

THEORIES OF COUNSELING AND PSYCHOTHERAPY: A CASE APPROACH, 2/E

© 2009

Nancy L. Murdock

ISBN-13: 9780132286527

ISBN-10: 0132286521

Visit www.pearsonhighered.com/relocator to contact your local representative.

Chapter 1 Theory Is a Good Thing

The pages of this Sample Chapter may have slight variations in final published form.



ALLYN & BACON/MERRILL EDUCATION
www.pearsonhighered.com

CHAPTER 1

Theory Is a Good Thing



Scarlett comes to counseling because she is troubled about an important relationship. It seems that her husband, Rhett, whom she realizes that she loves deeply, does not seem to return her love and has, in fact, vanished. Scarlett is also mourning the death of her 6-year-old daughter, Bonnie, 6 months ago. Sad and angry at the same time, Scarlett feels helpless to do anything about her situation. She blames Rhett for the problems in their relationship. Scarlett reports that she is not eating or sleeping well, and she has panic attacks and fainting spells almost on a daily basis.

Scarlett is the eldest daughter of a farmer; she has two younger sisters. Her father died 8 years ago in a fall from a horse. There is some evidence that Scarlett's father was drinking at the time; he was bereft because his farm had been plundered by an invading army and his wife had died of scarlet fever. This invasion cost the formerly wealthy family much, creating a situation in which Scarlett and her sisters had to scratch out a living for a number of years. Eventually, Scarlett started a successful business on her own. She has been married three times; Rhett is her third husband.

Scarlett has known Rhett for a long time. For years, Rhett had professed to be in love with Scarlett; she did not respond to him because she was in love with another man. After Scarlett lost her second husband, she agreed to marry Rhett. Scarlett describes her relationship with Rhett as distant, but reports that both she and Rhett doted on their daughter, Bonnie. During the years of the marriage, Scarlet did not feel that she loved Rhett; she simply tolerated him because he could support her and their daughter.

Six months ago, Bonnie died in a fall from her pony. Rhett and Scarlett were devastated and uncharacteristically took comfort in each other. In the grip of this grief, Scarlett finally realized that she loved Rhett. However, Rhett became angry at Scarlett and disappeared into a dark foggy night. Although Scarlet at the time vowed "tomorrow is another day," she is struggling with hurt and anger along with her grief about Bonnie.

You are Scarlett's counselor. She looks at you, imploring you to help her get Rhett back. How are you going to help her? She is crying, fainting, and having panic attacks. Should you address these symptoms first or help her make a plan to find Rhett and bowl him over with her love (which is what she wants most)? How do you help Scarlett with her grief over the loss of her daughter? What is the contribution of Scarlett's family background and more recent history to the current situation?

A consistent, coherent approach to helping Scarlett is found in the careful application of counseling theory. I do not mean just any theory that I make up off the top of my head. Although I am pretty smart, I don't think that writing down my ideas about people and the nature of change is going to produce a system that will reliably guide your work as a beginning therapist. Rather, I direct your attention to a set of theories that have received much work and scrutiny, for the most part, over many years. These theories are known to be helpful in our work as counselors. Before addressing them, however, I will offer some basic definitions.

WHAT IS THEORY?

On the surface, defining theory seems easy. Most definitions specify that a theory is composed of a set of concepts and their defined relationships, all intended to explain some phenomenon of interest. Why do we theorize? According to Maddi (1996), theories are meant "to foster understanding of something hitherto not understood" (p. 485). Put another way, theories, in a perfect world, should explain and predict behavior. In the counseling profession, we also hope that they tell us how to help our clients.

The theories you are most interested in are theories of counseling or psychotherapy. All of these theories attempt to explain the process of helping clients change; they all offer some sort of prescription for what one person, the therapist, can do to help the other person, the client, who has sought assistance. To complicate matters, however, some theories of counseling address how people are made (psychologically), developmental issues, and descriptions of healthy and unhealthy psychological functioning. Other theories bypass these issues as simply not relevant to helping the client change.

WHAT IS PSYCHOTHERAPY?

Although I am guessing that almost everyone who reads the previous question has an answer to it, it is probably useful to offer a definition of counseling or psychotherapy as a starting point for further discussion of the link between theory and therapy. Here are a few.

Division 17, the Society of Counseling Psychology of the American Psychological Association, described counseling as "helping to overcome obstacles to their personal growth, wherever these may be encountered, and toward achieving optimum development of their personal resources" (Committee on Definition, Division of Counseling Psychology, 1956, p. 283).

Wampold (2001) took a slightly different view: "Psychotherapy is a primarily interpersonal treatment that is based on psychological principles and involves a trained therapist and a client who has a mental disorder, problem, or complaint; it is intended by the therapist to be remedial for the client's disorder, problem, or complaint; and it is adapted or individualized for the particular client and his or her disorder, problem, or complaint" (p. 3).

Which definition do you think is better? As you can see, what we assume everyone knows is not necessarily so. What are the implications of using language such as “overcome obstacles to their personal growth” versus “remedial for the client’s disorder, problem, or complaint”? These kinds of philosophical differences supply the underpinnings for the various theories of psychotherapy that will be presented in this book.

One nagging question always surfaces at this point: Is there a difference between counseling and psychotherapy? Traditionally, psychotherapy was considered the realm of “personality change” and “*depth* work,” whereas counseling was seen as shorter in duration, problem-focused, and much less intense. Currently, most people do not differentiate between counseling and psychotherapy, acknowledging that the difference between the two activities is more in the ideology of the speaker than in the actuality of the event. I will therefore use *counseling* or *therapy* (and *counselor*, *psychotherapist*, or *therapist*) interchangeably in this book.

WHY BOTHER WITH THEORY?

Once you’ve tentatively decided what counseling is, the next step is to consider how to do it. A long-standing tradition, dating from Sigmund Freud, is that the practice of psychotherapy is guided by the use of a theory. For Freud, of course, there was *one* theory. In the 2000s, we can count over 400 different approaches to counseling (Corsini & Wedding, 2005). The situation may seem bewildering, and you may be wondering, Do I have to have a theory?

We’ve all heard the phrases “that’s just theoretical” or “Theoretically . . .” The general message seems to be that theory is one thing, reality is another. Theory is something that is the concern of ivory-towered fuzzy-headed intellectuals, and it is well known they live their lives far from reality.

I respectfully differ. I believe that theory is practical and important. Theory is fun. Theory works. Theory is essential to human life. Counselors who don’t have theory are likely to get lost in their very genuine efforts to help their clients.

These claims may seem pretty extravagant. In this chapter, and indeed in the rest of this book, I intend to convince you that these observations make some sense—that theory plays a critical role in your work with clients. I will explain a little more.

THEORY IS FUN

You probably think I am exaggerating a little in this statement, but really, for me, theory is fun. Looking at all of the different ways to understand human activity is entertaining to those of us who are people watchers, or even worse, nosy busybodies who are always asking, Now *why* did he or she do that?

THEORY WORKS

As you will see before this chapter is over, we are pretty certain that the major counseling theories are effective. Each of the theories I present explains why people behave as they do, how to help them grow, and how to change aspects of their lives if they wish to do so. Careful, critical application of these principles seems to result in decreases in psychological symptoms and other signs of psychological health. I’d also risk saying that good psychotherapy

results in increased self-understanding and, ultimately, can produce changes in lives that increase happiness.

THEORY IS ESSENTIAL TO HUMAN LIFE

I suppose I will admit to a little exaggeration in my choice of the above heading. I am talking about theory in a very general way here. What I mean is that humans can't exist unless they have ways of organizing the bath of information in which we constantly splash. Stop reading for a moment and just attend to everything *around* and *in* you. Note your physical environment—are you reading this book outside on a grassy lawn? Is it warm? Cold? What about your body? Is your stomach growling? What thoughts are going through your head?

I think you might be getting my point—how do we know which stimuli to attend to and which to put in the background? How do we tell the difference between a dog and a horse? The answer to these questions, of course, is theory, or put another way, some structure into which we fit information to create meaning. We sometimes call these structures schemas, which are defined as cognitive structures that help us organize information. The interesting thing about schemas is that they can be both helpful and harmful. First, a schema helps us organize information into a coherent whole (think about “elephant” and list the qualities of elephant). We do this instantaneously because our schema is already present in our minds. Schemas make us more efficient processors of information. Schemas also help us to communicate. We can talk to other people because they have similar schemas (never mind whether these things are real or simply agreed-upon interpretations of the world). The downside of schematic processing is that we tend to quickly identify information that is consistent with our schema and may ignore or forget information that is *not* consistent.

