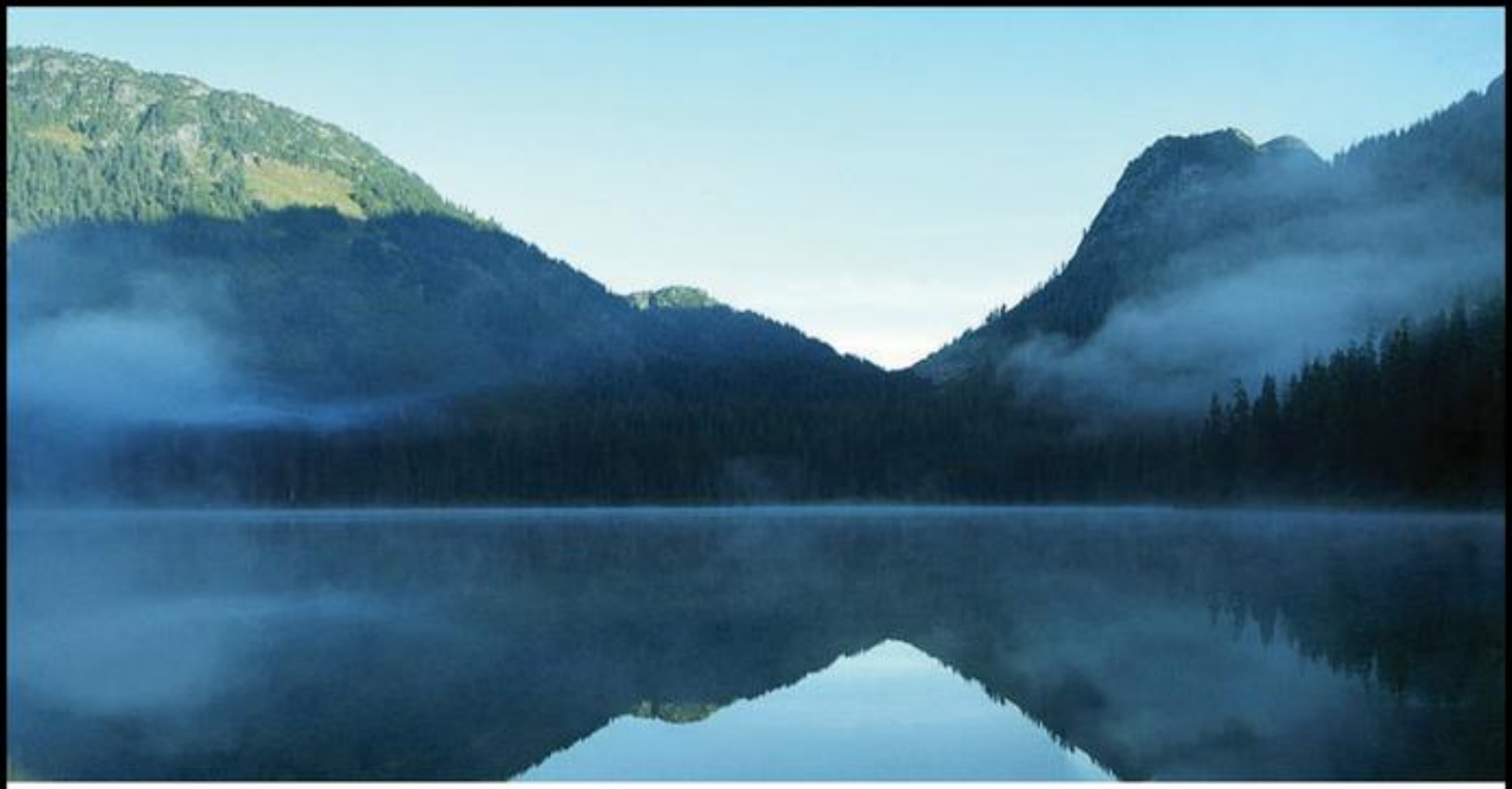

Third Edition

COUNSELING AND PSYCHOTHERAPY THEORIES IN CONTEXT AND PRACTICE

Skills, Strategies, and Techniques

JOHN SOMMERS-FLANAGAN
RITA SOMMERS-FLANAGAN

Counseling and Psychotherapy Theories in Context and Practice

THIRD EDITION

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WILEY

This edition first published 2018.

Published by John Wiley and Sons, Inc., Hoboken, New Jersey.

Library of Congress Cataloging-in-Publication Data

Names: Sommers-Flanagan, John, 1957- author. | Sommers-Flanagan, Rita, 1953- author.
Title: Counseling and psychotherapy theories in context and practice : skills, strategies, and techniques / by John Sommers-Flanagan and Rita Sommers-Flanagan.
Description: Third edition. | Hoboken, New Jersey : John Wiley and Sons, Inc., 2018. | Includes bibliographical references and index. |
Identifiers: LCCN 2017057071 (print) | LCCN 2017059381 (ebook) | ISBN 9781119279143 (pdf) | ISBN 9781119279136 (enhanced ePub) | ISBN 9781119473305 (loose-leaf)
Subjects: LCSH: Counseling psychology. | Counseling. | Psychotherapy.
Classification: LCC BF636.6 (ebook) | LCC BF636.6 .S658 2018 (print) | DDC 158.3—dc23
LC record available at https://lccn.loc.gov/2017057071

Cover image: ©Mike Powell/Getty Images
Cover design by Wiley

Set in 10/12 pt Janson Text LT Std by Aptara, Noida

Printed in the United States of America

10 9 8 7 6 5 4 3 2 1

Brief Contents

Contents

Preface

In 2003, around the time when Jack Johnson released his second studio album, titled, *On and On*, we published the first edition of *Counseling and Psychotherapy Theories in Context and Practice*. Fifteen years later, time has continued rolling on and on … and now we're entering the Third Edition of this theories text.

Since 2003, some things have changed and some have stayed the same. To keep pace with the changes, we've added well over 250 new citations and resources. To stick with (and respect) the past, we're still citing original sources from way back in the late 1800s and early 1900s. We think the best therapists keep one foot in the past, while embracing the future.

The older theories in this text are like fine wines; for the most part, they've aged well. Why? They've aged well because they started with strong foundations and adapted, changed, and incorporated new knowledge and skills along the way. Every chapter in this text combines the old and the new in ways that will enable you to help people change more quickly, overcome their personal problems, and face the turbulent times of the early twenty-first century.

Our biggest goal is to help you build your foundation for becoming a competent professional helper. In our wildest dreams, we hope to inform and inspire you to apply the theories in ways that will allow you to practice, on and on, into the future with wisdom, compassion, and professional integrity.

WHAT'S NEW IN THE THIRD EDITION?

Over the past several years, we gathered feedback to improve this textbook. We received written commentary from over 50 psychology and counselor education faculty, as well as several practicing clinicians. The feedback was positive, but many excellent ideas about how to improve the text were also provided. When possible and practical, we integrated this feedback into the Third Edition. The result: a theories textbook that's better than ever.

Here's a summary of what's new in the Third Edition.

The textbook is more tightly organized. Every chapter leads with refined learner objectives. To help readers immediately grasp the theories, key terms are defined very early in each chapter.

Based on reviewer passion for diversity and spirituality, new sections and content are integrated into all of the 12 major theory chapters. Each chapter now includes sections titled (a) cultural sensitivity, (b) gender and sexuality, and (c) spirituality.

Neuroscience is also a new feature. Although the text continues to focus on nonmedical approaches to counseling and psychotherapy, information on the brain is included throughout, via a feature called the "Brain Box."

New content is distributed throughout the text. Examples include:

- Multicultural humility (Chapters 1 and 13)
- Adlerian play therapy (Chapter 3)
- Motivational interviewing (expanded coverage in Chapter 5)
- Schedules of reinforcement (Chapter 7)
- Shame attacking exercises (Chapter 8)
- Relational cultural therapy (expanded coverage in Chapter 10)
- Intersectionality (Chapters 10 and 13)
- Narrative exposure therapy (Chapter 11)
- Multidimensional family therapy (Chapter 12)
- Multicultural and social justice counseling competencies (Chapter 13)
- Assimilative integration (Chapter 14)
- Mindfulness-based cognitive therapy (Chapter 14)

As noted previously, there are over 250 new, cutting edge citations. These citations address a wide range of issues, including the latest reviews and meta-analyses on the evidence-based status of specific counseling and psychotherapy approaches.

The end of every chapter includes a list of key terms. These key terms are in boldface when initially introduced and defined in the text.

WORDS TO THE WISE

As before, we've used cross-disciplinary terminology and resources when writing about counseling and

psychotherapy. What this means is that we relied on citations from across the psychology, counseling, and social work literature. Our focus was on the "best fit" for chapter content and not on emphasizing specific discipline-oriented resources. In keeping with this emphasis, we alternatively refer to counselors, psychotherapists, and therapists throughout the text.

Each theories chapter includes a sample informed consent. These informed consents are not comprehensive; they don't include traditional informed consent content such as potential therapy risks or emergency contact instructions. The samples are written in ways to give a flavor to how practitioners from different theoretical orientations could use theory to personalize an informed consent.

To bring the theories to life, this text includes many specific case examples and extended case material. Across all case examples, client confidentiality has been maintained. Sometimes pseudonyms are used; other times identifying information was changed.

ORGANIZATIONAL FEATURES

This textbook has a foundational introductory chapter, followed by 12 chapters focusing on specific counseling and psychotherapy theories, and a final chapter on psychotherapy and counseling integration. All of the theories chapters follow the same organizational structure:

- *Learner Objectives*: Readers can see the roadmap for their learning at the beginning of their journey.
- *Introduction*: Including a definition of key terms and, when appropriate, a short biographical profile of the person(s) who developed the theory.
- *Historical Context*: Every theory has cultural and historical context. In some cases, when needed, an additional history section may be included, for example, Evolution and Development in Psychoanalytic Theory and Practice.
- *Theoretical Principles*: Core theoretical principles are described and explained. As much as possible, concrete and real-life examples are included to help bring abstract theoretical principles to life.
- *The Practice of …*: This section describes the distinct assessment and therapy approaches associated with each theory and ends with two case vignettes to help readers apply the material.
- *Case Presentation*: For every theory there's an extended case presentation that includes (a) a problem (or goal) list, (b) problem (or case) formulation, (c) specific interventions, and (d) outcomes assessment.
- *Evaluations and Applications*: This section provides a review of the evidence-based status of each theory-based approach. In addition, an analysis of how well the approach addresses issues related to culture, gender, sexuality, and spirituality is included.
- *Concluding Comments*: Final quotations and commentary are included.
- *Chapter Summary and Review*: A detailed chapter summary and list of key terms are provided.

Additional learning features include *Reflections* boxes to help readers pause and engage in focused reflection. In addition, every chapter includes *Putting It in Practice* boxes. These boxes range from practitioner commentaries to sample informed consents, to specific practice activities. These boxes establish connections between dense or abstract theoretical material and concrete clinical practice.

