, 1986). However, the World Health Organization considers psychotherapies to be efficacious if they are used in conjunction with other forms of treatment of proven effectiveness, boosting and stabilizing the results[2].

Although psychotherapy has lost its effectiveness in the etiological assessment of disorders, and part of its therapeutic experience has merged with the methodology of counselling and other helping professions, the elements of a psychotherapeutic approach defined as "a-specific" have gained increasing clinical significance. Besides, a reduction in the professional profile of psychotherapies necessitates a reconsideration of the operational tools of the caring professions, in particular the "a-specific factors".

These include all the elements of the methodologies, setting and approach that are not linked to the psychological model of psychotherapy. These factors, already highlighted in the Freudian corpus, have always been considered not to be neutral, in the sense that studies in the field of psychotherapy, and indeed individual psychotherapists, has recognised their importance in the organisation of therapy. However significant, they have always been considered of secondary or even negligible importance. By contrast, it is argued here that non-specific factors are extremely important for the result and, occasionally, even more important than the specific factors of the model itself. There are various reasons for this:

- The non-specific factors of psychotherapy are ethically more valid than the specific factors (linked to the model).
- The non-specific factors of psychotherapy have an intrinsic therapeutic content.
- The non-specific factors of psychotherapy are active in most helping professions and are significantly similar in the doctor/patient relationship (Berti-Ceroni, 2005).

The term "non-specific" is restrictive and ambiguous and many essays talk about "common factors in psychotherapies (Wampold, 2015): but "non-specific" term is supported by the strained reasoning of attaching supreme importance to the psychological model so that these factors are considered non-specific only because they do not belong to the specific features of the selected model. On the contrary, non-specific factors should actually be considered highly specific for people seeking help or for the type of relationship created in the helping professions.

The central theme of this article is the need for psychotherapists or helping professionals to undertake a detailed study of non-specific

[1]Web site: http://sfprg.org/home.html
[2]Search in: http://www.euro.who.int/en/data-and-evidence/evidence-informed-policy-making/publications/hen-summaries-of-network-members-reports/what-are-the-effects-of-psychotherapy-for-adults-with-depression

factors, to receive special training about their use and the capacity to apply suitable tools for handling them correctly. If the professional becomes highly skilled in their use, the ethical quality of his/her work will increase significantly. For some time now I have been looking at the ethical, or rather bioethical, evaluation of the impact of psychiatric and psychotherapeutic clinical interventions on the individual's way of life. The choice of the neo-existential model is also linked to the possibility that the methodology based on the suspension of judgement (*epochè*) can favour a more ethical attitude on the part of the professional. While it is a methodological and philosophical principle pertaining to the specific, existential model, the suspension of judgement can be recognised in many psychotherapeutic approaches, particularly in the initial phases of the therapies. I believe I can state that the non-specific factors sustain the professional when she/he suspends judgments, a capacity that is always necessary during the initial phase of therapy.

The reassessment of the importance of the specific model for all psychotherapists and other helping professionals should be viewed from this perspective. Most studies today, together with the consensus of opinion, hold that the reference therapeutic model is orientative not diagnostic, viz. the wide-ranging survey carried out by Priebe et al (2011). As is argued in this review, the reference model improves the listening capacity but requires a strong "therapeutic alliance" to be developed and proposed to the patient.

Constructing a classification scheme of non-specific factors for the helping professions is a complex process, on account of both their number and the difficulty in pinpointing a factor within a context. Nonetheless, classification is still useful, especially in terms of the educational task of the professional training of helping professionals. I evaluate non-specific factors that depend on the following:

- the person seeking help (patient);
- the helping professional (counsellor);
- the setting;
- the interactive relationship (counselling);

and I focus on the factors which are commonly involved in most helping professions as mentioned above.

Factors linked to the patient

I shall discuss the following factors:

- The awareness of needing help.
- The decision.
- The organisation of the request.
- The narrative and the mental structure of what needs to be narrated.
- Readiness to empathise.