You can see the implications of schema theory for counselors. Theory, our professional schema, help us organize information about human experience, life, the universe, and our clients. It can make us more efficient and directed in our work. However, theory can also bias our perceptions, seducing us into tunnel vision of the worst sort. The problem is that despite these dangers, it is probably impossible to avoid using schemas in information processing, and I'd argue that it is equally impossible to avoid using some kind of theory-like structures and assumptions in working with clients. Using a formal theory simply makes the assumptions and predictions explicit and open to examination.

COUNSELORS WHO DON'T USE THEORY MAY GET LOST

What about those who don't think about theory or, even worse, reject it outright? Consider a metaphor.

If I wanted to travel from Lake Lotawana, Missouri, to Key West, Florida, how would I proceed? I consider flying on a plane, and then reject that notion in favor of my trusty old Miata, which I have always wanted to drive down the 7-mile bridge. So driving is the thing, but do I just pack my bags and sail out the door? Well, some folks might—but we will leave this approach for another paragraph. What I would do is find a map of the United States.

As I scrutinize my map, I discover several things. First, many major roads (interstate highways) would seem very efficient, well-trodden paths. There are also the back roads,

scenic, but perhaps less efficient. In essence, it appears that there are many ways to get from Lake Lotawana to Key West. Depending on the criteria you use (speed, beauty, traffic), each has strengths and weaknesses.

In my view, counseling theory provides the counselor with a map. On this map, counselor and client can locate where they are right now and see the path to where they want to go. The theory specifies the “good” way to go. In the blooming wild of the world, the theory tells the therapist which of the zillion bits of information presented in human experience are important, and how to organize them.

To refuse to adopt some form of theory is to be driving around without a map. Consider what would have happened if I had packed my bags, hopped in the car, and just started driving. Would I have gotten to Key West? Who knows? I could have ended up in California or Boston.

However, you might accurately point out that I probably had some idea that Key West is south and east of Lake Lotawana. That is a good point, and by analogy, beginning therapists often have some ideas about what directions to take with their clients. There are some potential problems, though, with this loose sense of understanding. Proceeding with a vague idea will probably lead to a lot of wrong turns; at best, it will probably take much longer to get there. You might even get lost.

If you are a risk-taking, adventurous, free-spirited type, you might be tempted to argue that maps are stultifying; it is much more exciting to set out unfettered. Sticking to the map keeps you from seeing out-of-the-way places that are interesting and potentially enriching. I have three responses to that argument. First, using a map does not mean that you *have* to take the interstate. You still have the option of taking the less-frequented roads. Second, you can always take side trips. Third, and most important, there is an ethical issue: You are not traveling alone. Your client is in the car with you and expects that you know how to drive and where you’re going. Although free-spirited wandering might be helpful to some clients, it could be very dangerous for others.

YOUR TASK: FIND YOUR MAP

As a beginning therapist, I remember being pretty nervous as I thought about greeting my first client. I recall that I had lots of theories in my head, but I did not feel very secure with any particular one. I was wandering around with too many maps and no idea which one to use.

The best advice I can give you is to find a map that you can live with in the form of one of the established theories of psychotherapy. As a beginner, you will find it much easier to learn from the masters than to invent your own theory. Taking this approach does *not* mean that you become a thick-headed, single-minded devotee of dogma. In fact, it is unethical to do so because the unique needs and characteristics of the client require you to be somewhat flexible. Theory should be applied in a critical way, with the recognition that other approaches exist (and are apparently valid, too) and that theories contain biases that can be dangerous to clients. Also, starting with one good theory does not mean you will stay with that theory forever. In fact you will probably change orientations several times over your career as a therapist. What I am suggesting is that you deliberately choose where you start and what map you will follow. By doing so, you will learn how to apply a theory while

at the same time having some comfort in adhering to an approach that has survived some years of scrutiny by those who have more experience than you have.

Am I advocating that you pick one theory and relentlessly pound your clients with it, regardless of the feedback you get? Aren't there times when other approaches or techniques not stipulated by your theory would be more helpful? Of course there are. In fact, I support a kind of technical eclecticism—relying on one theoretical structure (or as you gain experience, an integration of two or more similar approaches) but using techniques from others, *with a clear idea about why these techniques help you toward your theoretically defined goals.*

What I don't advocate is theory-hopping, treating theories like clothes that are easily discarded depending on the occasion. First, I am not sure that psychologically or intellectually we are able to change theories easily because an important part of choosing a theory is to find one that fits with your assumptions about life. Theories differ along these lines. Second, I think that theory-hopping can lead to a very superficial understanding of theoretical perspectives. Sometimes you just have to hang in there to really get to know a theory.

One other consideration about flexibility in theoretical approach is extremely important. Theories have biases, and sometimes these interfere with the understanding of your client, particularly in terms of ethnicity, culture, sexual orientation, gender, physical ability, and so forth. You must be very sensitive to potential problems in this realm. Any time you pick up that the client is not comfortable with your approach, check it out! Consult with the client, your supervisor, your peers (being careful to maintain client confidentiality). Never persist in using a theory that seems problematic to your client.

Now that you have accepted the challenge of finding your map, the next hurdle looms ahead: what theory should you pick? There are a number of ways to look at this question. I will review several in this chapter, and then revisit this complicated issue in my final chapter.

CHARACTERISTICS OF GOOD THEORY

You may be thinking that the way to choose a theory is simply to pick the best one. Of course! Unfortunately, there are several yardsticks proposed to measure theory. One way of starting our examination of theory is to begin with the notion that good theory corresponds to reality (however you define that); that is, its ideas are accurate and so are its predictions. Testing theory against the qualities of the world is the business of science, and the practice of counseling and psychotherapy has its roots in the scientific tradition.

For a very long time the ideals and products of science have been an important part of the enterprise of counseling and psychotherapy. Sigmund Freud, arguably the first theoretical psychotherapist, considered himself a scientist, and this tradition is alive today in the scientist–practitioner model, the dominant training model of professional psychologists (i.e., counseling, clinical, and school psychologists; Raimey, 1950). The same kind of respect for the scientific roots of intervention is evident in other counseling professions as well (e.g., professional counseling). What does the scientist–practitioner model mean? Does it mean that you have to be a scientist and a therapist? Do you have to conduct research and do counseling to qualify?

Questions about whether individuals can truly integrate the elements of the scientist–practitioner model have raged for years (Nathan, 2000). At one extreme, the model is interpreted to mean that professionals should routinely engage in both science

and practice in their everyday activities. Proponents of this view have been disappointed to find that very few practitioners engage in scientific research. Interestingly, some research indicates that individuals who are mainly scientists—college and university professors who teach counseling and psychotherapy—do practice what they preach (Murdock & Brooks, 1993). Over 60% of a sample of university faculty reported that they regularly worked with clients in some form (mostly individual counseling). Thus, it is at least possible to realize both components of the scientist–practitioner model, although it appears that, for practical reasons, very few professionals do.

A more moderate position on the model is that those who are mostly counselors or therapists (the largest group of scientist–practitioners) should approach their work with a scientific attitude. This perspective is the one I advocate, given the lack of incentives for most practitioners to do research. What does being a “scientific practitioner” mean? I propose that individuals in this mode understand the relationships among theory, research, and practice and are able and willing to read and evaluate research relevant to their practice. They approach their work with a critical, evaluative attitude and with the best interests of their clients firmly in mind.

Now that you understand the basic orientation, we can proceed to examine some of the qualities that have been identified as important in determining what a good theory is: precision and testability, empirical validity, parsimony, stimulation, and practicality.

PRECISION AND TESTABILITY

A theory should have clearly defined constructs and should clearly specify the relationships among them (Maddi, 1996; Monte & Sollod, 2003). This kind of arrangement makes the theory easier to use. Because scientist–practitioners like to test theory to see if it approximates our current view of reality, the constructs should be easy to measure, or to use the professional word, they should have operational definitions or be easily operationalized. An operational definition is a statement that describes how the construct is to be measured “in terms that differ from the data it is meant to explain” (Maddi, 1996, p. 486).

Take the notion of defense mechanisms. How would you measure the presence or absence of a defense mechanism? For example, if you were thinking that a defense mechanism causes some behavior (say, aggression), you’d want to measure the level of the defense mechanism and then measure aggressive behavior. To rely on aggression as the measure of the defense mechanism is problematic because other constructs could possibly explain the occurrence of aggressive behavior (habit, situational cues, an angry personality type).

Let’s consider the Rational Emotive Behavior Therapy construct of rational belief. Skip quickly to Chapter 9 and read the section on beliefs. Is the idea of rational belief clearly defined? How would you identify the presence of a rational or irrational belief? Could you easily measure whether an individual had rational or irrational beliefs?

Good theory generates predictions about behavior that are testable. For example, if defense mechanisms are operative, aggressive behavior results. If distorted thoughts are active, then psychological distress results.