ACCESS TO ENHANCED FEATURES

This edition comes with access to additional features via the enhanced ebook version, which contains dynamic content to further enrich your understanding of the text. This can be accessed by purchasing the enhanced ebook edition via www.wiley.com or www.vitalsource.com. This interactive e-text features the following interactivities:

Videos

This edition features 15 videos of different therapy approaches in action. These approaches include:

Psychoanalytic

Adlerian

Existential

Gestalt

Person-Centered

Motivational Interviewing

Behavioral

Cognitive Behavioral

Reality Therapy

Feminist

Solution-Focused

Family Systems

Whether you're watching these videos within the context of a Counseling and Psychotherapy course or on

your own, you may use the videos in any of several different ways. How you choose to use them will depend on your own individual teaching and learning needs. Here are a few ideas:

> You can watch the clip in its entirety and just focus on absorbing what you see as an example of a particular therapy prototype.
>
> You can watch the chapter in segments, as each video includes an introduction to the specific approach, followed by a video clip of the therapy session, followed by a brief discussion, followed by a final clip from the therapy session.
>
> You can also watch these videos or segments with a critical eye. Because the therapy sessions are spontaneous and nonscripted, you may notice points during which the therapist struggles (as John does while trying to illustrate the psychoanalytic approach during a 20 minute clip). These struggles may involve the challenges of adhering to a single theoretical model or, quite simply, the struggle of what to say at any given point in a therapy session. In fact, as we've watched these videos ourselves (and with students), some of our best learning has come when our students (a) notice a missed therapeutic opportunity, (b) notice a theoretical inconsistency, or (c) spontaneously begin discussing how they might have behaved differently (and more effectively!) had they been the therapist in the video.

No matter how you use the videos, we strongly recommend that you be sure to press the pause button (at least occasionally). We recommend this even if you're watching videos in their entirety. This is because, as with all therapy sessions, the interactions are rich and nuanced and therefore deserve thought, reflection, and, whenever possible, a lively discussion (you can even do the discussion with yourself if you're feeling in a Gestalt sort of mood). We hope you learn and enjoy the videos and that you find them helpful in your growth and development as a professional counselor or psychotherapist.

Practice Questions

At the end of each chapter, you will have the option to test your understanding of key concepts by going through the set of practice questions supplied. Each of these are tied back to the Learner Objectives listed at the start of each chapter.

In conclusion, although we're happy with the videos that accompany this textbook, all theory demonstration videos are imperfect. Therefore, we encourage you to not only view our videos but to also view others, and then use whatever fits your teaching style and purpose. To help us to keep improving our video demonstrations, please feel free to email John at john.sf@mso.umt.edu to share your perspective and offer compliments or constructive feedback.

BEYOND THIS TEXTBOOK

This textbook has additional resources available for students and faculty, which can be accessed using the book's product page at www.wiley.com. These include:

A *Student Manual and Study Guide* for students. Including content linked to each chapter, this supplementary resource provides students with more of what they need to learn and master the theories of counseling and psychotherapy. The *Student Manual and Study Guide* offers:

- A **theories beliefs pre- and post-test** in each chapter.
- An **opening professional development essay** written by a student, practitioner, or faculty member who is active within the counseling or psychology professions.
- A **theory review** section that includes a **glossary of key terms**, **theories crossword puzzle**, and **critical reflections** on each theory.
- A section on **practice activities** designed to help students experience and practice implementation of each theory.
- A section for each chapter titled **Testing Yourself** that includes a **25-item multiple choice practice test** and a comprehensive **short-answer question review**; these materials will help students succeed on even the most difficult examinations.
- **A closing essay** by another student or practitioner who has applied theory-based knowledge in a practice setting.

A revised online *Instructor's Resource Manual* that includes the following teaching aids is also available:

- Sample course syllabi.
- Supplementary lecture outlines and ideas.
- A test bank with 50 multiple choice questions for each chapter.
- Generic PowerPoint slides that can be downloaded and adapted for instructor needs.

ACKNOWLEDGMENTS

Like raising children, writing textbooks requires a small village of support people if you ever hope to get a well-developed child (or book) out of your house. We have many people to thank and will undoubtedly miss a few

and then need several years of therapy to get over our guilt. Oh well. We've never let the fear of additional therapy scare us out of trying to do the right thing … which in this case means thanking as many people as we can think of to thank.

Bunched in a small group at the first of the thank-you line is the Wiley team. In particular, we thank Tisha Rossi, Jenny Ng, Monica Rogers, Leah Michael, Christina Verigan, Veronica Visenti, and Audrey Koh. All of our Wiley support people deserve gold stars for walking us through the publishing process and assisting with last-minute details. Thank you again and again. Thanks also to Joey Moore for his help with key terms and a final editing review.

This next list includes individuals who have contributed to chapters either through helpful reviews or via contribution of written material. These honorees are listed alphabetically by first name.

Alan Tjeltveit, Muhlenberg University

Alyssa Swan, Eastern Illinois University

Amanda Minor, Salve Regina University

Amy Barth, University of Wisconsin—Whitewater

Ana Herrera, Wake Forest University

Angela Touchton, Lindsey Wilson College

Ann McCaughan, University of Illinois—Springfield

Ariel Winston, South University

Bearlyn Ash, Governors State University

Becca Morra, Xavier University

Benjamin Willis, Scranton University

Brenda O'Beirne, University of Wisconsin—Whitewater

Carleton Brown, University of Texas at El Paso

Chad Luke, Tennessee Tech University

Curt Tweedy, Missoula Youth Homes

Cyndi Matthews, University of Louisiana at Monroe

Dana Griffin, Independent Practice

Daniel McManus, Kent State University

Daniel Williamson, University of Mary Hardin-Baylor

David Jones, Cincinnati Christian University

David Julius Ford, James Madison University

David Pfaff, University of Central Oklahoma

Dawn Hudak, Pace University

Diane Shea, Holy Family University

Emily Petkus, Shenandoah University

Everett Painter, University of Tennessee—Knoxville

G. Collerone, National Institute of Education

Isabelle Ong, Wake Forest University

Jane Webber, Kean University

Jennifer Williamson, University of Mary Hardin-Baylor

Joan Vanderschaaf, National Louis University

Joanne Jodry, Monmouth University

JoAnne Sanders, Heidelberg University

Jon Carlson, Adler University

Judith Beck, Beck Institute for Cognitive Therapy and Research

Justin Lauka, Adler University

Jyoti Nanda, Regent's College, United Kingdom

K. Michelle Hunnicutt Hollenbaugh, Texas A&M University, Corpus Christi

Katerine Wix, Governor's State University

Kathleen McClesky, Longwood University

Kirk Schneider, Saybrook Graduate School

Kristen Langellier, Idaho State University

Kurt Kraus, Shippensburg University

Laura M. Schmuldt, Lindsey Wilson College

Lauren Ostrowski, Independent Practice

Leslie Greenberg, York University

Mary Mayorga, Texas A&M University—San Antonio

Megan Caldwell, Walden University

Michelle Johnson, Walden University

Michelle Santiago, Morarian Theological Seminary

Natalie Rogers, California Institute of Integral Studies

Nick Heck, University of Montana

Nicki Nance, Webster University

Olwen Anderson, Independent Practice

Patricia Robey, Governors State University

Quentin Hunter, University of Louisville

Rebecca Milner, East Tennessee State University

Reginald W. Holt, Central Connecticut State University

Reka Farago, University of Northern Colorado

Richard E. Watts, Sam Houston State University

Robert J. Zeglin, University of North Florida

Robert Wubbolding, International Center for Reality Therapy

Rochelle Cade, University of Mary Hardin-Baylor

Sally L. Kuhlenschmidt, Western Kentucky University

Sarah Campbell, Capella University

Susan Henderson, Sam Houston State University

Susan Schwendener, Northeastern Illinois University

Tamara Tribitt, University of Redlands

Thomas Burdenski, Tarleton State University

Tracey Duncan, New Jersey City University

Troyann I. Gentile, Lindsey Wilson College

Veronica I. Johnson, University of Montana

Finally, since authors typically thank their lovely spouses for support and patience, we'd like to finish by thanking each other for being the super-glue that helps everything stick together.

John Sommers-Flanagan
Rita Sommers-Flanagan
Absarokee and Missoula, Montana

About the Authors

John Sommers-Flanagan, PhD, is a clinical psychologist and professor of counselor education at the University of Montana. He is co-host of the "Practically Perfect Parenting Podcast" and is author or coauthor of over 50 professional publications. John is a long-time member of both the American Counseling Association and the American Psychological Association; he regularly presents professional workshops at the annual conferences of both these organizations. John has an active blog at https://johnsommersflanagan.com/.

Rita Sommers-Flanagan, PhD, is professor emeritus of counselor education at the University of Montana, where she taught for 24 years. Among her favorite teaching and research areas are ethics and women's issues. While at UM, she also served as the director of Women's Studies and acting director of the Practical Ethics Center. She is the co-author of quite a few professional articles, book chapters, and books. Probably over 40, maybe even 50, but who's counting? She also publishes essays, poems, and other creative writing endeavors. As a clinical psychologist, she has worked with youth, families, couples, and women for many years.

John and Rita work together and separately training professionals in counseling and psychotherapy, ethics, suicide assessment, and parenting. They have produced and are producing many different professional training videos with Alexander Street Press, Psychotherapy.net, and Microtraining Associates. John and Rita enjoy providing professional workshops, seminars, and professional presentations nationally and internationally.

Together, John and Rita have coauthored nine books, including:

- *How to Listen so Parents Will Talk and Talk so Parents Will Listen* (2011, Wiley)
- *Tough Kids, Cool Counseling* (2nd ed., 2007, American Counseling Association)
- *Clinical Interviewing* (6th ed., 2017, Wiley)
- *Becoming an Ethical Helping Professional* (2007, Wiley)

John and Rita have two daughters, one son-in-law, three grandchildren, and can hardly believe their good fortune. They are deeply rooted in Montana, and in the summers, alternate writing with irrigating and haying on the family ranch. Both John and Rita enjoy exercising, gardening, exploring alternative energy technologies, and restoring old log cabins, old sheds, and any other old thing that crosses their path—which, given the passage of time, is now starting to include each other.

CHAPTER 1

Psychotherapy and Counseling Essentials
An Introduction

LEARNER OBJECTIVES

- Identify key reasons for studying counseling and psychotherapy theories
- Place the development of counseling and psychotherapy in historical context
- Define counseling and psychotherapy
- Review and describe scientific achievements leading to evidence-based psychotherapy and counseling procedures
- List and articulate essential ethical issues within the mental health and helping professions
- Describe the historical context, complexities, and potential of neuroscience for counseling and psychotherapy research and practice
- Discuss issues pertaining to the emergence of your personal theory of counseling and psychotherapy
- Describe the authors' personal and professional biases
- Summarize core content and key terms associated with psychotherapy and counseling essentials

WHY LEARN THEORIES?

About a decade ago, we were flying back from a professional conference when a professor (we'll call him Darrell) from a large Midwestern university spotted an empty seat next to us. He sat down, and initiated the sort of conversation that probably only happens among university professors.

"I think theories are passé. There has to be a better way to teach students how to actually do counseling and psychotherapy."

When confronted like this, I (John) like to pretend I'm Carl Rogers (see Chapter 5), so I paraphrased, "You're thinking there's a better way."

"Yes!" he said. "All the textbooks start with Freud and crawl their way to the present. We waste time reviewing outdated theories that were developed by old white men. What's the point?"

