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Luiza Soares *

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Review Article

Self-Knowledge of Health Professional: Therapist Styles

Luiza Soares*

University of Madeira, Portugal.

***Corresponding Author:** Luiza Soares., University of Madeira, Portugal.

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Abstract

Therapist style is defined as the set of characteristics that each therapist applies in a given psychotherapeutic situation, discriminating and adjusting to the particularities of the therapeutic act (Fernandez Álvares, Garcia, Lo Bianco and Corbella, 2003). The therapist's characteristics seem to have been neglected by research, but recently, there has been greater interest in understanding them. Beutler, Machado and Allstetter Neudfelt (1994) state that the therapist's style is a relatively stable characteristic over time and has the particularity of helping to shape the specific way of implementing a given technique or procedure. An individual's style is determined by a set of traits through which he or she can be recognized by others and, in addition, contributes to him or her being able to reveal some consistency in his or her behavior when faced with different situations (Fernandez Álvares, Garcia, Lo Bianco & Corbella, 2003). When this idea is applied to psychotherapy and the therapist's style, the authors Fernandez Álvares et al. (2003) describe it as the personal mark of each therapist, and this personal way of acting in the therapeutic context has a relevant impact on the outcome of the Therapy. The therapist's style is a general principle for any psychotherapy, regardless of the therapeutic approach or the type of client (Fernandez Álvares et al., 2003). Considering the therapeutic Alliance as a measure of evaluation of the course of psychotherapeutic development, Corbella and Botella (2004), despite considering that the various studies carried out in this area present contradictory data, identify a set of attitudes of the therapists, which help in the establishment of the therapeutic Alliance and the positive development of the therapeutic process. Empathy and the therapist's appropriate acceptance are two qualities that most researchers seem to consider to be relevant, although not sufficient, for the establishment of a good alliance (Bachelor & Horvath, 1999; Corbella et al., 2003). Likewise, the authors cite the study by Henry and Strupp (1994), whose results support the idea that the therapist's exploration and appreciation behaviors facilitate the Alliance with the client and that little appreciation by the client harms the Alliance.

Keywords: psychotherapy; hand; body

Introduction

The level of Experience of the psychotherapist was another characteristic mentioned by the authors Corbella et al. (2003), and the results revealed that the relationship between the Alliance and the Experience of the psychotherapist is not significant (Dunkle & Friedlander, 1996; Hersoug, Hoglend, Monsen and Havik, 2001; Kivlighan, Patton & Foote, 1998), that is, the therapeutic Alliance does not reveal significant differences between the groups of therapists with greater and lesser Experience. Interestingly, Mallinckrodt and Nelson (1991) report that increased training of therapists positively influenced the establishment of the Alliance. However, in another study carried out by Hersoug, Hoglend, Monsen and Havik (2001), they found results that point to the fact that the training and education of therapists are variables that were positively related to the Alliance when therapists assessed it, but not when the client assessed it. Of note is a truly unusual study by Safran, Muran, and Samstag (1994), which found that the therapeutic Alliance was favored when the therapist was able to accept some responsibility for relational ruptures in Therapy and when he or she metacommunicated with the client regarding possible misunderstandings. I'm going here…Secondly, Dunkle and Friedlander (1996) found that certain therapist characteristics were associated with a better alliance, namely less self-directed hostility, greater self-perception of social support, and a greater degree of comfort in more intimate interpersonal relationships. On the other hand, Rubino, Barker, Roth, and Fearon (2000) studied the relationship between attachment styles and the therapist's decision to end the Alliance with the client, and the results indicate that more anxious therapists tend to end the therapeutic Alliance with less empathy, especially with anxious and secure clients. Corbella et al. (2003), Gaston and Ring (1992), and Marzili (1984) state that clients who have difficulty establishing a good therapeutic relationship may benefit more from specific techniques, while those who establish a good alliance with their therapist may benefit from less technical and more exploratory interventions. In order to understand each therapist's style of action, Corbella (2005), Fernández-Álvarez, Garcia, LoBianco, and Corbella (2003), and Beutler and Clarkin (1990) have been developing studies to characterize the therapist's style. They