Another quality related to testability is refutability (Monte & Sollod, 2003). In essence, you should be able to deduce what kind of information would lead to disconfirmation of the theory. However, because a theory is refutable does not mean it will be abandoned if

TABLE 1.1
DISCREDITED PSYCHOLOGICAL TREATMENTS

<i>Treatment</i>	<i>Mean Rating(SD)</i>	<i>Percent Not Familiar</i>
Angel therapy for treatment of mental/behavioral disorders	4.98 (.14)	46.4
Use of pyramids for restoration of energy	4.98 (.13)	28.0
Orgone therapy for treatment of mental/behavioral disorders	4.97 (.17)	16.9
Crystal healing for treatment of mental/behavioral disorders	4.95 (.21)	21.0
Past lives therapy for treatment of mental/behavioral disorders	4.92 (.27)	7.2
Future lives therapy for treatment of mental/behavioral disorders	4.88 (.33)	30.5
Treatments for PTSD caused by alien abduction	4.85 (.40)	20.5
Rebirthing therapies for treatment of mental/behavioral disorders	4.75 (.46)	4.8
Color therapy for treatment of mental/behavioral disorders	4.68 (.62)	50.6
Primal scream therapy for treatment of mental/behavioral disorders	4.61 (.72)	4.8

Note: SD=standard deviation; percent not familiar indicates the proportion of participants in the poll who were unfamiliar with the particular treatment.

Source: Adapted from Norcross, J. C., Koocher, G. P., & Garofalo, A. (2006). Discredited Psychological Treatments and Tests: A Delphi Poll. *Professional Psychology: Research and Practice* 37, 515–522 (p. 518). Adapted with permission.

disconfirming evidence emerges. The history of science shows us that it is indeed difficult to discard a theory because what constitutes good evidence is often a topic of debate (Kuhn, 1970). An interesting illustration of this phenomenon can be seen in Norcross, Koocher, and Garofalo's (2006) report on discredited psychological treatments. In this study, Norcross et al., using a technique called Delphi polling, asked a sample of experts to rate a set of psychological treatments on the degree to which they were discredited. Ratings were made on a scale of 1 (not at all discredited) to 5 (certainly discredited). Table 1.1 shows their top 10 results. With this evidence in mind, the issue of empirical validity will be taken up more extensively in the next section.

EMPIRICAL VALIDITY

A good theory should have some empirical support (Maddi, 1996). From a scientist–practitioner perspective, this is a given. The question is, What constitutes empirical support?

One theorist's placebo (e.g., nondirective discussion) is another's favorite treatment. (Haaga & Davison, 1989, p. 502)

Sigmund Freud's idea of empirical support was his own case descriptions, which he wrote mostly after the fact. These days, uncontrolled methods such as these are not considered good empirical support because they reflect one person's views and are therefore subject to much bias (Heppner, Kivlighan, & Wampold, 2007). More appropriate are controlled case studies, in which specific, standardized measurements are made over the course of counseling, and the interventions performed are well defined and verified (i.e., the extent to which the therapist faithfully performed the treatment is ascertained).

Over the years, great debate has raged about what evidence is considered acceptable in terms of validating the psychotherapy enterprise. In 1952 Hans Eysenck raised eyebrows

and tempers in the then-young profession of psychotherapy. Eysenck, a behaviorist, set out to study the effects of psychotherapy, which at that time was roughly categorized as either psychoanalytic or eclectic (note that behavioral methods were not considered in the “therapy” grouping). Eysenck (1952) compared the rates of improvement of clients in the two types of counseling to two groups of “untreated” individuals, state hospital patients and individuals who had made disability claims with their insurance companies on the basis of psychoneurosis. Over 2 years, the improvement rate for the untreated individuals was 72%. In contrast, Eysenck found that only 44% of clients in psychoanalytic therapy and 64% of clients in eclectic therapy improved. He concluded that these data “fail to prove that psychotherapy, Freudian or otherwise, facilitates the recovery of neurotic patients. They show that roughly two-thirds of a group of neurotic patients will recover or improve to a marked extent within about two years of the onset of their illness, whether they are treated by means of psychotherapy or not” (Eysenck, 1952, p. 322).

Of course, this kind of conclusion greatly disturbed professionals who believed in the benefits of therapy. Numerous rebuttals to Eysenck were published that included various recalculations of his data and criticisms of his “control” groups. Without summarizing these sometimes tedious arguments, it is probably safe to say that the most useful thing about Eysenck’s original study was that it caused professionals to realize that something more was needed to back up their statements regarding the effectiveness of psychotherapy.

Over the years since Eysenck’s article, huge numbers of studies have been conducted to test the effects of psychotherapy, and there is now agreement within the profession that psychotherapy is indeed effective (Lambert & Ogles, 2004; Wampold, 2001). In what is generally cited as the authoritative reference on psychotherapy outcome, Lambert and Ogles (2004) conclude that “providers as well as patients can be assured that a broad range of therapies, when offered by skillful, wise, and stable therapists, are likely to result in appreciable gains for the client (p. 180). The sheer amount of data gathered since the original 1952 challenge is overwhelming, but can generally be classified into three sets: meta-analytic studies, what I call “exemplar” outcome studies, and perhaps most controversial, consumer survey data (Seligman, 1995).

Meta-analysis is a statistical technique that combines the results of a selected set of studies into an overall index of effectiveness, called effect size. Effect size tells us whether, across all studies, the treatment being observed is associated with significant differences between treated and untreated groups, or differences between two theoretical or treatment approaches. For example, the earliest meta-analyses compared counseling to no treatment and found effect sizes in the 0.75 to 0.80 range (Smith & Glass, 1977, Smith, Glass, & Miller, 1980). These results indicate that across the research studies compiled, the average client in psychotherapy improved more than about 80% of clients who were not treated (Lambert & Ogles, 2004). Meta-analysis has also demonstrated that psychotherapy is at least equal to, and perhaps more powerful than, antidepressant medication (Gloaguen, Cottraux, Cuchherat, & Blackburn, 1998; Robinson, Berman, & Neimeyer, 1990; Steinbrueck, Maxwell, & Howard, 1983). In what is a disappointing finding for some, the various theoretical orientations have been repeatedly shown to be equally effective with a wide variety of client presentations (Lambert & Ogles, 2004; Wampold, 2001).

What I call “exemplar” studies are those that are generally recognized as stringent comparisons of psychotherapy groups to no treatment groups following the best scientific

procedures. They are also called efficacy studies and are based on the clinical trials approach adopted from pharmacy research. Efficacy studies involve random assignment of participants (clients) to treatments, rigorous controls, carefully specified treatments, fixed numbers of sessions offered to clients, narrowly defined entrance criteria (e.g., clients having only one identified disorder), and independent raters to assess client dysfunction and improvement. An important feature of these kinds of studies is that they use treatment manuals that detail the expectations for what the therapist will do. Of the exemplar studies I describe here, the National Institute of Mental Health Treatment of Depression Collaborative Research Program (TDCRP) and the Project MATCH studies are true clinical trials (efficacy) studies; the Temple study was not because it admitted clients presenting a wide range of concerns.

The Temple study (Sloane, Staples, Cristol, Yorkston, & Whipple, 1975) compared short-term Psychoanalytically Oriented Therapy and Behavior Therapy with a minimal contact control group. Experienced therapists provided the treatments to 90 clients over a 4-month period who were randomly assigned to one of the three groups. Therapist adherence to their approaches was assessed, and independent observers rated client outcomes, as did the participating counselors and clients. A 1-year follow-up assessment was included, along with pre- and posttherapy tests of symptoms. Across all measures of outcomes, the treated groups improved significantly more than the control group. Differences between the two therapeutic approaches were negligible.

Critics of meta-analysis and the early exemplar research suggest that the problem in finding differential effectiveness of counseling approaches can be attributed to ignoring significant client factors in these studies. Such client factors are usually operationalized as diagnosis as exemplified in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, (DSM-IV-TR, American Psychiatric Association, 2000). Perhaps specific approaches will work best for specific diagnoses. A second exemplar study adopted this philosophy, attempting to assess psychotherapy for depression. The National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program (TDCRP) focused solely on depression and compared psychotherapeutic treatment to antidepressant and placebo groups. The antidepressant and placebo groups also received clinical management, which apparently amounted to “minimally supportive therapy” (Elkin, 1994, p. 135). The two treatment types were interpersonal psychotherapy, a variant of psychoanalytically oriented therapy (see Box 1.1 for an overview), and cognitive behavioral therapy (most similar to Beck’s Cognitive therapy; Chapter 10). Thus, clients were randomly assigned to one of four treatment groups: interpersonal psychotherapy, cognitive-behavioral therapy, antidepressant plus clinical management, or placebo plus clinical management. Ten experienced therapists, carefully trained, administered the counseling at three research sites across the United States. A total of 239 clients participated, exhibiting a range of non-bipolar, nonpsychotic depression.