"The old theories seem pointless to you." John felt congruent with his inner Rogers.

"Worse than pointless." He glared. "They're destructive! We live in a diverse culture. I'm a white heterosexual male and they don't even fit for me. We need to teach our students the technical skills to implement empirically supported treatments. That's what our clients want and that's what they deserve. For the next edition of your theories text, you should put traditional theories of counseling and psychotherapy in the dumpster where they belong."

John's Carl Rogers persona was about to go all Albert Ellis (see Chapter 8) when the plane's intercom crackled to life. The flight attendant asked everyone to return to their seats. Our colleague reluctantly rose and bid us farewell.

****

On the surface, Darrell's argument is compelling. Counseling and psychotherapy theories must address unique issues pertaining to women and racial, ethnic, sexual, and religious minorities. Theories also need to be more practical. Students should be able to read a theories chapter and finish with a clear sense of how to apply that theory in practice.

However, Darrell's argument is also off target. Although he's advocating an evidence-based (scientific) orientation, he doesn't seem to appreciate the central role of theory to science. From early prehistoric writing to the present, theory has been used to guide research and practice. Why? Because theory provides direction and without theory, practitioners would be setting sail without proper resources for navigation. In the end, you might find your way, but you would have had a shorter trip with GPS.

Counseling and psychotherapy theories are well-developed systems for understanding, explaining,

Counseling and Psychotherapy Theories in Context and Practice: Skills, Strategies, and Techniques, Third Edition. John Sommers-Flanagan and Rita Sommers-Flanagan. © 2018 John Wiley & Sons, Inc. Published 2018 by John Wiley & Sons, Inc.
Companion website: www.wiley.com/go/sommers-flanagan/theories3e

predicting, and controlling human behavior. When someone on Twitter writes, "I have a theory that autism is caused by biological fathers who played too many computer games when they were children" it's not a theory. More likely, it's a thought or a guess or a goofy statement pertaining to that person's idiosyncratic take on reality; it might be an effort to prove a point or sound clever, but it's not a theory (actually, that particular idea isn't even a good dissertation hypothesis).

Theories are foundations from which we build our understanding of human development, human suffering, self-destructive behavior, and positive change. Without theory, we can't understand why people engage in self-destructive behaviors or why they sometimes stop being self-destructive. If we can't understand why people behave in certain ways, then our ability to identify and apply effective treatments is compromised. In fact, every evidence-based or empirically supported approach rests on the shoulders of counseling and psychotherapy theory.

In life and psychotherapy, there are repeating patterns. I (John) recall making an argument similar to Darrell's while in graduate school. I complained to a professor that I wanted to focus on learning the essentials of becoming a great therapist. Her feedback was direct: I could become a technician who applied specific procedures to people or I could grapple with deeper issues and become a real therapist with a more profound understanding of human problems. If I chose the latter, then I could articulate the benefits and limitations of specific psychological change strategies and modify those strategies to fit unique and diverse clients.

Just like Darrell, my professor was biased, but in the opposite direction. She valued nuance, human mystery, and existential angst. She devalued what she viewed (at the time) as the superficiality of behavior therapies.

Both viewpoints have relevance to counseling and psychotherapy. We need technical skills for implementing research-based treatments, but we also need respect and empathy for idiosyncratic individuals who come to us for compassion and insight. We need the ability to view clients and problems from many perspectives—ranging from the indigenous to the contemporary medical model. To be proficient at applying specific technical skills, we need to understand the nuances and dynamics of psychotherapy and how human change happens. In the end, that means we need to study theories.

Contemporary Theories, Not Pop Psychology

Despite Darrell's argument that traditional theories belong in the dumpster, all the theories in this text—even the old ones—are contemporary and relevant. They're contemporary because they (a) have research support and (b) have been updated or adapted for working with diverse clients. They're relevant because they include specific strategies and techniques that facilitate emotional, psychological, and behavioral change (see Figure 1.1). Although some of these theories are more popular than others, they shouldn't be confused with "pop" psychology.

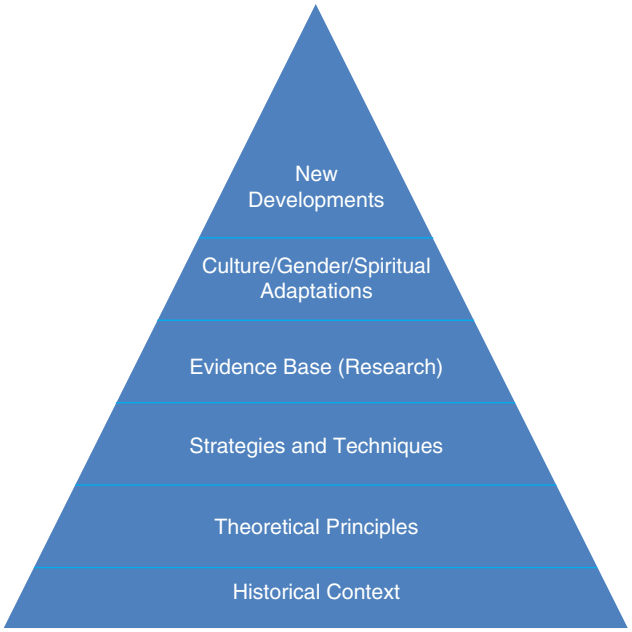

FIGURE 1.1 Counseling and Psychotherapy Theory: Foundations, Principles, and Practice

Another reason these theories don't belong in the dumpster is because their development and application include drama and intrigue that rival anything Hollywood has to offer. They include literature, myth, religion, and our dominant and minority political and social systems. They address and attempt to explain big issues, including:

- How we define mental health.
- Whether we believe in mental illness.
- Views on love, meaning, death, and personal responsibility.
- What triggers anger, joy, sadness, and depression.
- Why trauma and tragedy strengthens some people, while weakening others.

There's no single explanation for these and other big issues; often mental health professionals are in profound disagreement. Therefore, it should be no surprise that this book—a book about the major contemporary theories and techniques of psychotherapy and counseling—will contain controversy and conflict. We do our best to bring you more than just the theoretical facts; we also bring you the thrills and disappointments linked to these theories of human motivation, functioning, and change.

Human Suffering and Hope

A young man named Adrian came for counseling. He described these problems:

- Constant worry that he hadn't turned off his kitchen stove.
- Repeated checking to see if he had properly engaged his car's emergency brake … even when parked on level ground.
- Repeated thoughts of contamination. He wondered, "Have I been infected by worms and germs?"
- Hands that were red and chapped from washing 50+ times a day.

Midway through Adrian's second session, he reported intrusive obsessive thoughts. Adrian kept thinking that a woman in the waiting room had placed a foot on his (Adrian's) pop bottle. Adrian wanted to go back to double-check the scene.

The therapist did some reality testing. She gently asked Adrian how likely it was that his pop bottle had been contaminated. Adrian said the bottle had been in his own hands and that the other client had been seated across the room. He admitted that it probably didn't happen.

Then the therapist asked Adrian to engage in response prevention. Instead of giving into his checking impulse, she engaged Adrian in a relaxation activity, including deep breathing. This approach was used to help break the link between Adrian's obsessive thoughts and maladaptive checking behaviors.

After 20 minutes of relaxation and therapeutic conversation, Adrian reported feeling better. A few minutes later, he asked to use the restroom. As he left, the therapist wondered if Adrian might be leaving to perform a checking ritual. She waited a moment and then walked to the waiting room. Adrian was seated about 15 feet away from a pop bottle, leg stretched out as far as possible, trying to reach the bottle with his foot. His foot was still at least 10 feet from the bottle. The therapist interrupted the process and escorted Adrian back to the counseling office.

Although there's a mental disorder diagnosis for Adrian's condition (obsessive-compulsive disorder) and research-based therapies available, there's no guarantee he can successfully change. Psychotherapy is an imperfect science. There's much about human behavior, the brain, emotions, and interpersonal relationships that we don't know. However, hope remains. Many individuals like Adrian seek help, overcome their debilitating behaviors, and go on to lead happy and meaningful lives.

Understanding why people suffer, how they change, and how to help them live satisfying lives is a fascinating and important undertaking. It's also the reason this book exists.

What Is a Theory?

A **theory** involves a gathering together and organizing of knowledge about a particular object or phenomenon. In psychology, theories are used to generate hypotheses about human thinking, emotions, and behavior. A good theory should clearly explain what causes client problems (or psychopathology) and offer specific strategies for alleviating these problems. Think about Adrian: a good theory would (a) explain how he developed his obsessive-compulsive symptoms, (b) provide guidance for what strategies or procedures his therapist should use, and (c) predict how Adrian will respond to various therapy techniques. These predictions should guide Adrian's therapist on what techniques to use, how long therapy will last, and how a particular technique is likely to affect Adrian.

Theories provide therapists with models or foundations from which they provide professional service. To be without a theory or without direction and guidance is something most of us would rather avoid (Prochaska & Norcross, 2014).

Context

Context is defined as the particular set of circumstances surrounding a specific event or situation. Nothing happens without context.

The theories we cover in this book are products of their contextual origins. The socioeconomic status of the theorists and the surrounding politics, culture, wars, scientific discoveries, religions, and many other factors were operating together to create and sustain the theories we write about and the professional activity that we've come to know as counseling and psychotherapy. Even now, as you read this, contextual factors are influencing the way in which the public regards and professionals practice psychotherapy. Context will continue to define and redefine what we mean by counseling and psychotherapy into the future.

HISTORICAL CONTEXT

Contemporary psychology and psychotherapy originated in Western Europe and the United States in the late 1800s. During that time, women and other minorities were usually excluded from higher education. Consequently, much of psychotherapy's history was written from the perspective of educated white men, including Jewish males, advocating a particular theory. This tendency, so dominant in psychology, has inspired book and chapter titles such as, "Even the rats were white and male" (Guthrie, 2004; Mays, 1988).

Recognizing that there are neglected feminist and multicultural voices within the history of psychotherapy, we begin our exploration of contemporary theories and techniques of counseling and psychotherapy with a look back to its origins.

The Father of Psychotherapy?

Sigmund Freud is often considered the father of modern psychotherapy, but of course Freud had professional forebears as well. In fact, around the turn of the century the Frenchman, Pierre Janet, claimed that Freud's early work was not original:

> We are glad to find that several authors, particularly M. M. Breuer and Freud, have recently verified our interpretation *already somewhat old*, of subconscious fixed ideas with hystericals. (Janet, 1901, p. 290, italics added)

Janet believed *he* was developing a new theory about human functioning, a theory that Freud was simply helping to validate. Janet and Freud were competitive rivals. With regard to their relationship, Bowers and Meichenbaum (1984) wrote: "It is clear from their writings that Freud and Janet had a barely concealed mutual animosity" (p. 11).

Questions remain regarding who initially led the psychotherapy and counseling movements in Western Europe and, later, the United States. However, the whole idea of crowning one individual as the first, or greatest, originator of psychotherapy is a masculinized and Western endeavor (Jordan, Walker, & Hartling, 2004; Jordan, 2010). It's also inappropriate to credit white Western European males with the origins of counseling and psychotherapy theory and practice. All theories draw concepts from earlier human practices and beliefs.