It is possible to make a distinction between partially direct and partially indirect factors.

Leaving aside a therapist's natural inclination to carry out research (a feature of all cultural societies (Nathan T., Zajde N., 2012, p. 40 ff)) awareness of the need for help is a process that is partly direct, complex, lengthy and eventful. Although frequently supported by the advice of friends, relatives or the GP, the patient may find it hard to overcome the barriers of stigma which are always present, even though they differ from one culture and society to another. Awareness of the need for help takes second place to an initial awareness of the person's condition, unease and needs. This should be contrasted with the awareness of the possibility of modifying one's behaviour: this work on one's inner self represents the initial stage of "treatment".

The decision is partly an indirect process, mediated by information about illnesses, therapists, professionals, healers, forms of treatment. It will depend on the level of knowledge of the patient and his/her relatives. However, this process may also involve a component of "treatment" that is linked directly to the subsequent process – organising the request – which is also indirect. With regard to the latter aspect, the social status of the chosen professional plays an important role[3].

In the phases described so far, there are no elements where the therapist, psychiatrist or counsellor is able to intervene. However, I believe it is crucial for the professional concerned to be aware of the phases preceding the first interview since they may provide important material for beginning to explore the problem as it emerges in the initial anamnestic interview.

[3] Mara Selvini Palazzoli who, during the last conferences she attended, referred on several occasions to the significant role of the importance of the fame of the therapist for the potentially successful outcome of the therapy (late 1990s).

The intervention of the counsellor has a heuristic significance during the first interview which I define as the "narrative phase". This is the phase when the patient conveys his or her unease, which is often "felt" (perceived) rather than "thought" (worked through), from an inner awareness to an external descriptiveness using a self-narrative. The narrative is not an automatic process; it requires inner reflection, since what may seem immediately clear to the patient becomes garbled, complex and incomplete as soon as he/she decides to describe it to the counsellor. This is why even the process of ordering emotional and cognitive material so that it flows into a form that is intelligible for the listener is a form of "treatment", a kind of initial self-analysis. During this delicate phase, the counsellor's role is crucial, as for example when the patients are able to explain their experiences coherently, and even more so when they have problems transforming them into a narrative. The counsellor should have mastered good communicative skills for making implicit points more explicit as well as a thorough knowledge of the issues of a structured interview, while managing to adopt a non-invasive approach.

The last factor is the readiness to empathise. This factor is intrinsically linked to the personality of the patient and his/her personological development (Boella, 2008, pag. 87) and should be promptly recognised by the counsellor. In cases where there is a difficulty with empathising, one of the first steps that should be taken by the counsellor is to identify the causes of this difficulty in order to remove the obstacle or advise a different therapeutic approach. An inability to empathise is often accompanied by anxiety about the choice of therapeutic tool: in this case it is vital to have adequate information about the treatment and role of the counsellor which must be calibrated according to the cognitive traits of the patient.

Factors linked to the therapist (counsellor)

It has to be said that many of the factors pertaining to the counsellor are naturally specific (linked to the type of formation and chosen model) and all orientated. They are illustrated here because, while not always codified as such, they often occur in the initial phases of a therapy, whatever the reference model. In this case the specific formation plays a significant role. But apart from the differences linked to the model, the factors listed below feature, to differing degrees, in every type of professional training course.

- Clinical expertise.
- Authenticity, acceptance, empathy (Rogers, 1942).
- Search for syntony.
- Complementary/symmetrical approach (Brancaleone, 2010).
- Capacity to suspend judgement (epochè) (Husserl, 1913)[4].

I use the term "clinical expertise" to refer to the practical theoretical knowledge of a method of research and therapeutic intervention or treatment in relation to the patient's "clinical" problems (pathological problems or related emotional-behavioural problems that cause behavioural disorders).