Using multiple outcome measures, the study found virtually no differences among the four treatment groups. All groups showed improvement following treatment, even the placebo group. What remains unclear is whether the unexpected improvement in the placebo-clinical management group was a result of the placebo pill or the clinical management. Thus, this study clearly supports the effectiveness of psychotherapeutic

Box 1.1**Klerman and Weissman's Interpersonal Psychotherapy****THEORY**

The interpersonal psychotherapy (IPT) approach is a present-oriented, short-term therapy that was developed for clients who present with depression. Based in attachment and communications theories and with recognition of the importance of social factors in everyday functioning, IPT includes a medical model of depression used to educate clients, but then focuses on current interpersonal issues as the targets of intervention.

Four Relationship Problems

IPT theory identifies four basic interpersonal problems: grief, interpersonal role disputes, role transitions, and interpersonal deficits (Klerman, Weissman, Rounsaville, & Chevron, 1984; Markovits & Swartz, 1997; Stuart, 2006). **Grief** is defined as the persistence of depressive symptoms beyond a normal period of mourning following the death of a person significant to the client. **Role disputes** are when two or more individuals disagree on the nature of their relationship. Current overt or covert conflict with another is present. Three general phases of role dispute are distinguished: renegotiation, impasse, and dissolution. Clients who are in the midst of a major life change are generally struggling with **role transition**, which includes events such as divorce, retirement, job change, or being diagnosed with a major physical illness. The **interpersonal deficits** category of problems is the last-resort category. It signifies a long-term pattern of interpersonal deficits or lack of relationships. Prognosis is considered to be poor for these clients (Markowitz & Swartz, 1997).

IPT does not present a causal theory of depression; depression is probably the result of many factors. Interpersonal problems can either cause or exacerbate depressed mood. What is important in IPT is that the client accept a conceptualization that her depression is linked to a specific area of interpersonal functioning, one of the four problem areas (Weismann & Markowitz, 1994).

THERAPY

Two kinds of assessment are important in IPT. First, the counselor confers a formal (DSM-IV-TR) diagnosis. A complete medical evaluation of the client is recommended (Klerman et al., 1984). Second, the counselor conducts an interpersonal inventory with the client (Stuart, 2006). All of the important interpersonal relationships in the client's life are reviewed with the goal of establishing a link between changes in one or more of these relationships and the onset of the depression.

Counseling focuses on current problems, not historical events. In this approach, the therapist is an active problem solver and advocate for the client. Although the therapeutic relationship is used as a vehicle for change, no transference interpretations are used. Clients are expected to become experts on depression and to use this expertise to work actively to solve their problems (Markowitz & Swartz, 1997).

Conceptualized as a time-limited (12–16 weeks) weekly therapy (Weissman & Markowitz, 1994), IPT has two basic interlocking **goals** (Klerman et al., 1984): to reduce the client's depressive symptoms and to remedy the interpersonal difficulties associated with the depression. The client and counselor must agree on the conceptualization of the problem; this agreement promotes the therapeutic relationship and also signals the strategies and goals of the therapy (Markowitz & Swartz, 1997).

IPT has three stages (Klerman & Weissman, 1993). In stage 1 (the first three sessions or so), assessment, diagnosis, and conceptualization are the focus.

The medical model conceptualization of depression is presented to clients, and they are given the “sick role.” Clients are told that depression results from the interaction of biological and environmental factors (i.e., life events). Advocates of this approach argue that making psychological dysfunction partly biological in nature relieves clients of the overwhelming responsibility for their problems and allows separation of the problems from clients' sense of self (Markowitz & Swartz, 1997). Adopting the sick role is significant because it relieves clients from significant social responsibilities and stressors, but also creates in clients a commitment to working in therapy (Weissman & Markowitz, 1998).

Stage 1 also involves giving clients the conceptualization of their depression in one of the four areas: role dispute, role transition, grief, and interpersonal deficits. Only one of these areas should be identified for each client.

In stage 2, attention is focused on the problem area that was identified in stage 1 (Markowitz & Swartz, 1997). Counselors with grieving clients help them mourn and then support them in establishing new activities and relationships. Clients experiencing role disputes examine the nature of the dispute and devise ways to resolve it. Counselors attempt to help clients in role transition negotiate the life changes smoothly and to the best outcomes. The interpersonal deficits category is the most difficult to treat, according to Markowitz and Swartz (1997), because it is basically a default category. These clients tend to have lots of interpersonal problems and very few supportive relationships. Clients are encouraged to understand the connection between depression and social difficulties and to learn new social skills.

Stage 3 of IPT is termination and comprises the last few sessions of therapy. Client and counselor discuss the client's progress and acknowledge the ending of the therapeutic relationship. The potential for relapse and triggers that might be associated with it are discussed (Markowitz & Swartz, 1997).

TECHNIQUES

IPT is basically an eclectic approach. The following seven categories of intervention are presented; example of specific techniques within the categories are excerpted from Klerman, and colleagues (1984, pp. 142–153), which is generally considered the treatment manual for IPT.

Exploration: Nondirective exploration of the problem; supportive acknowledgement

Encouragement of affect: acceptance of painful emotion; facilitating suppressed affect

Clarification: rephrasing; attending to contradictions

Communication analysis: identifying problems in communication such as assuming that one is understood; communicating ambiguously on nonverbal channels

Use of the therapeutic relationship: encouraging client to reveal thoughts and feelings about the therapist and the therapeutic relationship; used to help client learn about other relationships

Behavior-change techniques: advice and suggestions; education; modeling

Adjunctive techniques: forming a therapeutic contract

interventions, but also calls into question the specificity of these effects because the therapies did not outperform the reference conditions (the drug and placebo groups).

Project MATCH represented yet another step in outcome research. This elaborate research project was specifically designed to see if client characteristics moderated treatment effects for a specific problem, in this case alcohol dependence and abuse (Project MATCH Research Group, 1997). In this very large and powerful study, over 1,500 clients received either cognitive behavioral treatment (12 sessions), motivational enhancement (4 sessions), or a treatment designed to help clients begin to work on the Alcoholics Anonymous 12 steps (12 sessions and clients were encouraged to attend AA meetings). Ten client characteristics thought to predict client response to the type of treatment were carefully assessed (e.g., alcohol involvement, gender, motivation).

The results of Project MATCH were consistent with previous studies. There were no differences in the effectiveness of the three treatments, and virtually no effects of client factors were found. Of the client characteristics, only one significant difference was apparent—clients who were relatively low in psychological distress did better with the 12-step approach than the others did. These differences were not evident in more distressed clients.

Several other carefully conducted studies have shown similar outcomes. One of these was Crits-Cristoph et al.'s (1999) study of treatments for cocaine dependence, in which clients received individual drug counseling plus group drug counseling (GDC), cognitive therapy plus GDC, supportive-expressive therapy plus GDC, or GDC alone. The drug counseling conditions used nonprofessional counselors. Surprisingly, GDC plus individual drug counseling produced the best results. Shapiro et al. (1994) compared psychodynamic interpersonal and cognitive-behavior therapy for depression and found the approaches equivalent. Generally, then, the results of exemplar studies tend to confirm meta-analytic findings that there are no differences in the effectiveness of theoretically-based treatments.

A final, and controversial, approach to studying counseling outcome involves what has been called the *effectiveness* approach to emphasize the difference between this and the efficacy or clinical trials method (Seligman, 1995). The *Consumer Reports* (CR) study is the most famous effectiveness study, and in fact, the distinction between efficacy and effectiveness was proposed by Seligman, who consulted with CR on the research and presented it to the psychological community in the *American Psychologist*. The intent of the CR study was to assess the outcomes of counseling *as it is actually practiced in the real world* (Seligman, 1995). Fixed numbers of sessions, strict adherence to manuals, and random assignment are serious distortions of what actually happens when real people go to therapy.

Further, clients usually have more than one specific problem (which they don't present as DSM-IV diagnoses), and the client and the counselor are concerned with overall client functioning, not just improvement in specific symptoms. This approach is quite controversial, for it does away with control groups, random assignments, and all of that other hard-core scientific stuff. Instead, effectiveness studies simply ask clients about their experiences using a large-scale survey method.