Bankart (1997) articulated this point about historic discovery:

> My best friend has a bumper sticker on his truck that reads, "Indians Discovered Columbus." Let's heed the warning. Nineteenth-century European physicians no more discovered the unconscious than John Rogers Clark "discovered" Indiana. Indeed, a stronger argument could be made for the reverse, as the bumper sticker states so elegantly. (p. 21)

Of course, nineteenth century European physicians didn't discover the unconscious (Ellenberger, 1970). Nevertheless, we're intrigued by the implications of Bankart's comment. Could it be that European physicians, Russian feminists, the Senoi Indians, and many other individuals and cultural groups were "discovered" by the human unconscious? Of all the theorists we write about, we think Carl Jung would most appreciate the idea of an active unconscious seeking recognition in the human community (our Jungian chapter is on the companion website www.wiley.com/go/sommers-flanagan/theories3e).

Four Historical–Cultural Perspectives

Early treatments for human distress and disturbance typically consisted of biomedical, spiritual, psychosocial, and indigenous procedures. Often, theorists and practitioners repeatedly discover, rediscover, and recycle explanations and treatments through the ages; this is one reason why a quick historical review is useful.

The Biomedical Perspective

The **biomedical perspective** involves belief that biological, genetic, or physiological factors cause mental and emotional problems and are central to therapeutic strategies. Consistent with the biomedical perspective, archaeological evidence exists for an ancient treatment procedure called **trephining**. Trephining involved using a stone tool to chip away at a human skull to create a circular opening. It's believed, in the absence of written documentation, that this was a shamanic treatment designed to release evil spirits from the afflicted individual's brain, although trephining involved a physical intervention. Apparently some patients survived this crude procedure, living for many years afterward (Selling, 1943).

About a half million years later, a similar procedure, the prefrontal lobotomy, emerged as a popular medical treatment in the United States. This medical procedure was hailed as an important step forward in the treatment of mental disorders. Prefrontal lobotomies were described as an exciting new medical procedure in *Time* magazine in 1942 (from Dawes, 1994).

Although lobotomies and trephining are no longer in vogue, current brain-based physical or biomedical interventions include psychotropic medications, electroconvulsive therapy (ECT), transcranial magnetic stimulation, vagus nerve stimulation, and deep brain stimulation (Blumberger et al., 2016; Brunoni et al., 2016). The biological perspective is an important area for research and treatment. Although responsible counselors and psychotherapists keep abreast of developments from the biomedical perspective, this text focuses on nonbiological or psychosocial explanations and treatments.

The Religious/Spiritual Perspective

Clergy, shamans, mystics, monks, elders, and other religious and spiritual leaders have been sought for advice and counsel over the centuries. It was reported that Hild of Whitby (an abbess of a double monastery in the seventh century) possessed prudence of such magnitude that not only ordinary folk but even kings and princes would come to ask advice for their difficulties (Petroff, 1986). For many Native Americans, spiritual authority and practices still hold more salience for healing than counseling or psychotherapy (Francis & Bance, 2016; King, Trimble, Morse, & Thomas, 2014). The same is true for other indigenous people, as well as Western Europeans who have strongly held religious commitments. Many Asian and African cultures also believe spiritual concerns and practices are intricately related to psychological health (D. W. Sue & D. Sue, 2016).

The **religious/spiritual perspective** emphasizes spiritual explanations for human distress and recovery.

Contemporary psychosocial interventions sometimes incorporate spirituality (Johnson, 2013). Two prominent approaches with scientific support, dialectical behavior therapy (DBT) and acceptance and commitment therapy (ACT), use Buddhist mindfulness approaches to facilitate emotional regulation (Hayes, 2002; Hayes, Strosahl, & Wilson, 1999; Linehan, 2000). Most practitioners readily acknowledge the emotional healing potential of spiritual practices. Matching client spirituality with spiritually oriented treatments tends to improve outcomes (Worthington, Hook, Davis, & McDaniel, 2011).

The Psychosocial Perspective

Humans have probably always understood that verbal and relational interactions—the essence of the **psychosocial perspective**—can change thoughts, mood, and behavior. At a minimum, we know that indigenous healers used psychological and relational techniques similar to current theory-based psychosocial strategies. Typical examples include Siddhartha Gautama (563–483 b.c.), better known as the Buddha, and the Roman philosopher Epictetus (50–138 a.d.), both of whom are forebears to contemporary cognitive theory and therapy.

A less cited example, from the tenth and eleventh centuries, is Avicenna (980–1037 a.d.), a renowned figure in Islamic medicine. The following case description illustrates Avicenna's psychological approach:

> A certain prince … was afflicted with melancholia, and suffered from the delusion that he was a cow … he would low like a cow, causing annoyance to everyone, crying "Kill me so that a good stew may be made of my flesh," [and] … he would eat nothing.… Avicenna was persuaded to take the case.… First of all he sent a message to the patient bidding him to be of good cheer because the butcher was coming to slaughter him. Whereas … the sick man rejoiced. Some time afterwards, Avicenna, holding a knife in his hand, entered the sickroom saying, "Where is this cow that I may kill it?" The patient lowed like a cow to indicate where he was. By Avicenna's orders he was laid on the ground bound hand and foot. Avicenna then felt him all over and said, "He is too lean, and not ready to be killed; he must be fattened." Then they offered him suitable food of which he now partook eagerly, and gradually he gained strength, got rid of his delusion, and was completely cured. (Browne, 1921, pp. 88–89)

Avicenna's treatment approach appears to fit within a strategic or constructive theoretical model (see Chapter 11).

The Feminist/Multicultural Perspective

The **feminist/multicultural perspective** uses social and cultural oppression and liberation from oppression as primary explanations for mental disorders and therapeutic recovery. As an organized, academic discipline, feminist and multicultural pedagogy is relatively young. However, because these perspectives have likely simmered in the background or operated in indigenous cultures, we include them here.

As discussed previously, traditional historical voices have been predominately white and male. The fact that much of what we read and digest as history has the sound and look of whiteness and maleness is an example of context. Human history and knowledge can't help but be influenced by those who write and tell the story. Nevertheless, as human service providers, mental health professionals must be aware of alternative perspectives that include minority voices (Hays, 2013; D. W. Sue & D. Sue, 2016).

Brown (2010) discussed one way in which the feminist mindset differs from traditional male perspectives.

> Feminist therapy, unlike many other theories of therapy, does not have an identifiable founding parent or parents who created it. It is a paradigm developed from the grassroots of many different feminists practicing psychotherapy, and its beginnings occurred in the context of many people's experiences and interactions in personal, political, and professional settings. Because there is no central authority, accrediting body, or founder, those who identify as its practitioners do not always agree on the boundaries of what constitutes feminist therapy. (p. 7)

Feminist influences have quietly (and sometimes less quietly) influenced therapy process. Over the past 40-plus years, many feminist concepts and procedures have been integrated into all counseling and psychotherapy approaches. Mutuality, mutual empathy, client empowerment, and informed consent all give psychotherapy a more feminist look and feel (Brown, 2010; Jordan, 2010; J. Sommers-Flanagan & Sommers-Flanagan, 2017). Similarly, as the United States has become more culturally diverse and the dominant culture has opened itself to alternative cultural paradigms, new therapeutic possibilities have emerged and been woven into therapy. Most notably, we now know that cultural sensitivity and cultural humility (and therefore multicultural training) improve therapy outcomes with diverse client populations (Griner & Smith, 2006; Smith, Rodríguez, & Bernal, 2011). Additionally, Eastern wellness techniques and strategies such as mindfulness have been integrated into contemporary and evidence-based therapy approaches (Linehan, 1993).

Historically, counseling and psychotherapy focused on helping individuals move toward individuation, independence, and rational thinking. Behavior associated with dependence and emotional expression was often viewed as pathological. In contrast, feminist and multicultural perspectives emphasize relationship and community over individuality (Jordan, 2010). Going forward, feminist and multicultural values will continue to influence and be integrated into traditional psychotherapy systems.

DEFINITIONS OF COUNSELING AND PSYCHOTHERAPY

Many students have asked us, "Should I get a PhD in psychology, a master's degree in counseling, or a master's in social work?"

This question usually brings forth a lengthy response, during which we not only explain the differences between these various degrees, but also discuss additional career information pertaining to the PsyD degree, psychiatry, school counseling, school psychology, and psychiatric nursing. This sometimes leads to the confusing topic of the differences between counseling and psychotherapy. As time permits, we also share our thoughts about less-confusing topics, like the meaning of life.

Sorting out differences between mental health disciplines is difficult. Jay Haley (1977) was once asked: "In relation to being a successful therapist, what are the differences between psychiatrists, social workers, and psychologists?" He responded: "Except for ideology, salary, status, and power, the differences are irrelevant" (p. 165). Obviously, many different professional tracks can lead you toward becoming a successful mental health professional—despite a few ideological, salary, status, and power differences.

In this section we explore three confusing questions: What is psychotherapy? What is counseling? And what are the differences between the two?

What Is Psychotherapy?

Anna O., an early psychoanalytic patient of Josef Breuer (a mentor of Sigmund Freud), called her treatment the **talking cure**. This is an elegant, albeit vague, description of psychotherapy. Technically, it tells us very little, but at the intuitive level, it explains psychotherapy very well. Anna was saying something most people readily admit: talking, expressing, verbalizing, or sharing one's pain and life story is potentially healing.

As we write today, heated arguments about how to practice psychotherapy continue (Baker & McFall, 2014; Laska, Gurman, & Wampold, 2014). This debate won't soon end and is directly relevant to how psychotherapy is defined (Wampold & Imel, 2015). We explore dimensions of this debate in the pages to come. For now, keep in mind that although historically Anna O. viewed and experienced *talking as her cure* (an expressive-cathartic process), many contemporary researchers and writers emphasize that the opposite is more important—that a future Anna O. would benefit even more from *listening to and learning from her therapist* (a receptive-educational process). Based on this perspective, some researchers and practitioners believe therapists are more effective when they actively and expertly *teach their clients* cognitive and behavioral principles and skills (aka psychoeducation).

REFLECTIONS

Where do you stand on this issue? What are the advantages of listening to clients? What are the advantages of actively teaching clients skills? Might these perspectives be combined?

We have several favorite psychotherapy definitions:

- A conversation with a therapeutic purpose (Korchin, 1976, p. 281).
- The purchase of friendship (Schofield, 1964, p. 1).
- When one person with an emotional disorder gets help from another person who has a little less of an emotional disorder (J. Watkins, personal communication, October 13, 1983).

What Is Counseling?

Counselors have struggled to define their craft in ways similar to psychotherapists. Here's a sampling:

- Counseling is the artful application of scientifically derived psychological knowledge and techniques for the purpose of changing human behavior (Burke, 1989, p. 12).
- Counseling consists of whatever ethical activities a counselor undertakes in an effort to help the client engage in those types of behavior that will lead to a resolution of the client's problems (Krumboltz, 1965, p. 3).
- [Counseling is] an activity … for working with relatively normal-functioning individuals who are experiencing developmental or adjustment problems (Kottler & Brown, 1996, p. 7).

We now turn to the question of the differences between counseling and psychotherapy.

What Are the Differences Between Psychotherapy and Counseling?