Several non-specific forms of knowledge that cannot be excluded from the expertise are involved:

- it is necessary to have a reasonable knowledge of the psychiatric symptoms and psychological risk behaviours to guide the choice of treatment of the patient;
- it is crucial to possess several operational tools that can be adapted to the methodology according to what emerges during the relationship with the patient;
- rather than using the model rigidly, it is advisable to use it with a modular approach;
- this should lead to its use with other methodologies and other professionals;
- readiness to engage in dialogue and share ideas with other professionals, instead of adopting a conflictual approach.

The rules that Rogers identified as crucial for the success of psychotherapy are still relevant and universally accepted, at least theoretically. The problem with respecting these parameters is that there is no objective criterion for evaluation based on the counsellor's self-evaluation.

[4] The term epochè is used in the sense of the "process of suspending judgement": it is impossible to avoid mak-ing a judgement but it is possible to learn procedures for suspending judgement, in order to avoid affecting the dialogue between counsellor and patient.

Training in respect for one's own authenticity, showing constant acceptance and sustaining empathy, takes on a key role in the intrinsic quality of the counsellor's approach to dialogue. Group training is a good way of encouraging the adoption of a suitable *habitus*. This provides a chance for direct discussion between colleagues and enables trainees to carry out the various roles of counselling through practical tasks and simulations.

Linked to Rogers' factors mentioned above, syntony[5] is the special form of empathy in which communicative systems reach a high level of mutual understanding and exchange (I use the term 'understanding' as the translation of the German word *verstehen* as opposed to *erklären*, clarification, following the definition suggested by K. Jaspers (von Engelhardt, 2012)); syntony is facilitated by metacommunicative and logico-analytical tools (Brancaleone et al. 1989, p. 81). The trainee counsellor must have extensive, continuous practical experience to gain mastery of these tools.

The symmetrical/complementary relationship between patient and counsellor is almost a consequence of these factors: while complementarity is the direct result of the different capacities of the two people involved whereby the counsellor is the expert and the patient is the client who turns to the expert, the relationship is based on the symmetry of two people who, despite their distinctive individual traits, share mutual respect. From this perspective, one form of training that is commonly employed by most schools of psychotherapy and counselling is designed to curb the invasiveness of "therapeutic supremacy", the counsellor's conviction that he/she is impartial by virtue of possessing an almost mystical, miraculous healing power.

The trainee counsellor, psychotherapist or psychiatrist should learn to live with doubt, as Jaspers maintained. We are unable to avoid making judgments; all our knowledge of others involves judgement: we therefore have to learn ways of suspending judgement, not by eliminating it but by putting it to one side for a subsequent discussion so that our work does not come across as invasive.

The capacity for *epochè* is the key feature that distinguishes an ethically correct approach from an ethically incorrect one.

Non-specific factors of the setting

The term setting, which originated in experimental psychology, is borrowed from dynamic psychotherapy, particularly from the Freudian Anglo-Saxon tradition. I shall use the term 'setting' in the sense of the rules of engagement which, as can be readily imagined, will differ according to the methodology employed and the model. Yet several features of the setting can be interpreted as common features not just of various forms of psychotherapy but also of other forms of assistance, including the medical consultation (Langs, 1998).

In particular, there is convergence in two spheres, respectively the quality and management of the setting, including the implementation of recognisability.

- Quality of the setting (Frank, 1991):
  - definition of a space-time structure,
  - attention focused on the patient,
  - open-mindedness,
  - reliability.
- Creating a yes-set.
- Implementation of the sense of "belonging" and recognisability.