Imagine having folks rate therapy the way they do washing machines. Actually, that's what the *Consumer Reports* study did. CR sent out 180,000 surveys instructing individuals to complete the section on mental health if in the past 3 years they had sought help for stress or emotional difficulties. A total of 4,100 respondents reported having obtained professional help of some kind (e.g., attended support groups, visited physicians or mental health professionals); of these, 2,900 reported having received the services of a mental health professional. Twenty-six specific questions explored the participants' experiences with counseling. Without getting too detailed, the results of this study suggested that the efficacy studies were perhaps right—the vast majority of the respondents reported improving as a result of counseling. The amount of improvement was correlated with the length of counseling. Most relevant for our study of theory was that, once again, no theoretical approach was found to be superior to any other.

Even long before the era of meta-analyses, clinical trials, and effectiveness studies, Rosenzweig (1936/2002) captured the state of psychotherapy outcome research by quoting the Dodo bird from Carroll's *Alice in Wonderland*: “Everybody has won and *all* must have prizes” (p. 5). However, this verdict is not fully accepted by all scholars involved in psychotherapy research (Ollendick & King, 2006). In fact, a large group of psychologists support a movement to develop a list of treatments that work—known as empirically supported treatments, or ESTs. The idea behind the EST movement is that identifying specific treatments that are efficacious for specific problems is the solution to the Dodo bird dilemma.

The EST movement began in Division 12 of the American Psychological Association (APA), the Society of Clinical Psychology. Later, a special issue of the *Journal of Consulting and Clinical Psychology* was published presenting a review of literature in focused areas with the intent of identifying ESTs. In the special issue, ESTs were defined as “clearly specified psychological treatments shown to be efficacious in controlled research with a delineated population” (Chambless & Hollon, 1998, p. 8). This provision meant that the treatments considered had to be assessed within an efficacy design, specifically a randomized clinical trial study. If two independent research teams demonstrated that the treatment was better than no treatment, the treatment was labeled *efficacious*. A treatment was considered *efficacious and specific* for a given population or problem if it produced better outcomes when compared to “conditions that control for nonspecific processes” (e.g., client expectation or effects of attention of an interested other, p. 8) or other recognized treatment approaches.

It is not possible to summarize the results of the entire special issue here. Some examples of the approaches labeled efficacious include Cognitive Therapy for panic disorder and depression, Exposure Therapy for agoraphobia and obsessive-compulsive disorder (this with response prevention), and Cognitive-Behavior Therapy for generalized anxiety disorder (Crits-Christoph, 1997; DeRubeis & Crits-Christoph, 1998). Very few approaches were

labeled efficacious *and specific*—that is, better than comparison approaches for a given disorder. Efficacious and specific approaches include Cognitive Therapy for generalized anxiety disorder and panic disorder, exposure plus response prevention for obsessive-compulsive disorder, and Exposure Therapy for agoraphobia. However, DeRubeis and Crits-Christoph point out that the conclusion that Cognitive Therapy is specific for depression relative to other psychological treatments is probably premature, particularly in light of results found in such careful and powerful studies as the NIMH TDCRP study.

The EST movement set off a major controversy within professional psychology. Opponents of the movement criticize it on the grounds that it is biased toward cognitive and behavioral approaches (i.e., those approaches that are easily manualized) and that the requirement for clinical trials methodology was too strict. Others reiterated the criticisms elaborated by Seligman (1995) (i.e., clinical trials don't represent reality). Various political, philosophical, and methodological issues are still debated heatedly (Norcross, Beutler, & Levant, 2006). One of the bottom line issues is that if we conclude that there are no specific effects of psychotherapy, what are we to tell managed care organizations about what kind of therapy is acceptable? The lack of such a stance leaves those who pay for the treatment (and presumably have less knowledge about its intricacies than we do) free to determine the treatment clients receive based on other factors (e.g., length, cost; Beutler, 1998).

A different way of looking at empirically supported interventions was proposed by Division 17, the Society of Counseling Psychology (SCP) of the American Psychological Association (Wampold, Lichtenberg, & Waehler, 2002). In an issue of *The Counseling Psychologist*, the division's Special Task Group presented seven principles by which research concerned with empirical support for interventions could be reviewed; these are shown in Figure 1.1. In the first principle, the task group proposed four levels of specificity in counseling outcome research and suggested that the credential "empirically supported" could apply at each level. Level 1 is the most general level, the level of types of actions such as prevention, psychotherapy, and classroom intervention. Level 2 of this system includes major approaches to level 1 activities, such as group therapy, career exploration, or cognitive-behavior therapy. Level 3 is the level of the Division 12 empirically supported treatment, the application of major approaches (as in level 2) to specific problems or populations. Level 4 interventions are specific approaches (from within the major modalities or approaches) to specific populations or problems. An example of this level would be

1. Level of specificity should be considered when evaluating outcomes.
2. Level of specificity should not be restricted to diagnosis.
3. Scientific evidence needs to be examined in its entirety and aggregated appropriately.
4. Evidence for absolute and relative efficacy needs to be presented.
5. Causal attributions for specific ingredients should be made only if the evidence is persuasive.
6. Outcomes should be assessed appropriately and broadly.
7. Outcomes should be assessed locally and freedom of choice should be recognized.

FIGURE 1.1 Society of Counseling Psychology's Principles of Empirically Supported Interventions.

Source: Wampold, B. E., Lichtenberg, J. W., & Waehler, C. A. (2002). Principles of empirically supported intervention in counselling psychology. *The Counseling Psychologist*, 30, 197–217.

“well-specified Prevention Program A for persons with Risk Factor B and Cultural Characteristic C” (Wampold et al., p. 205).

The SCP task force argued that level of specificity should not be defined solely by DSM-IV diagnosis because many other dimensions are meaningful in understanding the client or treatment effects. For example, differences attributable to individual and cultural diversity are not considered in the original EST approach, nor are client values or other client characteristics. A final important point the task force made was that outcomes should be assessed globally rather than simply in terms of symptom remission, the usual practice in clinical trials studies. Clients and counselors, as I noted earlier, care about quality of life, too. Many people come to counseling for that basic reason, not because they have specific, identifiable symptoms.

What does this new perspective mean in terms of understanding the empirical support for what we do? Basically, it means that there are different ways of cutting the pie, so to speak. These principles were demonstrated in three articles in the same issue of *The Counseling Psychologist* that reviewed empirical support for career counseling, family interventions, and anger management (Deffenbacher, Oetting, & DiGiuseppe, 2002; Sexton & Alexander, 2002; Whiston, 2002). Each article reviewed the evidence for the intervention on all four levels of specificity, if appropriate. Each article also considered available research evidence in light of the other six principles. These reviews produced a broad and informative stack of information and also highlighted the strengths and weaknesses of the existing research.

A second perspective on the Dodo bird verdict is called the *common factors* approach. Observing the similarities among outcomes has led to the proposal that there are commonalities among therapies that are the *real* curative factors (Lambert & Ogles, 2004). Lambert and Ogles (2004) proposed the taxonomy of common factors shown in Table 1.2, and opined that “interpersonal, social, and affective factors common across therapies still loom large as stimulators of patient improvement” (p. 163). One of the most often cited common factors is the therapeutic relationship or alliance. Estimates of the effect of the therapeutic relationship range up to 30% of the variance in client outcomes (Asay & Lambert, 1999). Wampold (2001) maintained that the therapeutic relationship “accounts for dramatically more of the variability in outcomes” (p. 158) than do any specific factors offered based on theoretical approaches. For example, in the TDCRP study, alliance accounted for up to 21% of the variance in outcomes, whereas differences in treatments (e.g., interpersonal psychotherapy, cognitive-behavior therapy, placebo, drug) accounted for only 2%.

Other common factors that have been proposed are (a) client and counselor sharing similar views of the world, (b) positive client expectations, and (c) rituals or interventions that are acceptable to client and counselor (Fischer, Jome, & Atkinson, 1998). Fischer and colleagues (1998) suggested that our understanding of counseling relationships between diverse individuals (i.e., when client and counselor differ on significant dimensions such as sex, race, ethnicity) could be understood using a common factors perspective. For example, the counselor’s possession of knowledge about the client’s culture aids in building shared worldview, which may in turn contribute to the therapeutic alliance and allow the counselor and client to formulate culturally appropriate rituals or interventions. Understanding the culture of the client may also boost client expectations (hope and faith) by giving the counselor credibility in the eyes of the client.

In summary, the research on counseling and counseling theory suggests that many approaches can be taken to helping clients grow or alleviate troubles that bring them to

TABLE 1.2
LAMBERT AND OGLE'S COMMON FACTORS

<i>Support Factors</i>	<i>Learning Factors</i>	<i>Action Factors</i>
Catharsis	Advice	Behavioral regulation
Identification with therapist	Affective experiencing	Cognitive mastery
Mitigation of isolation	Assimilating problematic experiences	Encouragement of facing fears
Positive relationship	Cognitive learning	Taking risks
Reassurance	Corrective emotional experience	Mastery efforts
Release of tension	Feedback	Modeling
Structure	Insight	Practice
Therapeutic alliance	Rationale	Reality testing
Therapist/client active participation	Exploration of internal frame of reference	Success experience
Therapist expertness	Changing expectation of personal effectiveness	Working through
Therapist warmth, respect, empathy acceptance, genuineness Trust		

Source: Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.) *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change*, 5th Ed. (pp. 139–193). NY: John Wiley and Sons. Used by permission.

therapy. As I describe each theoretical viewpoint in this book, I will also provide a summary of research relevant to the approach. We will return to the issue of empirical validity in Chapter 16.