Years ago, Patterson (1973) wrote: "There are no essential differences between counseling and psychotherapy" (p. xiv). We basically agree with Patterson, but we like how Corsini and Wedding (2000) framed it:

> Counseling and psychotherapy are the same qualitatively; they differ only quantitatively; there is nothing that a psychotherapist does that a counselor does not do. (p. 2)

This statement implies that counselors and psychotherapists engage in the same behaviors—listening,

questioning, interpreting, explaining, and advising—but may do so in different proportions.

The professional literature mostly implies that psychotherapists are less directive, go a little deeper, work a little longer, and charge a higher fee. In contrast, counselors are slightly more directive, work more on developmentally normal—but troubling—issues, work more overtly on practical client problems, work more briefly, and charge a bit less. In the case of individual counselors and psychotherapists, each of these tendencies may be reversed; some counselors work longer with clients and charge more, whereas some psychotherapists work more briefly with clients and charge less.

REFLECTIONS

How are counseling and psychotherapy viewed in your community or university? Are they equal (or unequal) in status? Why? Who sees a counselor? Who sees a psychotherapist? How do training programs in counseling, social work, psychology, and psychiatry distinguish themselves from one another on your campus or in your community?

A Working Definition of Counseling and Psychotherapy

There are strong similarities between counseling and psychotherapy. Because the similarities vastly outweigh the differences we use the words counseling and psychotherapy interchangeably. Sometimes we use the word therapy as an alternative.

To capture the natural complexity of this thing called psychotherapy, we offer the following 12-part definition. Counseling or psychotherapy is:

> (a) a process that involves (b) a trained professional who abides by (c) accepted ethical guidelines and has (d) competencies for working with (e) diverse individuals who are in distress or have life problems that led them to (f) seek help (possibly at the insistence of others) or they may be (g) seeking personal growth, but either way, these parties (h) establish an explicit agreement (informed consent) to (i) work together (more or less collaboratively) toward (j) mutually acceptable goals (k) using theoretically based or evidence-based procedures that, in the broadest sense, have been shown to (l) facilitate human learning or human development or reduce disturbing symptoms.

Although this definition is long and multifaceted, it's still probably insufficient. For example, it wouldn't fit for any self-administered forms of therapy, such as self-analysis or self-hypnosis—although we're quite certain that if you read through this definition several times, you're likely to experience a self-induced hypnotic trance state.

THE SCIENTIFIC CONTEXT OF COUNSELING AND PSYCHOTHERAPY

This section reviews historical and contemporary developments in the evaluation of counseling and psychotherapy.

Eysenck's Review

In 1952, Hans Eysenck published a controversial article titled "The Effects of Psychotherapy: An Evaluation." He concluded that after over 50 years of psychotherapy, research, and practice, no evidence existed attesting to its beneficial effects. He stated that "roughly 2/3 of a group of neurotic patients will recover or improve to a marked extent within about two years of the onset of their illness [in the absence of treatment]" (Eysenck, 1952, p. 322). He compared this natural recovery rate with rates produced by traditional psychotherapy and reported:

> … patients treated by means of psychoanalysis improved to the extent of 44%; patients treated eclectically improved to the extent of 64%; patients treated only custodially or by general practitioners improved to the extent of 72%. There thus appears to be an inverse correlation between recovery and psychotherapy. (p. 322)

Eysenck's article sparked strong reactions among psychotherapy researchers and practitioners. Supporters of psychotherapy complained that Eysenck's conclusions were based on poorly controlled studies; they claimed that he didn't address severity of diagnosis issues, and that the outcome measures used in the studies were generally poor and crude. The critics were correct—Eysenck's review was flawed, primarily because many existing studies of counseling and psychotherapy effectiveness were also flawed. Despite the fact that psychotherapy researchers and practitioners in the 1950s believed psychotherapy was more effective than no treatment, they hadn't gathered scientific evidence to support their beliefs.

A Psychotherapy Research Boom

Eysenck's scathing critique motivated psychotherapy researchers. Outcome studies proliferated, and Eysenck's critique was (mostly) laid to rest in the 1970s and early 1980s after several substantial and positive reviews of psychotherapy efficacy.

Mary Smith and Gene Glass published two highly influential reviews of psychotherapy outcomes. They used a new statistical method (meta-analysis) to combine information across different treatment outcomes studies (Smith & Glass, 1977; Smith, Glass, & Miller, 1980). **Meta-analysis**, now a household name in research and statistics, pools together and obtains an overall average treatment effect size across different therapy research

Table 1.1 A Closer Look at Effect Sizes

Descriptive terms	ES or *d*	Percentile rank magnitude of ES
Extremely large	+2.00	97.7 [The treated group scores two standard deviations better on the outcome measures]
Very large	+1.00	84.0 [The treated group scores one standard deviation better on the outcome measures]
Large	+0.80	79.0
Smith & Miller, 1977	+0.68	75.0
Medium	+0.50	69.0
Small	+0.20	58.0
None	+0.00	50.0 [There is no difference between the treatment and a control group]
Adverse effects	−0.20	42.0

Note: This table places the Smith and Glass (1977) meta-analysis results in context of Cohen's (1977) traditional descriptive terms of small, medium, and large effect sizes. These effect sizes are also listed in terms of their percentile rank. When researchers, like Smith and colleagues, state: "the average client treated with psychotherapy was better off than 75% of clients who received no treatment" they're using percentile rankings. As you can see from the table, if there is no effect size ($d = +0.00$), then "the average person receiving the intervention would be better off than 50% of people not receiving treatment." Although some participants may improve or get worse, on average, there is no effect.

studies. **Effect size** (ES or *d*) is a statistic used to estimate how much change is produced by a particular intervention. ES is reported as the statistic *d* and represents the difference in efficacy between evaluated interventions (e.g., psychoanalytic psychotherapy or cognitive therapy) and no-treatment control groups. Additional information about the meta-analytic effect size (ES or *d*) is given in Table 1.1.

Smith and Glass published their first review in 1977: "Meta-analysis of Psychotherapy Outcome Studies." They evaluated 375 outcome studies and reported that the average study "showed a 0.68 standard deviation superiority [ES or *d*] of the treated group over the control group" (Smith & Glass, 1977, p. 756). They concluded that the average client treated with psychotherapy was better off than 75% of clients who received no treatment (see also Table 1.1). Later, they expanded their study to 475 outcome studies and published the results in a book and concluded that the average treated person was better off than 80% of the untreated sample (Smith, Glass, & Miller, 1980).

Although Smith and colleagues helped settle the issue of whether psychotherapy is generally efficacious, they didn't clear up the big debate over whether one form of therapy was more effective than others. This is because they found that different theory-based techniques didn't produce significantly different outcomes. Their findings, consistent with previous and later research, lent support to the conclusion that "Everybody has won and all must have prizes" (a quotation from *Alice in Wonderland*'s Dodo bird). The relative equivalent efficacy of various therapy approaches is now commonly referred to as the **Dodo bird effect** (Luborsky, Singer, & Luborsky, 1975; Marcus, O'Connell, Norris, & Sawaqdeh, 2014).

Overall, despite initial outrage over Eysenck's article, he provided the field of psychotherapy with a much-needed reality check. Perhaps the most important and enduring consequence of Eysenck's critique was a stronger emphasis on scientific evidence to support counseling and psychotherapy practice.

The Great Psychotherapy Debate

At the close of the twentieth century, Hubble, Duncan, and Miller (1999) reflected on psychotherapy outcomes research with undaunted optimism:

> The uncertainties loosed on the clinical and counseling disciplines by Eysenck and like-minded critics have now been set aside. Therapy works.… More than 40 years of outcome research make clear that therapists are not witch doctors, snake oil peddlers, or over-achieving do-gooders.… Study after study, meta-analyses, and scholarly reviews have legitimized psychologically based or informed interventions. (1999, pp. 1–2)

Nearly everyone still agrees that psychotherapy is more effective than no treatment (Corey, 2017; Norcross & Lambert, 2011).

Given the celebratory language, you might be thinking: What's left to argue about? Well, as is typically the case with humans, there's plenty to keep arguing about. The biggest of these arguments focuses on the following point and counterpoint:

- *Point*: Research has demonstrated the superiority of specific psychotherapy techniques for specific mental disorders; these techniques should be identified as "empirically supported" or "evidence-based" and should constitute the specific procedures that mental health practitioners employ.
- *Counterpoint*: A broader examination of the research reveals that different therapy approaches include common therapeutic factors. These factors account for most of the positive change that occurs in psychotherapy and so psychotherapists should deliver therapy in ways that emphasize these common factors.

Wampold (Wampold et al., 1997; Wampold & Imel, 2015) labeled the specific techniques versus common factors conflict as: **The Great Psychotherapy Debate**. In this section we dive headlong into the great psychotherapy debate and then step back to examine questions about what constitutes science and whether we can generalize scientific research findings to clinical practice.

Common Therapeutic Factors

Common therapeutic factors (aka common factors) are elements that exist across a wide range of different therapy approaches. Some researchers and practitioners view common factors as the primary reason why therapy is effective (J. Sommers-Flanagan, 2015). Common factors include, but are not limited to:

- A culturally appropriate or sanctioned explanation (or myth) for client distress combined with a similarly sanctioned rationale for the treatment (ritual) procedures.
- A healing setting where the therapy takes place.
- Advice or education.
- An emotionally charged relationship bond between client and therapist.
- Catharsis or emotional expression.
- Exposure to feared stimuli.
- Feedback from the therapist.
- Insight into one's problems.
- Positive expectations (aka hope).
- The working alliance.
- Therapist credibility or expertise.
- Trust in the therapist (this alphabetized list is compiled and adapted from Frank & Frank, 1991; Lambert & Ogles, 2014; Laska, Gurman, & Wampold, 2014).

Common factors were previously called "*nonspecific factors*" (Strupp & Hadley, 1979). More recently researchers and practitioners have begun operationalizing common factors and so the term nonspecific factors has been criticized and, for the most part, discarded.

Many different researchers have proposed theoretical models and empirical analyses focusing on common factors (Frank, 1961; Lambert & Ogles, 2014; Rosenzweig, 1936; Wampold & Imel, 2015). The following discussion focuses on Lambert's (1992) four-factor model. We focus on this model because it is simple, straightforward, and has empirical support (Cuijpers et al., 2012). However, other common factor models exist.

In a narrative review of the literature, Lambert (1992) identified and described four common therapy factors. He then estimated each factor's contribution to positive therapeutic change (see Figure 1.2).

Lambert's estimates weren't perfectly precise predictions for every case (Beutler, 2009). However, his conceptual framework has become a popular way of thinking about how therapy works.