developed the Therapist's Personal Style Questionnaire (Q.E.P.T.), which aims to enrich the training of psychotherapists since it can help train them in different forms of communication and psychotherapeutic intervention, respecting and taking advantage of each person's style. The aim is not to find out which is the best style of therapist but rather to help each person find their style based on their variables, theoretical positions and therapeutic attitude. Each therapist may usually have a certain style, that is, make more frequent use of a certain function/action in psychotherapy. The different styles were organized based on the different functions/actions that the therapist may have in their therapeutic work: a) Instructive (establishing the scenario for Therapy), b) Attentional (grouping information), c) Expressive (a form of communication), d) Operative (instrumental implementation), e) Evaluative and f) Interpersonal commitment. When characterizing a therapist with one or more of these styles, we characterize him or her in his or her way of acting and in his or her tendency to use one of these functions more frequently. It should also be added that the therapist's style is not static; it is characterized by sufficient dynamism to allow him/her to use one function or another, depending on the demands of the therapeutic moment and the characteristics of the client.

The following table (Table 2) presents each of the functions of the therapist's style and its corresponding bipolar continuous dimension, which fits the therapist's profile (Fernández-Alvarez, 1998; Corbella, 2005).

Personal style	Therapist's profile
Instructive Function	Therapists fluctuate between RIGID and FLEXIBLE.
Attentional Function	Therapists fluctuate between ACTIVE and RECEPTIVE.
Expressive Function	Therapists fluctuate between DISTANCING and PROXIMITY.
Operative Function	Therapists fluctuate between DIRECTIVE and PERSUASIVE/SPONTANEOUS.
Evaluative Function	Therapists fluctuate between OPTIMISTIC/STIMULATING and CRITICISTIC.
Interpersonal Engagement	Function Therapists fluctuate between HIGHLY COMMITTED and LOWLY COMMITTED
Fomentation Function (Beutler and Clarkin, 1990; Beutler, Clarkin and Bongar, 2000)	Use of procedures aimed at fostering more ACTION or INSIGHT in the client.

Table 2: The functions of the therapist's style and the corresponding bipolar dimensions of the therapist's profile (Fernández-Alvarez, 1998; Corbella, 2005).

Table 2: The following table presents each of the functions of the therapist's style and its corresponding bipolar continuous dimension, which fits the therapist's profile (Fernández-Alvarez, 1998; Corbella, 2005).

When communicating with the client, according to Corbella (2005), the therapist uses multiple levels of communication and combines stylistic forms and singular modalities adjusted to each therapeutic situation (Fernández-Alvarez, 1998; Corbella, 2005). These characteristics, referring to their communicative style, structure the personal profile of action in Therapy, including the way in which they relate to the client. These characteristics constitute their style and are grouped into different functions that will be presented in more detail below.

Instructional Function – Therapists fluctuate between Rigid and Flexible.

Rigidity vs. Flexibility: This is the way the therapist finds to establish limits. It can be more or less rigid, both in carrying out therapeutic actions or tasks and in the exchanges that occur within the therapeutic relationship.

High asymmetry vs. Moderate asymmetry: High asymmetry places the therapist's role at a distance from the client; moderate asymmetry tends to be an invitation for the client to participate engagingly and actively in intervention. It is highly recommended when psychotherapy is only aimed at the client's personal development, but it can be risky in clients with very impulsive behaviors (Fernández-Alvarez, Garcia & Scherb, 1998).

According to Corbella (2005), the therapist initiates the therapeutic process through a set of prescriptions that relate to the different tasks that the client must follow and the system of rules and norms that govern the psychotherapeutic process. According to Corbella (2005), the most relevant prescriptions are the following:

A. Actions to be carried out by the client.

i. Relating to the formal fulfillment of the therapeutic contract.

1. Attend the established times on time.

2. Pay the established fees.

3. Accept the therapist's decisions about the work rules.

ii. Relating to the work of change that is sought with the treatment.