PARSIMONY

The principle of parsimony or simplicity (Maddi, 1996) says just that: The simplest explanation that can handle the data is the best. If comparing two theories, one elaborate and one very simple, that are both effective, then choose the simple one. Sounds good, right? Well, there are a few problems with taking such an approach. First, who makes the rules that say what's simple and what's not? Second, what is simple today may be simplistic tomorrow or next week. A more complex theory may be just right.

STIMULATION

Good theories get people excited (Maddi, 1996). The best theories prompt thought, writing, and research. Good theory can also provoke attempts to disconfirm it, although whether theories can actually be disconfirmed is a subject of debate. One wonders, though, about approaches that become “fadlike” and the devotees who, like worshipers, may not be the best critics of their faiths.

PRACTICALITY

Practicality implies applicability. For our purposes, all of the approaches in this book are practical; I chose them because they provide solid conceptual frameworks that are well-known for their applicability. Some roadmaps are easier to use than others, and I will note that the

approaches presented in this book vary to some degree on this criterion. Also, the degree to which an approach lends itself to particular problems and other modes of counseling varies considerably.

SO HOW DO I CHOOSE A THEORY?

Well, to start, you have to know some theories. That's why we have books about theory. Once you have the basics of the major theories, perhaps you will be a step farther down the path.

Will you choose based on the "good theory" criteria? As scientist-practitioners, we have an obligation, I think, to consider the empirical merits of a theory, which we will do for each of the theories presented in this book. The controversy over empirically supported treatments is not yet settled, so prudent professionals should be conversant with these issues.

The question always arises, Why do I *have* to pick a theory? Can't I borrow from several (or more) of the major ones? In fact, many therapists do this; it is a theoretical stance called *eclecticism*. Consider Table 1.3, which shows the theoretical orientations found in six studies conducted between 1982 and 2001. Based on these data, it appears that the most popular orientation is eclectic, with about 30–40% of the respondents choosing this option. The exception is Jensen et al., who cited 70%. However, their sample size was much smaller than

TABLE 1.3
THEORETICAL ORIENTATIONS OVER THE YEARS

	1982 ¹	1983 ²	1986 ³	1990 ⁴	2001 ⁵	2001 ⁶	2003 ⁷
Eclectic	41	30	40	70	39	36	29
Cognitive	10	8	11	5	21	16	28
Psychodynamic	11	18	10	9	10	21	15
Other	9	8	5	2	7	5	7
Systems	N/A	3	5	3	5	3	3
Interpersonal/Sullivan	N/A	1	2	1	5	3	4
Behavioral	7	6	6	8	4	3	10
Existential	2	4	3	0	3	1	N/A
Person Centered	9	2	8	1	2	2	1
Humanistic	N/A	4	4	1	2	2	1
Gestalt	2	3	2	0	2	2	N/A
Psychoanalytic	N/A	9	2	N/A	1	8	N/A
Adlerian	3	2	2	0	1	N/A	N/A

N/A means not assessed.

¹ Smith, 1982; *N* = 422, 1/2 Division 12 (Clinical Psychology), 1/2 Division 17 (Counseling Psychology)

² Prochaska & Norcross, 1983; *N* = 410, Division 29 (Psychotherapy)

³ Watkins et al., 1986, *N* = 716; Division 17

⁴ Jensen, Bergin, & Greaves, 1990; *N* = 122, Division 12 members

⁵ Murdock, 2001; *N* = 691, Division 17 members

⁶ Norcross, Hedges, & Castle, 2001; *N* = 538, Division 29

⁷ Norcross, Karpiak, & Santoro (2005)

those in the other studies, so the higher percentage may be an anomaly related to the sample. This kind of research is usually cited as evidence that therapists are mostly eclectics. Let me draw your attention to two issues. First, even if we consider the high end of the range, 40% is less than half of a sample. Over 60% of these therapists endorsed a single orientation.

Second, studies of those who endorse an eclectic orientation suggest that eclectics do identify with particular orientations from among the major theoretical approaches. In Jensen and colleagues' sample of clinical psychologists, 63% and 62% of the eclectics said they were cognitive or psychodynamic, respectively (they were allowed to choose more than one approach). Fifty-six percent indicated a behavioral orientation. In my own research (Murdock et al., 2001), we asked individuals to identify their first and second choices of orientations. Of the participants who specified eclectic as their primary theoretical orientation, 15% did not specify a second theoretical influence. Of the 85% who did indicate a second theory, the most frequent response was cognitive (39%). Other respondents indicated psychodynamic, systems, and humanistic, ranging from 9% to 12% of the sample of eclectics. The largest proportion of these eclectics (more than 83%) characterized themselves as synthetic eclectics, indicating that they integrated two or more theoretical approaches. An interesting sidelight to this study was our exploration of who the therapist chooses for a therapist (see Box 1.2 for the results).

Box 1.2

Do Counselors Seek Counseling? With Whom? Some Revelant Data

Beginning with Freud, personal therapy has been thought to be important in the development of counselors. Whether for growth or remediation, mental health professions have long encouraged counselors and therapists to undertake personal therapy (American Psychological Association, 1992; Geller, Norcross, & Orlinsky, 2005; Norcross, Strausser-Kirtland, & Missar, 1988). Various studies have looked at the kinds of personal problems experienced by psychologists, but few have examined their perceptions of their psychotherapy (Good, Thoreson, & Shaughnessy, 1995; Mahoney, 1997; Pope & Tabachnick, 1994). An exception was a study by Watkins, Lopez, Campbell, and Himmel (1986), who found that 66% of their sample had engaged in personal counseling; their counselors' orientations most often fell into the category labeled "other," which the researchers defined as a mixture of approaches that was not identified as "eclectic" by respondents. Norcross and Guy (2005) surveyed the surveys on therapists' therapies, which on average found that 72% of therapists in the United States report having been in personal therapy. They also found that insight-oriented psychotherapists were more likely to have had personal counseling than were therapists of other orientations.

In a 2001 study, my colleagues and I surveyed Counseling Psychologists, asking, among other things, about their experiences with personal counseling (Goodyear et al., in press; Murdock 2001). We sent questionnaires to 1,500 APA members who identified themselves as Counseling Psychologists; 691 returned surveys. These Counseling

Psychologists were employed in a wide variety of settings (e.g., independent practice, university counseling centers, academic faculty positions).

In our sample, a large percentage of respondents, 84.5%, reported having been in personal therapy. This percentage is comparable to or higher than those reported in previous surveys.

We found that participants who self-identified as “clinical practitioners” were more likely to have engaged in personal counseling than those who identified in other ways (e.g., researcher, administrator, academician, supervisor). We looked at participants’ theoretical orientations and their perceptions of the importance of personal counseling to the work of a psychotherapist. Our respondents were very similar to those of Norcross and colleagues in that those who endorsed psychodynamic theoretical orientations were the most likely to have sought personal counseling (97%), followed by humanistic/existential types (93%). Behaviorally oriented psychologists were least likely to have undergone therapy (71%). Psychodynamic respondents also thought that personal counseling was more important than did respondents of other theoretical orientations (cognitive therapists had the lowest importance ratings). Table A shows the theoretical orientations of the therapists’ therapists, demonstrating that the most popular orientation was psychodynamic or eclectic. When we compared the theoretical orientations of respondents to those of their counselors, we found that 32% of our respondents had counselors of the same or similar theoretical orientations. However, we found no relationships between a match of theoretical orientations and reported satisfaction with counseling.

TABLE A
THEORETICAL ORIENTATIONS OF COUNSELORS’ COUNSELORS

<i>Orientation</i>	<i>Percent of Respondents</i>
Psychodynamic	24.5
Eclectic	20.1
Humanistic	9.9
Cognitive	8.3
Systems	7.1

So why hasn’t eclecticism taken over the profession? Certainly the idea of doing what will work best for the client is an attractive one. Several factors probably account for the fact that we have not overwhelmingly jumped on the eclecticism bandwagon. For one thing, it is hard to say exactly what eclecticism is . . . which theories do you borrow from? From our data, my hunch is that eclectics borrow from several approaches within the same general theoretical domain—for example, Beck’s cognitive therapy and rational emotive behavior therapy. A second question is, do you borrow ideas about how human beings function, or do you steal techniques? If so, how do you know which technique to use when? These are some tough questions, particularly for a beginning therapist. I’d also note that it is difficult to scientifically test eclecticism because by definition the counselor does different things with different clients at different times. I don’t know about you, but that would make me a little nervous.