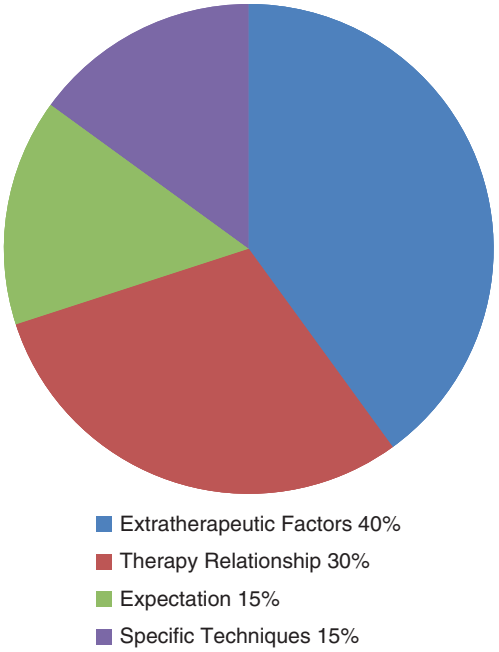

FIGURE 1.2 Lambert's Common Factors

Extratherapeutic Factors

Extratherapeutic factors include client factors such as severity of disturbance, motivation, capacity to relate to others, ego strength, psychological-mindedness, the ability to identify a single problem to work on in counseling, and "sources of help and support within [client] environments" (Asay & Lambert, 1999, p. 33). For example, many clients who experience spontaneous remission (sudden improvement without therapy) probably do so because of positive support from important people in their lives. Lambert (1992) linked extratherapeutic change factors to about 40% of client success. In a meta-analysis of 31 studies of nondirective treatment of depression, Cuijpers et al. (2012) estimated that 33.3% of improvement was related to extratherapy factors.

Therapeutic Relationship

Therapeutic relationship is a broad term used to refer to many different factors that contribute to rapport and a positive working relationship between therapist and client. When most practitioners think of the therapeutic relationship, they think of Rogers (1942a, 1957) core conditions of (a) congruence, (b) unconditional positive regard, and (c) empathic understanding. Although Rogers's concepts are complex and sometimes elusive, information is available on how to operationalize these core relationship conditions (see Chapter 6; Norcross, 2011; J. Sommers-Flanagan, 2015).

In addition, Bordin (1979) described three dimensions of the working alliance. The **working alliance** includes:

1. A positive interpersonal bond between therapists and clients.

2. The identification of agreed-upon therapy goals.
3. Therapists and clients collaboratively working together on therapeutic tasks linked to the identified goals.

Bordin's tripartite model of the working alliance has strong research support (Constantino, Morrison, MacEwan, & Boswell, 2013; Horvath, Re, Flückiger, & Symonds, 2011). Lambert believes that the therapeutic relationship is the most powerful therapeutic factor over which therapists can directly exert control. He estimated that therapeutic relationship factors account for about 30% of positive therapy outcomes.

Expectancy

Frank (1961) defined **expectancy** as hope for positive outcomes. Vastly different procedures can facilitate positive expectancy in psychotherapy. Obviously, hope is a complex emotional and cognitive state. Interestingly, controlled research studies indicate that clients treated with placebos (an inert substance with no inherent therapeutic value) are significantly better off than clients who receive no treatment and often do just as well as clients who take antidepressant medications for depressive symptoms (J. Sommers-Flanagan & Campbell, 2009; Turner, Matthews, Linardatos, Tell, & Rosenthal, 2008). Lambert estimated that expectation, hope, and placebo factors account for about 15% of the variation in therapy outcomes. One way in which modern practitioners foster hope is by providing clients with a persuasive rationale for why the specific treatment being provided is likely to effectively remediate the client's specific problems (Laska & Wampold, 2014).

Techniques

In the 1870s, Anton Mesmer, then famous for "mesmerizing" or hypnotizing patients, claimed that his particular technique—using purple robes, rods of iron, and magnetic baths—produced therapeutic change due to shifting magnetic fields. More recently, psychoanalysts believe that helping clients develop insight into repeating destructive relationship patterns is essential; in contrast, behaviorists claim exposure and response prevention techniques are powerful interventions.

Common factor proponents view Mesmer, the psychoanalysts, and the behaviorists as incorrect regarding the mechanisms of change in psychotherapy (Laska et al., 2014; Norcross & Lambert, 2011). Instead, they believe extratherapeutic factors, the therapy relationship, and expectation are more robustly linked to positive outcomes. Duncan and colleagues (2010) wrote:

> To be frank, any assertion for the superiority of special treatments for specific disorders should be regarded, at best, as misplaced enthusiasm, far removed from the best interests of consumers. (p. 422)

This isn't to say that techniques are unimportant to therapy success. In most cases, extratherapeutic factors, the relationship, and expectation are all activated when therapists employ specific therapy techniques. Consequently, although different techniques don't produce superior outcomes, doing counseling or psychotherapy without theory-based techniques is difficult to imagine.

Lambert estimated that 15% of positive treatment outcomes are related to the specific techniques employed. In contrast, Wampold and Imel (2015) reported that it may be as low as 1%. Cuijpers and colleagues (2012) reported that specific therapy approaches accounted for 17.1% of treatment outcomes.

What Constitutes Evidence? Efficacy, Effectiveness, and Other Research Models

Contemporary helping interventions should have at least some supportive scientific evidence. This statement, as bland and general as it seems, would generate substantial controversy among academics, scientists, and people on the street. One person's evidence may or may not meet another person's standards.

It may sound odd, but subjectivity is a palpable problem in scientific research. Humans are inherently subjective and humans design the studies, construct and administer the assessment instruments, and conduct the statistical analyses. Consequently, measuring treatment outcomes inevitably includes error and subjectivity. Despite this, we support and respect the scientific method and appreciate efforts to measure (as objectively as possible) psychotherapy outcomes.

There are two primary approaches to counseling and psychotherapy outcomes research: (1) efficacy research and (2) effectiveness research. These terms flow from the well-known experimental design concepts of internal and external validity (Campbell, Stanley, & Gage, 1963). **Efficacy research** employs experimental designs that emphasize **internal validity**, allowing researchers to comment on causal mechanisms; **effectiveness research** uses experimental designs that emphasize **external validity**, allowing researchers to comment on generalizability of their findings.

Efficacy Research

Efficacy research involves tightly controlled experimental trials with high internal validity. Within medicine, psychology, counseling, and social work, **randomized controlled trials (RCTs)** are the gold standard for determining treatment efficacy. An RCT statistically compares outcomes between randomly assigned treatment and control groups. In medicine and psychiatry, the control group is usually administered an inert placebo (i.e., placebo pill). In the end, treatment is considered efficacious if the active medication relieves symptoms, on average,

at a rate significantly higher than the placebo. In psychology, counseling, and social work, treatment groups are generally compared with a waiting list or attention-placebo control group.

To maximize researcher control over independent variables, RCTs require that participants meet specific inclusion and exclusion criteria prior to being randomly assigned to a treatment or comparison group. This allows researchers to statistically determine with a greater degree of certainty whether the treatment itself had a direct or causal effect on treatment outcomes.

In 1986, Gerald Klerman, then head of the National Institute of Mental Health, gave a keynote address to the Society for Psychotherapy Research. During his speech, he emphasized that psychotherapy should be evaluated systematically through RCTs. He claimed:

> We must come to view psychotherapy as we do aspirin. That is, each form of psychotherapy must have known ingredients, we must know what these ingredients are, they must be trainable and replicable across therapists, and they must be administered in a uniform and consistent way within a given study. (Quoted in Beutler, 2009, p. 308)

Klerman's speech advocated for the medicalization of psychotherapy. Klerman's motivation for medicalizing psychotherapy was probably based in part on his awareness of increasing health care costs and heated competition for health care dollars. This is an important contextual factor. The events that ensued were partly an effort to place psychological interventions on par with medical interventions.

The strategy of using science to compete for health care dollars eventually coalesced into a movement within professional psychology. In 1993, Division 12 (the Society of Clinical Psychology) of the American Psychological Association (APA) formed a "Task Force on Promotion and Dissemination of Psychological Procedures." This task force published an initial set of **empirically validated treatments**. To be considered empirically validated, treatments were required to be (a) manualized and (b) shown to be superior to a placebo or other treatment, or equivalent to an already established treatment in at least two "good" group design studies or in a series of single case design experiments conducted by different investigators (Chambless et al., 1998).

Division 12's empirically validated treatments were controversial. Critics protested that the process favored behavioral and cognitive behavioral treatments. Others complained about forgoing clinical sensitivity and intuition in favor of manualized treatment protocols (Silverman, 1996). In response, Division 12 held to their procedures for identifying efficacious treatments, but changed the name from empirically validated treatments to **empirically supported treatments (ESTs)**.

Advocates of the EST perspective often refer to treatment providers as "psychological clinical scientists" and view the need for cost-efficiency in health care delivery as driving EST use (Baker & McFall, 2014, p. 483). Further, they don't view the understanding or implementation of common factors in psychotherapy as an "important personal activity and goal" (p. 483).

Baker, McFall, and Shoham (2008) argued that treatments based on efficacy research (i.e., RCTs) generally remain highly efficacious when directly "exported" to clinical settings. Their position is aligned with the medical model and strongly values efficacy research as the road to developing valid psychological procedures for treating medical conditions. However, other researchers are less optimistic about the ease, utility, and validity of generalizing efficacy research into real-world clinical settings (Santucci, Thomassin, Petrovic, & Weisz, 2015; Singer & Greeno, 2013).

Effectiveness Research

Sternberg, Roediger, and Halpern (2007) described effectiveness studies:

> An effectiveness study is one that considers the outcome of psychological treatment, as it is delivered in real-world settings. Effectiveness studies can be methodologically rigorous …, but they do not include random assignment to treatment conditions or placebo control groups. (p. 208)

Effectiveness research focuses on collecting data with external validity. This usually involves a "real-world" setting, instead of a laboratory. Effectiveness research can be scientifically rigorous, but it doesn't involve random assignment to treatment and control conditions. Similarly, inclusion and exclusion criteria for clients to participate are less rigid and more like actual clinical practice, where clients come to therapy with a mix of different symptoms or diagnoses. The purpose is to evaluate counseling and psychotherapy as it is practiced in the real world.

Other Research Models

Other research models are also used to inform researchers and clinical practitioners about therapy process and outcomes. These models include survey research, single-case designs, and qualitative studies. However, based on current mental health care reimbursement practices and future trends, providers are increasingly expected to provide services consistent with findings from efficacy and effectiveness research—and the medical model (Baker & McFall, 2014).

Techniques or Common Factors? The Wrong Question

Wampold (Wampold, 2001, 2010; Wampold & Imel, 2015) and others claim that common factors provide a

better empirical explanation for treatment success than specific treatment models. In contrast, Baker and McFall (2014) and like-minded researchers contend that common or nonspecific factors contribute little to the understanding and application of counseling and psychotherapy interventions (Chambless et al., 2006). Although it would be nice if everyone agreed, when prestigious scientists and practitioners genuinely disagree, it typically means that important lessons can be learned from both sides of the argument. The question shouldn't be, "Techniques or common factors?" but, instead, "How do techniques *and* common factors operate together to produce positive therapy outcomes?" There's nothing wrong with applying principles and techniques from both the common factors and EST perspectives (Constantino & Bernecker, 2014; Hofmann & Barlow, 2014). In fact, we suspect that the best EST providers are also sensitive to common factors and that the best common factors-oriented clinicians are open to using empirically supported techniques.

Empirically Supported Treatments (ESTs)

ESTs are manualized approaches designed to treat specific mental disorders or other client problems. In 2011, Division 12 of APA (the original architect of the EST movement) launched a new website on research-supported psychological treatments. Using the criteria that Chambless et al. (1998) initially outlined, this website includes treatments that are (a) strong (aka well-established), (b) modest (aka probably efficacious), and (c) controversial (when there are conflicting empirical findings or debates over the mechanism of change).