1. Communicate the contents necessary to carry out the task (ideas, emotions, memories).

2. Carry out the tasks agreed between sessions.

B. Nature and limits of the bond between client and therapist.

C. Tolerated involvement of other people close to the client during the therapeutic process.

D. Organization and activities carried out by the therapist (or team of therapists).

The form of communication between the two is both digital and analog. In many cases, the expected actions are communicated in a less than explicit way, and the client must gradually deduce what is expected of

him/her indirectly (Corbella, 2005). When a therapist is more rigid, he/she may convey to the client that there will be no changes to the established plan of tasks. Alternatively, on the contrary, a more flexible therapist may anticipate the possible need to make certain changes, under certain conditions. Each theoretical model has its general prescriptions, and each of its techniques requires specific conditions for application. However, each therapist leaves his/her mark on the way in which he/she expresses these general prescriptions. An example that typifies this dimension is "I tend to demand strict adherence to schedules."

Attentional Function – Therapists fluctuate between Active and Receptive.

Activity vs. Receptiveness: Therapists who are concerned with achieving quick results tend to operate in an active direction; they present new information that goes in a new direction. When the therapist operates in a more receptive manner, his or her attention is more directed toward capturing spontaneous emissions produced by the client.

Concentrated vs. Openness: When the therapist positions himself or herself before the client in a very concentrated manner, he or she facilitates the recording of well-defined information. This posture tends to be found in therapists who prefer orthodox models or very structured therapeutic approaches. The more open style, on the other hand, is more common in therapists who use more eclectic models and who tend to work at multiple levels of intervention (Fernández-Alvarez, Garcia & Scherb, 1998). The therapist must be attentive to what is happening throughout the process. His or her ability to do so depends on the quantity and quality of information that he or she is able to collect and that he or she should use to decide on his or her interventions, as well as to assess the development of the therapeutic process (Corbella, 2005). For example, when the intervention program is highly structured or when the theoretical model emphasizes directiveness in the intervention, the therapist will feel some pressure to act actively and focus his or her attention on certain aspects. However, when faced with less structured therapeutic programs, his or her attention tends to be more open and distributed. Thus, the theoretical model and the techniques implemented influence in some way the way in which information should be circulated. However, the therapist will almost always find a wide range of options regarding the best way to act. The therapist may believe that this information will emerge spontaneously or, on the contrary, act in a certain way so that it emerges (Corbella, 2005). In orthodox psychoanalysis, the analyst (who is guided by free association) may believe that he needs to activate the client so that he can express what he is thinking. To do this, he can use direct or indirect strategies to make his intention understood. There is a certain tendency to believe that the more active the therapist's attention is, the more concentrated his focus will be. However, according to Corbella (2005), active attention and focus do not always coincide. A typical example of this dimension is "I am interested in working with clients who present focused problems." At the opposite end of the spectrum are situations in which the therapist believes that the client will naturally understand what is intended. In any case, Corbella (2005) argues that it is not necessary to insist that the client produce certain information, stating that when this is done, it is more likely that attention will spread openly and over different levels in the client's production, rather than being focused on what the therapist intends in order to produce change.

Expressive Function – Therapists fluctuate between Distancing and Proximity.

Low Emotional Tone (Distancing) vs. High Emotional Tone (Closeness): The form of emotional expression that can contribute to the success of an intervention may require forms of low or high emotional intensity. A style of high emotional intensity may be necessary as the complexity of the therapeutic process increases, whether in terms of the severity of the problem, the depth of the objectives, or the total duration of the intervention.

Bodily vs. Verbal: Some therapists usually use bodily forms in their expressive communication, such as facial gestures, certain looks, tone of voice, and body movements. However, others express themselves through verbal intonations, such as verbal fluency or modifications in the rhythm of communication (Fernández-Alvarez, Garcia & Scherb, 1998).

The therapist must be empathetic enough to establish a certain level of emotional exchange with the client so that the client feels emotionally secure and confident enough to ask for help. To this end, the therapeutic relationship must be maintained within a framework of active collaboration.

According to Corbella (2005), the expressive function is the one that presents the greatest diversity of techniques among the different models. For example, in the old psychodynamic tradition, the principle of analytical neutrality is defended for psychotherapy. In this model, the therapist should not influence the client with his/her expressions. On the other hand, some experiential theoretical models are at the opposite pole and build their intervention model based on expressive strength. According to the author, the way in which the therapist expresses himself/herself emotionally during the sessions is a factor that summarises this function; they are, in essence, the actions carried out by the therapist to ensure emotional communication with the client ("real changes occur during sessions with an intense emotional climate"). Operative Function – Therapists fluctuate between Directive (regulated/structured) and Persuasive/Spontaneous (intuitive/non-directive).