The qualitative features of the setting highlighted by Frank – focusing on the patient, open-mindedness and reliability - include many of the unwritten rules of psychotherapeutic work: the organisation of the counselling session, the way of paying attention to the patient without "distractions" of any type, time-limited sessions which reduce any possible subliminal communication of the unease of the counsellor and the risk of overrunning the time, professionalism and precision in scheduling the sessions etc. The definition of a spatial structure is also linked to the management of the setting: the affirmative setting is the set of behaviours and proxemic spheres that provide a favourable environment for the patient to carry out interior work and engage in dialogue with the counsellor. This sphere includes the following: the management of the space of the setting; the quality of the "privacy"; the face-to-face relationship; all the motor behaviours, non-verbal

[5] Training on the search for syntony in the patient-therapist relationship has been included in the training course in existential counselling by F. Brancaleone.

behaviour (e.g. gestures such as nodding), truisms that instill a sense of security and sharing in the patient. This important non-specific aspect has been analysed in detail by Milton Erickson (Bandler-Grinder, 1975) and has become a training tool used by many schools of psychotherapy and counselling; however, if specific knowledge is neglected, or seen merely as a matter of counsellor's intuition, the desired yes-set risks being transformed into a "no-set".

The management of the space of the setting also includes the possibility of the setting being recognised by the patient and the consequent sense of belonging: the place, the arrangement of the furniture, the choice of a specific vantage point by the patient may reduce or reinforce the recognisability of the place and, in a broader sense, the recognisability of the therapy room. Knowledge of these factors and the propensity to address them are significant professional assets for the counsellor.

Non-specific factors of the therapeutic relationship

I shall discuss a few aspects of the patient-therapist relationship which are common features of several forms of assistance. They are only examined briefly because many schools of psychotherapy treat some of these aspects as specific factors (for example, focalisation is a specific factor for most forms of brief counselling) and because they all deserve specific, individual and detailed discussion which would go beyond the scope of this paper.

They are the following:

- Focalisation.
- Cognitivisation.
- The construction of a scale of values.
- The extension of maps of the inner world.
- A change in the view of the world
- Communicative tools that imply:
  - recognition of relationship factors, self-revelation factors and appeal factors;
  - clarification of aspects of the contents.
- Prescription.

Focalisation and cognitivisation are complex processes that develop differently in different models of the patient-therapist relationship: however, all professionals need to be aware of the need for these stages. Focalisation should be regarded as an initial intervention rather than a phenomenon generated spontaneously during therapy; cognitivisation (the examination of the reality of dynamic forms of psychotherapy) should be viewed as a process that is constantly evoked during the patient-therapist relationship.

The extension of the possibilities and inner capacities of problem-solving can lead to a change in the view of the world which, although restricted, is meaningful for the patient: "change 2" as described by Watzlavick (1974).

More specific tools, such as the construction of a scale of values and the use of special communicative techniques, are to be found in several models of psychotherapy and counselling, but dialogue implies communication. It will prove detrimental if the counsellor does not receive training about specific communicative tools, just as the counsellor should be aware of the fact that the patient can revise his/her scale of values during the patient-therapist relationship.

With regard to prescription, I would refer readers to one of my previous studies[6]: I would merely like to emphasise here that, whether it is implicit or explicit, liminal or subliminal, shared or insinuated, a prescription should always be part of the patient-therapist relationship.

Non-specific factors and training

Although the factors taken into consideration here are known to psychotherapists and many helping professionals, training that is concerned mainly with improving understanding and management of them is often insufficient. A counsellor's knowledge of them is frequently fragmentary and empirical. Operational biases towards non-specific factors can sometimes lead to anomalies in the therapy.

I believe that it is essential for all trainers and training institutions to ensure that future counsellors are capable of managing all the factors described here sufficiently. If counsellors possess this expertise, this will lead to:

[6] in http://www.isue.it/index.php/papers/sessione-di-brevi-saggi

- support for greater awareness on the part of the patient;
- a reduced risk of existential "relapses" due to bias in the treatment;
- "well thought-out" containment of the intrusiveness ad invasiveness of the counsellor in the patient's personal sphere which depends more on the needs of the counsellor than those of the patient;
- a significant element of treatment, contributing to greater effectiveness and efficiency of the specific treatment.