So, whether you turn out to be an eclectic or a single-theory proponent, knowing the major approaches to counseling and psychotherapy is essential. Even eclectics need to know the approaches from which they borrow.

WHAT ABOUT ME?

With all of this argument about science, empirically supported treatments and so on, you are probably wondering how you fit into the picture. What is the relationship between who you are and which theoretical approach you choose? When quite a few approaches seem effective, you probably don't just want to choose one at random.

You need to find an approach that is consistent with your assumptions about people, your values, and your preferred way of relating to others. Studies of therapists' choices of theories are rare; those that are available document that personality style is associated with theoretical orientation (Murdock, Banta, Stromseth, Viene, & Brown; 1998; Tremblay, Herron, & Schultz, 1986). For example, Walton (1978) found that psychodynamic types "perceive themselves as complex and serious. RET therapists (now Rational Emotive Behavior Therapy) maintain a diametrically opposed position, namely, simple and humorous" (p. 392). Because different studies look at different characteristics, it is difficult to fully integrate the results, and it is probably risky to apply them directly. In Box 1.3, I describe a study of philosophical assumptions and personality characteristics that some of my students and I did to give you an example. However, what is clear is that you need to fit your theory (and it needs to fit you).

Philosophical assumptions about people are also involved with theory choice, as you can see from the study described in Box 1.3. Although you might not want to use the dimensions identified by Coan (1979), you will still want to consider the assumptions made by different theories about the nature of human beings. To help you with this assessment, I have incorporated a section on basic philosophy for each of the theories I describe in this book.

The way we relate to others is core in how we conduct ourselves as counselors. As our study suggested, the way we choose to relate to others is probably connected to our choice of theory. Activity level is also an important consideration; as I tell my students, I could *never* be a psychoanalyst because that would require me to sit still too long (literally and metaphorically). I prefer an active approach to helping. For this reason, I am a family systems theorist and therapist.

You may also want to consider the type of practice that you plan to engage in as another factor. Although I present classic psychoanalysis in this book, not many therapists make a living doing classic analysis exclusively. Psychoanalysis requires a very special kind of client to engage in therapy for long periods of time. These clients are few and far between. If you don't have a trust fund, you might want to consider a different orientation.

HOW TO USE THEORY

The problem with theory is that if you don't know how to apply it, it seems sort of worthless. That's probably where the ivory tower thing came from—it is sometimes difficult to see the connection between the theory and what you see as the "real" world, the client who actually comes in the door asking for help. It is my mission in this book to help you learn

 Box 1.3

Joining a Theoretical Club

Some years ago (after gaining some experience in teaching theories of counseling), I began to wonder about what really determined therapists' choices of theoretical orientation. Several students agreed that this might be an interesting research question, so we developed a study to try to find out. We surveyed more than 100 therapists and counselors, some students in graduate programs, and some professionals working in the field. We asked these therapists to identify their theoretical orientations and then to rate (a) the degree to which they endorsed a set of philosophical assumptions (derived from Coan's 1979 model) and (b) their perceptions of their interpersonal behavior on the dimensions of interpersonal control (dominant–submissive) and affiliation (friendly–hostile).

The theoretical orientations of our respondents fell into five broad groups: psychoanalytic, cognitive/cognitive-behavior, systems/interpersonal, person-centered, and existential/Gestalt. Here's how our five groups fell out, with the location of their names indicating their relative placement on the dimensions:

PHILOSOPHICAL ASSUMPTIONS

<i>Emphasis on Behavioral Content</i>	<i>Emphasis on Experiential Content</i>
Cognitive/Cognitive behavioral Systems/Interpersonal	Psychoanalytic Person-centered Existential/Gestalt
<i>Elemental Emphasis</i>	<i>Holistic Emphasis</i>
Psychoanalytic Systems/Interpersonal Cognitive/Cognitive behavioral	Person-centered Existential/Gestalt
<i>Emphasis on Physical Causation</i>	<i>Emphasis on Psychological Causation</i>
Systems/Interpersonal Cognitive/Cognitive-behavioral	Existential/Gestalt Psychoanalytic Person-centered
<i>Interpersonal Behavior: Interpersonal Dominance</i>	
High Psychoanalytic	Low Existential/Gestalt Person-centered Systems/Interpersonal Cognitive/Cognitive behavioral

to actually use theory through applying it to individuals. I limit my presentation to individual counseling and psychotherapy (with the exception of the family systems chapter) and will illustrate the application of each theory to a client. This method gives you an example of the application process. Before you go on to the theories, I think I can give you a start on the application process by providing a general model of case conceptualization, or the application of theory to the individual client.

A STEP-BY-STEP GUIDE

In the interest of helping you learn how to apply theory, I now present one model that describes how to do this. My model presents a series of questions to answer within three broad steps to conceptualization. If you answer these questions, the application process will be easier and more accurate.

STEP 1: KNOW YOUR THEORY

To fully understand your theoretical perspective, answer the following questions:

1. What does the theory say is the primary or core motivation of human existence? Theories vary on how explicitly they address this issue as well as on what the motivations actually are. Psychoanalysis, for example, rests on a model of humans as driven by conflicting instinctual forces. Behavior therapists are less vocal on this issue; they see humans as motivated to survive and adapt to the environment.
2. What are the major constructs of the theory?
3. What is the process of development from the theory's perspective (if it specifies one)? Some theories are very detailed in their descriptions of psychological development, such as Psychoanalysis. Others don't have much to say about how people grow psychologically (Solution-Focused Therapy) or offer somewhat vague, general statements about it (Person-Centered or Cognitive Therapy). A useful question here is, What stages are key in development, if any?
4. What is psychological health? What is psychological dysfunction? If you can tell what the theory sees as healthy, you can probably deduce what it sees as unhealthy.

An important point to note at this juncture is that you must *always* take into account the client's cultural background in the theoretical conceptualization process. When I say culture, I mean the term in its broadest sense—differences among people that are a function of age, race or ethnicity, sex, sexual orientation, religion, and so on. Theories, for the most part, are pretty blind to these differences. They generally assume that everyone is just like everyone else. Worse, theories are inherently biased because they are the products of the cultural experience of the theorist who created them and the times in which they were created. Definitions of psychological health vary from culture to culture. What was considered psychologically healthy 25 years ago may not be so today.

5. Who are the important individuals in a client's life? Parents? Siblings? In the case of Bowen family systems theory, the perspective is multigenerational. At least three generations are thought to be important in any client's presentation.
6. Relatively speaking, how important are behavior, cognition, and affect in the client's situation? For the rational emotive behavior therapist, thoughts are the most important aspect

of the person. For Gestalt therapists, emotion is primary. The behavior therapist is most interested in actions.

When considering the behavior, affect, and cognition triad, it would be a mistake to neglect any of the three components because they are all important to understanding a theory. What I am trying to emphasize here is that the relationships of these components can help to define a given theoretical approach.

STEP 2: KNOW YOUR CLIENT

Two sorts of information are critical here. The first is general information that is essential to understanding the person, such as demographics (age, sex, race or ethnicity, sexual orientation, ableness, religion, or other cultural information). You probably want to know things such as family composition, current living situation, and physical health.

The second kind of information you want is theoretically oriented. If you are a Cognitive therapist, you ask about the client's thoughts. If you are a Reality therapist, you look at the individual's current relationships and the relative satisfaction of the other important needs specified by that theory.

Some theoretical approaches seem to deny this kind of information seeking. For instance, the Gestalt therapist doesn't want to know "stuff"; she or he wants to have an experience with the client. I propose that even though therapists may not seem to actively search for information in the form of questioning, they are gathering it nonetheless. The Gestalt therapist is looking for "holes" in the personality, areas where experience is blocked. Person-centered therapists are looking for areas of clients' experience that do not fit with their views of themselves. In my opinion, it is wise to acknowledge and make explicit this search.

STEP 3: PUT IT TOGETHER

Now you have to fit the knowledge you have together, carefully. This step is a process of translating the client's presentation into the terms of the theory. Here is another helpful question:

7. Does the client's presenting problem fit with the views of the theory about psychological functioning? Sometimes the fit seems perfect. The client comes to the interpersonal therapist with stormy relationships. The individual psychology counselor gets the client who is very insecure.