At the time of this writing, 80 ESTs for 17 different psychological disorders and behavior problems were listed on the Division 12 website. For example, relaxation training is listed as having "strong research support" for treating insomnia. Other organizations also maintain empirically supported or evidence-based lists. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) has a broader list referred to as the National Registry of Evidence-Based Programs and Practices. This registry includes 397 evidence-based programs and practices. Recently, the *Journal of Clinical Child & Adolescent Psychology* published an "Evidence Base Update." The authors wrote:

> Six treatments reached well-established status for child and adolescent anxiety, 8 were identified as probably efficacious, 2 were identified as possibly efficacious, 6 treatments were deemed experimental, and 8 treatments of questionable efficacy emerged. (Higa-McMillan, Francis, Rith-Najarian, & Chorpita, 2016, p. 91)

To become proficient in providing a specific EST requires professional training on how to implement the treatment. In some cases certification is necessary.

It's impossible to obtain training to implement all the ESTs available. Professionals select trainings that reflect their unique interests. In an interview some years ago, Dr. Eliana Gil (Gil, 2010; Gil & Shaw, 2013), a renowned expert in child trauma, indicated that she obtained training in as many different approaches to treating child trauma as possible. Although she valued some approaches over others, she had trained in child-centered play therapy, eye movement desensitization reprocessing (EMDR), trauma informed cognitive behavior therapy, and others. She believed that having expertise in many different approaches for treating childhood trauma made her a better trauma therapist.

With the abundance of ESTs and the fact that many clients have problems outside the scope of ESTs, we sometimes wonder if we should abandon theory and technique and focus instead on how best to employ the common factors. Although a case might be made for doing just that, it's probably impossible to separate common factors from technique (Safran, Muran, & Eubanks-Carter, 2011). Norcross and Lambert (2011) wrote:

> The relationship does not exist apart from what the therapist does in terms of method, and we cannot imagine any treatment methods that would not have some relational impact. Put differently, treatment methods are relational acts. (p. 5)

Each theory-based approach, when practiced well, includes or activates common factors. In fact, when employed sensitively and competently, the specific techniques instill hope, strengthen the therapeutic relationship, and activate extratherapeutic factors. In summary, embracing a reasonable and scientifically supported theoretical perspective and using it faithfully is one of the best ways to:

- Help clients activate their extratherapeutic factors.
- Develop a positive working relationship.
- Create expectancy or placebo effects.
- Know how to use many different techniques that fit within your theoretical frame.

As Baker, McFall, and Shoham (2008) described, even though it's a research-based fact that physicians with a better bedside manner produce better outcomes, medicine involves more than a bedside manner—it also involves specific medical procedures. The EST movement is an effort to establish psychological procedures that are as effective as medical procedures. As we move into the future, we need to embrace both an understanding of psychological procedures and common factors; this can also be framed as the science and art of psychotherapy.

REFLECTIONS

Which common factors do you think are most important? Do you agree that the common factors can be activated by specific techniques?

ETHICAL ESSENTIALS

A good ethics code defines the professional knowledge base, describes the activities sanctioned in the profession, and provides a clear picture of the boundaries of professional activity. Most codes have three discernable dimensions: educational, aspirational, and judicial (Elliott-Boyle, 1985). As you read your professional ethics code, see if you can recognize these three components.

What follows is a bare-bones consideration of basic ethical issues. Graduate training programs usually include a whole class or seminar in applied ethics, and ethical issues should be a common discussion topic in classes and supervision throughout graduate studies.

Competence and Informed Consent

Competence is a central tenet of all professional codes: practitioners must have adequate knowledge and skills to perform specific professional services (R. Sommers-Flanagan & Sommers-Flanagan, 2007). As a student, you're expected to strive toward competency. Your path includes training and supervision from knowledgeable instructors and supervisors. However, competency is an elusive goal (J. Sommers-Flanagan, 2015). The knowledge base for competent counseling and psychotherapy is ever-changing. We think this is one of the best parts of being a mental health professional. There's always more to learn. Most ethics codes and state licensing boards encourage or mandate continuing professional education to maintain your professional license (Welfel, 2016).

Researchers have identified three primary strategies for developing counseling and psychotherapy competence (Hill, 2014; Woodside, Oberman, Cole, & Carruth, 2007).

1. *Working out your own issues*: This involves a journey of improving yourself—a journey that includes self-awareness, personal growth activities, and sometimes personal therapy. Engaging in self-care that helps you live a balanced and healthy lifestyle is recommended—because you're the instrument through which you provide services. Your purpose in providing therapy should be to help others and not as a means of meeting your own personal needs.
2. *Working within a learning community*: A learning community not only increases your access to cutting-edge knowledge and information, it also provides unmatched opportunity to observe practicing therapists through video, audio, and role-plays. Learning communities facilitate critical analysis and critical thinking processes.
3. *Skills practice and feedback*: Allen Ivey once wrote that therapy skill development requires "Practice, practice, practice, feedback, feedback, feedback" (J. Sommers-Flanagan & Heck, 2012, p. 152). Whether learning to ride a bicycle, navigate the Internet, or develop therapy skills, there's nothing quite like practice and feedback to facilitate learning.

Closely related to competence is the important ethical concept of informed consent. **Informed consent** refers to clients' rights to know about and consent to ways you intend to work with them. Clients have the right to know your training status, supervision arrangements, the type of therapy you're offering, your rationale for your particular treatment approach, how long therapy is likely to last, and potential benefits and harm associated with therapy. Informed consent includes a written statement as well as an interactive discussion. Involving your client in a dialogue around the preceding topics can be empowering (Harris & Robinson Kurpius, 2014; Pomerantz & Handelsman, 2004).

Multicultural Sensitivity, Competence, and Humility

From a different cultural perspective, even the most basic therapy components (e.g., the 50-minute hour and the talking cure) can seem odd or unnecessary. D. W. Sue and Sue (2016) noted that all too often traditional counseling and psychotherapy have reinforced cultural stereotypes and forced minority clients to fit into a dominant, white American frame.

Despite historical cultural insensitivity, for the past 30-plus years, the mental health professions (counseling, psychology, social work, and psychiatry) have promoted multicultural knowledge and competence. Each discipline has made commitments to multicultural sensitivity and published multicultural competencies (be sure to peruse your professional association's website for multicultural competencies from the American Counseling Association, American Psychological Association, and the National Association of Social Work). Even further, multicultural competencies have been integrated into professional training programs and in the ethical standards for counselors, psychologists, and social workers. For example, the latest revision of the ACA ethical standards includes "honoring diversity and embracing a multicultural approach" as one of several "core professional values of the counseling profession" (American Counseling Association, 2014, p. 3). When it comes to teaching or training

individuals to become professional counselors, ACA Standard F.11.c. reads:

> Counselor educators infuse material related to multiculturalism/diversity into all courses and workshops for the development of professional counselors. (p. 14)

Multicultural competencies across counseling, psychology, and social work are very similar. The focus is on competency within four general areas (these areas are listed below and described in greater detail in Chapter 13):

1. Self-awareness.
2. Multicultural knowledge.
3. Culturally specific techniques.
4. Advocacy.

Confidentiality

Confidentiality means that information clients share with therapists is private and not shared without client permission. Confidentiality helps build trust. When clients come to counseling, they'll wonder if you will keep their words private. You'll be expected to hold what your client says to you in strict confidence.

Many professions include client confidentiality. In fact, honoring confidentiality boundaries is often part of what it means to be a professional. This is true in fields ranging from architecture to law to business (R. Sommers-Flanagan, Elliott, & Sommers-Flanagan, 1998).

Confidentiality is central to psychotherapy. Mental health professionals create safe environments where clients can disclose and work on their deepest issues. Practically speaking, you need to keep the identity of your client confidential, you need to keep therapy notes and videos secure, and you can't discuss the content of therapy sessions in ways that identify your client. You also need to research the limits of confidentiality legally and ethically in your state, province, or region, and in the context of the clinic or lab in which you work. As a part of informed consent, you should provide a written description of confidentiality and its limits to clients and review confidentiality verbally as well. Clients should understand the limits of confidentiality before therapy begins.

Why is confidentiality so important? The theories in this book vary in their explanations of why things go wrong for people and how therapists should intervene. They also vary in how much they value the therapeutic relationship between client and practitioner, but all theoretical perspectives involve an interpersonal enterprise in which the professional relationship is foundational and trust is essential.

Multiple Roles

Because psychotherapy involves a relationship with strict boundaries and expectations, mental health professionals usually restrict their work to people they don't know from other contexts. Consequently, you'll typically avoid holding multiple roles in clients' lives—including roles or relationships characterized as friendship, romance, or business (Barnett, Lazarus, Vasquez, Johnson, & Moorehead-Slaughter, 2007). **Multiple roles** are defined as situations where professionals simultaneously hold more than one role in their clients' lives (Welfel, 2016).

To make matters more complex, ethics codes also include an acknowledgment that sometimes multiple relationships are beneficial to clients. However, sorting out your own best interests from the best interests of your clients can be difficult. Our advice is to seek supervision and consultation when potential multiple roles emerge. This will help you manage these relationships in sensitive and ethical ways.

There are many examples of boundary breaks that lead to inappropriate or unacceptable client–therapist relationships. It's especially hard to find a portrayal of a good therapist in film or on television. If you watch therapists on the screen, you might assume that all therapists are reckless, unprofessional risk-takers who establish multiple roles and violate relationship boundaries. You also might assume that therapists can't resist their sexual impulses, often ending up in bed with their clients (or their client's husband, wife, sibling, or best friend). In truth, therapist–client sexual relations occur among a small minority of therapy cases. Even so, any instance of therapist–client sex is too many (Gottlieb & Younggren, 2009).

As you begin learning about theories and techniques associated with mental health work, it will be natural for you to try out some of the less risky ideas you're learning with friends or family members (e.g., active listening, visual imagery). However, even low-risk activities aren't without potential negative consequences. For example, engaging in nondirective, active listening with someone who's accustomed to having lively, interactive exchanges won't go unnoticed. One of our friends told us that she was very relieved when we finally got over our "Carl Rogers" stage and she could hear a direct, bossy opinion from us again.

Overall, it's best to restrain your impulse to practice therapy techniques on friends, family members, or even innocent bystanders—with the exception of listening respectfully.

Doing No Harm: A Convergence of Ethics and Science

The Latin phrase, **primum non nocere** ("first, do no harm") is an ethical mandate for medical and mental

health professionals. Despite this mandate, research shows that psychotherapy can and does produce *negative outcomes* or client deterioration; estimates indicate that approximately 3–10% of psychotherapy cases result in client deterioration (Lambert & Lambert, 2010; Lambert, 2013b). Negative effects may even climb as high as 15% with substance abuse treatments (Moos, 2005, 2012).

PUTTING IT IN PRACTICE

1.1 Beneficence: Helping Not Hurting

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"I want to help people," many people reply when asked, "Why do you want to go into psychology or counseling?" That desire to benefit others is essential to being a good psychotherapist or counselor. However, that desire to help may also contribute to dangerous unforeseen consequences.