We still lack an overall methodological framework for training that focuses on non-specific aspects even though many schools, mainly in the field of psychotherapy, devote attention to individual factors or the global training of counsellors which also takes account of non-specific factors.

There is also little emphasis on these non-specific factors, especially those linked to the capacity to suspend judgement, in lifelong learning programmes devoted to helping professionals.

I believe it is necessary to define training programmes, both those for trainee counsellors and refresher courses for professional counsellors, which always include extensive work on non-specific factors involved in the helping professions.

References

1. Bandler R., Grinder J.: I Modelli della tecnica ipnotica di Milton Erickson; (Patterns of the hypnotic techniques of Milton H. Erickson M.D., 1975), Astrolabio Ubaldini Ed., Rome 1984.
2. Berti Ceroni G. (cur.): Come cura la psicanalisi; Franco Angeli Ed., Milan 2005.
3. Boella L.: Neuroetica; Raffello Cortina ed., Milan 2008.
4. Brancaleone F., Buffardi G.: Manuale di counseling esistenziale; Ed. SEAM, Formello (RM), 1999.
5. Brancaleone F.: Etica, psicoterapia e comunicazione; Studia Bioethica, 2010, Vol. 3, n° 3, pp. 35-38.
6. E. Husserl: La crisi delle scienze europee, in Idee per una fenomenologia pura e per una filosofia fenomenologica; (1913) Einaudi, Turin 1965.
7. Engelhardt D. von: Spiegare e comprendere in medicina e psichiatria, Comprendre, 2012, vol. 22, pp. 70-85.
8. Frank J.D.: Persuasion and healing; 3rd ed. Baltimore, John Hopkins, 1991.
9. Freud S.: Casi Clinici (Il Piccolo Hans- 1908, L'uomo dei topi- 1909, Il giudice Schreber- 1910, L'uomo dei lupi- 1914) in Sigmund Freud, Opera Omnia, vol. V, VI and VII, Boringhieri Ed., Turin, 1989.
10. Langs R.: Le regole base della psicoterapia e del counseling; (Ground Rules in Psychotherapy and Counseling, H. Karnac books, London 1998), G. Fioriti Ed. Rome 2000;
11. Nathan T., Zajde N.: Psicoterapia democratica; (Psychothérapie démocratique, 2012); R. Cortina ed., Milan 2013, p. XVII.
12. Priebe S, Dimic S, Wildgrube C. et al. (2011). Good communication in psychiatry--a conceptual review. Eur Psychiatry vol. 26, (7) 403-407.
13. Rogers C.R.: Psicoterapia di consultazione; (Counseling & Psychotherapy, 1942, ren. 1970), Astrolabio Ubaldini Ed., Rome 1971.
14. Selvini Palazzoli M., Cirillo S., Selvini M., Sorrentino A.M: I giochi psicotici della famiglia; Raffaello Cortina Ed., Milano 1988.
15. Smith M., Glass, G. & Miller, T. (1980). The Benefits of Psychotherapy. Baltimore, MD: John Hopkins University Press.
16. Wampold BE: How important are the common factors in psychotherapy? An update; World Psychiatry, Vol. 14, n° 3, Oct. 2015, pp. 270-277.
17. Watzlawick P., Weakland J.H., Fisch R.: Change; Ubaldini Ed., Rome 1974.
18. Weiss, J., Sampson, H., and The Mount Zion Psychotherapy Research Group. The Psychoanalytic Process: Theory, Clinical Observations, and Empirical Research. New York: Guilford Press, 1986.

Web sites

http://sfprg.org/home.html
http://www.isue.it
http://www.isue.it/index.php/papers/sessione-di-brevi-saggi.

Corrispondenza
G. Buffardi
e-mail: gbuffardi@isue.it, g.buffardi@legalpecitalia.it
website: www.isue.it, www.assoisue.it