When the pieces don't seem to fit well, you really struggle. Clients don't usually come to counseling speaking in theoretical terms. Client Janey comes to the rational emotive behavior therapist talking about problems with relationships. Oh no. She's supposed to have irrational beliefs! However, if you take a step back, and really know your theory, you will realize that your job is to figure out how these relationship problems are driven by irrational thinking. The psychoanalyst's client wants to be more assertive. The analyst does not immediately morph into a behavior therapist. Instead, she thinks about what lack of assertion means in a psychoanalytic framework (something about discomfort in relationships that probably stems from early trauma).

In rare cases, the conflict between the client's presentation and the theoretical orientation of the therapist is not resolvable. Often, this situation arises because the client is from a different culture (and again, I mean this term in its broadest sense) than that from which the theory sprung. Consider this simple example: A Chinese client comes to a Bowen family systems therapist. The therapist may see the client's problem as stemming from a lack of differentiation from his¹ in family of origin. If the therapist works to get the client to differentiate, problems arise because these efforts may be in conflict with Chinese norms about how individuals relate to parents and other family members. If you run into a case of serious mismatch, I'd suggest, as I did earlier, that you consult with your supervisor as a first step.

HOW THEORY IS PRESENTED IN THIS BOOK

Now that you know the issues involved in being a theoretical scientist practitioner, it is time to proceed to the theories themselves. I will close this chapter by explaining my structure for presenting the major approaches to counseling that I have chosen. (If you want to know why I chose these, see the Preface.)

A CASE STUDY

Each chapter begins with a case study. Most are actual clients, either based on my former clients or modified from case studies offered by students and helpful professionals. Information that could potentially identify the clients has been changed.

I begin with an actual client case because my interest is in teaching how to *apply* theory, not just read it. In my mind, theory is meant to be used on the ground, even if it was developed in an ivory tower. In each chapter I apply the theory immediately after a major section or heading so that you can see how the theory works for the individual client. I have chosen to use different clients in each chapter, partly to keep you from getting bored, but more to emphasize the diversity and complexity that you will face in your profession.

BACKGROUND

For each theory, I present relevant background information, historical aspects of the theory, and a few places you can go to get current information on the approach (mostly websites). One of the more interesting parts of reading background sections, I think, is to look at the life of the person who developed the theory in relation to the theory. In many cases I provide relevant information about the major proponent of an approach.

BASIC PHILOSOPHY

I have attempted to capture the view of human nature underlying the approach in this section. I believe that examining how a theorist or theory views human existence is an important basis from which to start your exploration of the theory.

¹ Concern about sex bias in language leads me to the following solution about singular pronouns: in the theory chapters, pronouns match the sex of client and counselor; in Chapters 1 and 16 masculine and feminine pronouns are alternated randomly.

HUMAN MOTIVATION

A very basic quality of a theory is found in its assumptions about the primary motives of human behavior. Sometimes these are explicit in the theory; at other times I had to infer them.

CENTRAL CONSTRUCTS

To understand any theoretical approach, you need to understand the central constructs it presents. These constructs are essential to the theory's predictions about health and dysfunction and tie into the developmental progression (if any) proposed in the theory.

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

Many theories propose a developmental sequence that is critical to understanding the behavior of the individual. In this section I outline developmental concepts if the theorist proposes them—and some don't.

HEALTH AND DYSFUNCTION

To help your clients, you must understand the theory's ideas about healthy individuals as well as how dysfunction is conceptualized. Because I am a counseling psychologist, I am prone to looking first at an individual's strengths; emphasizing the nature and characteristics of the healthy person from a theoretical perspective is one way of honoring the strengths of a client. No matter how distressed your clients, you will find some aspects of health and strength in them.

You've noticed by now that I choose the term *dysfunction* rather than *mental disorder* or *pathology* or a number of other terms. I do this for two reasons. The first relates to my dislike of seeing folks as "sick" rather than emphasizing strengths. Second, the theories I present disagree wildly about the nature of dysfunction. Some are more on the "disorder" end of the continuum; others simply refuse to use a medical model that conceptualizes human problems as disease. These latter approaches tend to see dysfunction as faulty learning, complaints, or even normal reactions to oppressive environmental conditions.

NATURE OF THERAPY

This section in each chapter has subsections in which I attempt to describe how therapy goes in the approach. I describe assessment, the general atmosphere, and assumptions of the therapy, including the expectations for the length of counseling and the activity level of the counselor. Next, I outline the expectations of the participants in the therapeutic relationship (roles) and then, finally, the goals of the counseling enterprise based in the theoretical approach.

Assessment. In this section I attempt to describe two approaches to assessment, formal and informal. Some theories use both kinds; others, only one. When I say formal, I mean ritualized kinds of procedures, such as giving tests (e.g., the Rorschach) or administering structured techniques (e.g., Adlerian early recollections). Informal assessment means things such as talking with the client or simply observing the client's behavior during the counseling session.

Overview of the Therapeutic Atmosphere. Here I describe the general tenor of the counseling sessions. Issues such as structure of sessions, general approach to the client, and the expected length of therapy are included.

Roles of the Client and Counselor. In many cases, the theory specifies distinct roles for the therapist and client. Some are more “medical” in nature, such as in psychoanalysis, in which the doctor–patient model is evident. Other theories specify egalitarian relationships between client and counselor.

Goals. The map of your theory helps you to determine your destination in terms of its definition of the healthy person.

PROCESS OF THERAPY

In this section I attempt to describe any critical events, processes, or stages associated with an approach. Sometimes this section includes information on the theory’s conceptualization of resistance, transference, and countertransference (don’t worry if you don’t know what these are right now—you’ll get to them in the next chapter). Theorists sometimes propose stages of counseling. Generally, what you see in this section will vary somewhat from theory to theory.

THERAPEUTIC TECHNIQUES

After a general introduction, various techniques associated with the theory are presented.

EVALUATION OF THE THEORY

I chose a number of dimensions upon which to evaluate the theories I present. First, I provide a general summary of critiques of the approach that are found in the literature.

Qualities of the Theory. Following this general summary, I proceed to evaluate the approach on two of the qualities of good theory described earlier, operationalization (or testability) and empirical support. I decided not to discuss parsimony because it doesn’t seem like a useful criterion. Practicality and stimulation were neglected because I chose approaches that have high values on these dimensions.

Research Support. In this section I review the research that is relevant to the theory. I chose to divide the research into two categories. First, I review the outcome research on the approach. Does it work? What kind of outcome research is available? Next I focus on studies that potentially test the theory’s explanatory power. Just because an approach produces client improvement does not mean that its explanations of *how* that happens are verifiable. I believe that one way of furthering our knowledge about psychotherapy is to test the process. Understanding how approaches produce change is as important as knowing that they do.

ISSUES OF INDIVIDUAL AND CULTURAL DIVERSITY

Theories are often, and quite rightly, criticized for bias. This bias can take many forms, and to be ethical counselors, we must examine approaches we use to understand how we could

go wrong. Clearly, Caucasian individuals, mostly male heterosexuals, developed most counseling theories. The level of awareness of the theorists about individuals from other backgrounds varies from theory to theory.

THE CASE STUDY

In this section, which is probably the least consistent in terms of what is included, I attempt to assess the fit between theory and client case presented in the broadest sense. If some things were difficult to conceptualize from the theoretical perspective, I describe them. If the process was easy, I say that too. One thing for sure is that doing case conceptualization is not an easy task. There are almost always going to be bits and pieces that you struggle to understand from the theory's viewpoint.

Summary

To close each chapter, I attempt to summarize the important aspects of the theory, the relevant research, and the criticisms of the approach.

ANOTHER RESOURCE ON LEARNING TO USE THEORY

As I have probably made clear by now, learning to use theory is important, but the process of doing so can be difficult and trying. To further assist you in this process, I've developed another resource that should help, the video series that accompanies this book, called *Theories in Action*. On your DVD, you'll find six counseling sessions with the same client, Helen. The therapists are experts in six different theoretical orientations presented in the book: Psychoanalytic, Cognitive, Family Systems Theory, Feminist, Narrative, and Gestalt. After each session, the therapists and I discuss what they did in their sessions that was particularly characteristic of their approaches, and what they would do with Helen in the next counseling session. It is my hope that watching these experts work with Helen will further help you to learn how to apply theory.

CLOSING REMARKS

As I close this chapter, I am remembering my own struggles to find a theoretical home. I think that you will find something to offer in each of the approaches I present, as I did when I was a neophyte counselor. It took quite a while for me to settle where I am, and even longer to believe that I was really using my theoretical approach. As you begin your counseling adventure, I hope you appreciate the value of counseling theory in the helping process. If I have done a really good job, you should be feeling some excitement about what the rest of this book offers.

Visit Chapter 1 on the Companion Website at www.prenhall.com/murdock for chapter-specific resources and self-assessments.