Directiveness vs. Persuasion: Intervention manuals are a good example of techniques that benefit from a more directive therapeutic style. At the opposite extreme, we find therapists who use a more persuasive and less directive approach in their clinical practice. In these cases, there is a great interest in achieving greater client participation in the process, and this occurs in interventions that seek to work on the client's entire personality (Fernández-Alvarez, Garcia & Scherb, 1998).

Psychotherapy is a field of action that encompasses a wide range of procedures. One way of classifying its different variants is to consider them as open or closed procedures. Corbella (2005) states that some therapists feel more comfortable when they know each of the session procedures in advance (for example, therapeutic manuals), while others prefer to have a large margin for improvisation (dynamic, expressive models). The more delimited the psychotherapy is, the greater the possibility of controlling its course of action. According to Corbella (2005), to plan psychotherapy, it is necessary to take into account a set of factors that may facilitate or hinder the process:

a) The more difficult the problem is, or the less one knows about it, or similar problems, the less likely it is to know in advance what should be done;

b) The more directive forms of intervention are linked to more predictive models, while the more discursive forms are related to more open

modalities; c) The simplest devices only allow for more sensitive therapeutic programs;

d) Some techniques are clearly designed to be applied rationally and follow well-defined steps, while other modalities imply a more intuitive form of intervention.

Examples that are part of this dimension are: "In my interventions, I am predominantly directive" or "I feel more inclined to accompany the client in their exploration rather than to indicate the paths to follow."

Evaluative Function – Therapists fluctuate between Optimism/Stimulatory (oriented towards the result) and Critical (oriented towards understanding how they achieved the objectives).

Optimism vs. Criticism: Although there are objective evaluation criteria based on observation or the use of instruments, each therapist makes parallel evaluations throughout his/her intervention. An optimistic tendency favors aspects related to an empathetic expression and inspiration for change. However, it can be harmful to underestimate the problems that the client faces.

Focused on Means vs. Focused on Effects: When the evaluation focuses on the effects, we are faced with an evaluation more directed towards research, while the evaluation focused on the means is more directed towards exploring interest and clinical practice (Fernández-Alvarez, Garcia & Scherb, 1998).

Therapists evaluate psychotherapy throughout the process. Evaluation is an action that is carried out spontaneously as a means of regulating the course of Therapy. It can also be carried out deliberately, taking into account certain rules. In both cases, it always involves the personal participation of the therapist. Continuous evaluation affects all moments of psychotherapy. The therapist must evaluate the beginning, the development and the results achieved. Evaluating the development involves exploring/evaluating both the constitution of the therapeutic relationship and the implementation of the techniques. Some therapists prioritize in their evaluation the way in which they followed all the intervention procedures, while others focus on the degree of satisfaction perceived by the client. According to Corbella (2005), those who focus more on the correct application of the procedures are more critical in their evaluation process, while therapists who focus on client satisfaction have a more optimistic attitude.

Commitment Function (Inter and intra-personal involvement) – Therapists fluctuate between closeness/highly committed and distancing/lowly committed. This function summarizes the involvement advocated in all modes of communication that occur during the therapeutic act (Fernández-Alvarez, Garcia & Scherb, 1998).

Interpersonal Commitment: Closeness vs. Detachment. Some therapists only feel comfortable when they can maintain a relationship with the client that does not involve personal involvement. This profile is more common in those therapists who prefer individual intervention rather than a group or with clients whose problems are not very serious, who have a high level of autonomy and with focused therapeutic programs.

Intrapersonal Commitment: Focused vs. Extensive. It refers to the degree of involvement that the therapist feels in relation to his/her work and relation to other areas of his/her life. The focused model refers to the type of therapist who rarely involves aspects of his/her personal life in his/her work (in terms of time, family, interpersonal relationships, economic expectations and social prestige). The other model (Extensive) refers to the type of therapist who feels more committed to his/her work, and this commitment has effects and repercussions in several areas of his/her personal life.

Psychotherapy involves a high level of personal involvement on the part of the therapist. In some cases, it involves a high level of risk, depending on the complexity of the clinical cases and the personal stability of the therapists. An adequate level of intrapersonal involvement is moderate in level. However, in certain circumstances, very intense or very light levels of involvement may be more beneficial to the therapeutic process. Some clients need therapists with a high level of intrapersonal involvement. At the same time, in other cases, the opposite is true, meaning that some clients benefit if the therapist is not overly involved in the client's life. An example of the type of question that involves this dimension is, "I think a lot about my work, even in my free time."

Promotive Function – procedures aimed at fostering Action and Insight in the client.

Psychotherapists tend to use therapeutic strategies or procedures that seek to stimulate the client's self-awareness/insight or that seek to change behavior by acting directly on the symptom. The therapist's theoretical orientation has a specific weight in the use of one or other procedures, depending on the objectives to be achieved. Therefore, the fostering function is directly related to the theoretical orientation that the therapist adopts. Based on the "action-directed vs. insight-directed" dimension proposed by Beutler and Clarkin (1990) in their Systematic Treatment Selection model, this function illustrates well, according to Corbella (2005), the therapist's preference with regard to stimulating insight or stimulating change through action.

Systematic Treatment Selection, proposed by Beutler (Beutler and Clarkin, 1990) and which will be explored later, is an interesting methodological approach that the authors have been developing and presenting to the scientific community regarding the relationship between the therapist's interventions and variables related to the client. This methodological approach encompasses two major dimensions of analysis: a) the therapist's directiveness in relation to the client's resistance and b) the therapist's tendency to direct his/her attention more towards the client's action or more towards the client's insight, taking into account the client's coping style. For example, the author considers that, given the results obtained with this model of analysis, a more resistant client with a more internalizing coping style will benefit more if he/she is working with a therapist who is less directive and more focused on insight than on action.

Therapist style can be understood from two basic domains: the first domain is predominantly cognitive (including the attentional and operative dimensions), and the second domain is more motivational-emotional (which includes the expressive and interpersonal commitment dimensions). The instructive dimension, according to the authors (Fernandez Álvares et al., 2003), seems to include aspects of both domains.

According to Ceberio (2003), not all tactics are techniques, although all techniques are part of tactics. Tactics are the product of the therapist's spontaneity and creativity, and techniques are more standardized and their creativity lies in knowing when and how to apply them. Ceberio (2003), a South American psychologist, has an interesting perspective on the

intervention of a therapist. He states that the set of techniques and tactics applied by the therapist can be divided into 3 types:

A) Verbal interventions are those that are developed in the context of the session. They are characterized by the level of persuasion by the ability to be directive in the field of semantic landmarks.

B) Body interventions are those that are implemented through body techniques such as psychodrama, body expression and Gestalt exercises and games. It includes everything that involves analogical language, that is, everything that involves language through gestures, actions and the use of the body in the session space (placing a hand on a shoulder, for example).

C) Action interventions are mostly carried out outside the context of the session and are the classic prescriptions of behavior.

According to the author (Ceberio, 2003), the therapeutic relationship can be conceived as a choreography where the 3 types of interventions are implemented. It does not mean, from his point of view, that the therapist must handle the entire set of techniques with total expertise since some of these techniques will be his favorites, others will have his mark (a natural ability when implementing them), and others are incorporated through his clinical training. The important thing in this dance of interventions, which requires much training, is to incorporate the ability to detect the most pertinent moment to introduce the best type of intervention and to know which intervention is most appropriate for that client's style.

Clinical Experience shows that some styles may be better suited than others for certain clinical situations. Rather than adapting to a particular therapeutic pattern, therapists may benefit more from discovering in which situations their style may be most appropriate (Fernández-Álvarez et al., 2003).

A large proportion of research studies conducted with English-speaking subjects (Beutler, Clarkin & Bongar, 2000; Beutler, Moleiro, Malik Harwood et al., 2003; Beutler, Moleiro & Talib, 2002; Caine, Wijensinghe & Winter, 1981) and Spanish-speaking subjects (Corbella, Garcia, Botella & Keena, 2001) suggest the importance of assessing the compatibility between the personal characteristics of the therapist, the characteristics of the client, and aspects of the treatment, as a way of making the therapeutic intervention more effective. Following this idea that has been presented throughout this chapter, a brief exploration of the research studies that have been developed within the scope of understanding customer characteristics will now be carried out.

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