Beneficence, the American Psychological Association (APA, 2010) ethics code notes, means striving "to benefit those with whom [psychologists] work" (Principle A, p. 1062). Similarly, Principle A1a of the American Counseling Association (ACA, 2014) ethics code begins, "The primary responsibility of counselors is to respect the dignity and promote the welfare of clients" (p. 4). This fits with what "profession" has historically meant. The "defining characteristic" of the professional, Pope and Vasquez (2016) note, has been "an ethic of placing the client's well-being foremost and not allowing professional judgment or services to be drawn off course by one's own needs" (p. 64).

So, how can wanting to help people be problematic or even dangerous?

Suppose a 23-year-old client enters counseling because painful, ongoing tension with his parents, with whom he is living, distresses him profoundly. Motivated to help the client, the counselor advises him to move out and become more independent. The client complies, breaking off family ties, but then becomes very depressed because he and his culture deeply value close family relationships. That intervention, though well-intended, harmed that client, in whose culture family relationships are very important.

In addition to a motivation to benefit others, excellent clinical work and optimally ethical practice thus requires:

- Competence. We must possess or obtain relevant knowledge and skills so we can, in fact, help people. This includes reliable scientific knowledge.
- Recognizing diverse ideas about what "benefit" means. Determining what will benefit a particular client is often challenging. "Benefit"—which is tied to the goals of psychotherapy—has to do with ideas about what is a good life for a person, obligations, and what is right and wrong (Tjeltveit, 2006). Deep cultural and philosophical differences exist about such ideas. Ideas about benefit may also be tied to client and therapist religiousness, spirituality, religiousness and spirituality, or neither. It is crucial that psychotherapists don't assume that their ideas about a good life ("benefit") are the only or only correct ideas, in part so they don't impose their views on clients.
- Openness to relevant, reliable empirical evidence. Our intuitions about what will help a person may be mistaken. Obtaining relevant empirical evidence about what actually benefits people in general is thus essential, as is evidence about what harms people (Lilienfeld, 2007). Where relevant, reliable empirical evidence about the benefits and risks of treatment options is not available, or client characteristics indicate that an intervention that is generally effective may not help (or even harm) a particular client, we need to make the best possible judgment. Taking client views and choices very seriously and substantial humility are, however, essential, so we exhibit the respect for clients addressed in the APA (2010) and ACA (2014) ethics codes.

- Cultural sensitivity. Insensitivity and imposing ideas about the good life and well-being that are foreign to the client may result in harm to them, despite our wanting to help them. Sensitivity benefits clients and avoids harming them.
- Avoiding harm. The ethical principle of beneficence is often yoked with the ethical principle of nonmaleficence or harm avoidance (don't harm clients). Expressed in medical ethics as *Primum non nocere*, or "Above all [or first] do no harm" (Beauchamp & Childress, 2013, p. 150), its relevance to psychotherapy and counseling is this: any intervention that has the power to benefit also has the power to harm. Mental health professionals need to be aware of the potential negative consequences of the services they provide and avoid such harm. The goal is to benefit clients in ways that don't harm them. How to do so, of course, is one of the great challenges of clinical practice.
- Self-care. Professionals are not obligated to harm or impoverish themselves in order to benefit others. Neglecting oneself is, however, an occupational hazard of the mental health professions. Care for others thus needs to be matched with self-care. We need to be able to sustain ourselves in order to continue to benefit others. Psychotherapists who don't do so get burned out, provide substandard care, develop their own psychological problems, and/or act unethically. A variety of self-care strategies exist, with each professional needing to develop a repertoire that works, including interpersonal support, the right balance of work and relaxation, and so forth.
- Drawing on ethical and psychological sources that sustain a commitment to help others. Entering a field with a desire to help others is relatively easy. Far more difficult is identifying rich, sustaining sources that enable us to continue to be motivated to help others across the span of a career. Doing so is difficult, but mental health professionals face few more crucial tasks.

Those factors all help structure, channel, and empower professionals' commitment to beneficence, to helping others. Technical knowledge and training is not enough if a professional is not committed to helping those with whom he or she works.

When we draw on sustaining psychological, social, and ethical resources, avoid harming clients, exhibit humility about what we know, attend to relevant empirical evidence, respect client views on the meaning of benefit, and exhibit cultural sensitivity, then we can provide the greatest benefit to our clients. That is what the mental health professions are, at core, all about.

One of three sources usually accounts for client deterioration: (1) therapist factors, (2) client factors, or (3) specific psychological interventions.

1. Therapist Factors

Counselors and psychotherapists can differ dramatically in their therapeutic skills and talents. In a study of 71 therapists who provided counseling services for clients with similar problems, Lambert (2007) reported that "One therapist who saw more than 160 patients had a 19% deterioration rate, whereas another saw more than 300 patients, with less than 1% deteriorating" (p. 11). If you could choose between these two therapists, your choice would be obvious. Unfortunately, the therapists in Lambert's study were anonymous and therefore no conclusions could be made regarding specific qualities associated with high success and failure rates. However, other research suggests that the following four therapist factors or behaviors may be linked with negative outcomes:

1. Therapists who show little empathic attunement or warmth in their interactions with clients (Greenberg, Watson, Elliot, & Bohart, 2001).
2. Therapists who employ overly confrontational or intrusive therapy approaches (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010; Mohr, 1995).
3. Therapists using poor assessment procedures (including culturally biased assessments; Pieterse & Miller, 2010).
4. Therapists whose personality or approach is a poor fit for a given client (Beutler, 2009).

Therapists may be unaware of their negative behaviors and negative treatment outcomes. Clearly, therapists need to make great efforts to scrutinize themselves and systematically evaluate their outcomes (Meier, 2015).

2. Client Factors

Extratherapeutic factors likely account for the greatest proportion of positive therapy outcomes (Lambert, 1992; Wampold & Imel, 2015). It follows that negative client characteristics (including a lack of personal resources) might contribute to negative treatment outcomes. Client factors that can contribute to adverse outcomes include:

- Low client motivation (Clarkin, Levy, Lenzenweger, & Kernberg, 2004; Dimidjian & Hollon, 2011).
- High client psychopathology (e.g., comorbidity, paranoia, antisocial behavior; Davidson, Perry, & Bell, 2015).
- Limited client personal resources (e.g., limited intelligence, insight, family, or social support; Leibert, Smith, & Agaskar, 2011).

It's difficult to change or modify extratherapeutic factors that clients bring into the therapy office and it's impossible to know what strengths or weaknesses clients have before they arrive for treatment. Given these limitations, developing a strong working alliance is even more important when clients have few extratherapeutic factors (Leibert, Smith, & Agaskar, 2011).

Beutler's (2009) review shows that one of the most significant contributors to positive treatment outcomes is goodness of fit. Beutler wrote: "The fit of the treatment to the particular patient accounted for the strongest effects on outcomes of all variable classes at one year after treatment" (p. 313). Consequently, practicing therapists should modify their approaches based on individual client features.

3. Psychological Intervention Factors

Lilienfeld (Lilienfeld, 2007; Lilienfeld, Lynn, & Lohr, 2003) systematically reviewed psychotherapy outcomes literature and identified specific therapy approaches that produce unacceptable negative effects. He refers to these therapy approaches as **potentially harmful therapies** (PHTs). In developing his PHT list, Lilienfeld (2007) relied on (a) at least one replicated RCT showing potential harm; (b) meta-analytic reviews of multiple RCTs; and (c) research reports linking sudden adverse events to the initiation of therapy (p. 58).

The potential negative psychotherapy effects are not minor. In many situations charismatic therapists can have a powerfully positive or negative influence on clients. As Beutler (2009, p. 307) wrote: "In some cases, such as rebirthing therapy, the result has been death; in others, such as reprogramming therapy, it has been the psychological destruction of lives and families."

The seriousness of PHT effects is a reminder of psychotherapy potency. It's also a reminder of how important it is for ethical therapists to stay attuned not only to efficacy and effectiveness studies but also to research that identifies treatment approaches that have heightened risks. Lilienfeld listed 11 PHTs:

Potentially Harmful Therapies

1. Critical incident stress debriefing.
2. Scared straight interventions.
3. Facilitated communication.
4. Attachment therapies (e.g., rebirthing).
5. Recovered-memory techniques.
6. DID-oriented therapy.
7. Induction of "alter" personalities.
8. Grief counseling for individuals with normal bereavement reactions.
9. Expressive-experiential therapies.
10. Boot-camp interventions for conduct disorder.
11. DARE (Drug Abuse Resistance Education) programs.

We should emphasize that PHTs are not harmful therapies; they're potentially harmful therapies. Although some are dangerous and sometimes lethal, others can be implemented appropriately (for detailed information, see Lilienfeld, 2007).

Going Forward and Getting Positive

After focusing on negative therapy outcomes, negative therapist characteristics, and PHTs, it's time to refocus on the positive. Overall, there are good reasons to be hopeful about achieving positive outcomes. In particular, there are several steps you can take to minimize negative outcomes and maximize positive ones.

A Plan for Maximizing Positive Outcomes

William Glasser and Robert Wubbolding (see Chapter 9) would likely say: there's nothing like a good plan to help with goal attainment. Here are some ideas for maximizing your positive outcomes.

1. The therapy relationship (working alliance) is your best tool for creating positive outcomes. This means you should intentionally try to be genuine, accept clients for who they are, and show empathy (see Chapter 6 for much more on these person-centered therapy conditions). Additionally, consistent with Bordin's (1979) tripartite working alliance, you should: (a) establish an emotional connection with clients; (b) set common goals; and (c) collaborate on therapy tasks linked to therapy goals (J. Sommers-Flanagan, 2015; see Norcross, 2011, for more on "evidence-based relationships").
2. Integrate empirically supported treatments (ESTs) into your therapy practice. Many different ESTs are available, but to use them, you'll need advanced

training and supervision. Also, because there are so many ESTs, you should learn a few for working with specific populations (e.g., if you want to work with individuals suffering from trauma, learning both trauma-focused cognitive behavioral therapy (TF-CBT) and/or eye movement desensitization reprocessing (EMDR) would be useful).

3. Use evidence-based principles (EBPs). There will be situations when clients don't perfectly fit an EST approach. In those cases you should follow EBPs. For example, using Beutler's systematic treatment selection model (see Chapter 14), you can select approaches that are a good fit for specific clients and their particular problems (Beutler, 2011; Beutler, Harwood, Bertoni, & Thomann, 2006).
4. To avoid negative outcomes, you should: (a) continually work on self-awareness using individual supervision, peer supervision, and client feedback or progress monitoring; (b) individualize therapy approaches to fit clients—rather than expecting all clients to benefit from one approach; and (c) avoid using PHTs or use them in ways that reduce potential harm (Lilienfeld, 2007).
5. Use flexible, but systematic and culturally sensitive assessment approaches to tailor the treatment to clients and their problems. Ethical therapists conduct assessment prior to using specific therapy interventions. As you read each chapter, you'll see that each theory includes recommended assessment strategies. However, regardless of theory, therapeutic assessment should be collaborative, empathic, and culturally sensitive (Finn, Fischer, & Handler, 2012).
6. Use **practice-based evidence** or **progress monitoring** (PM) to track therapy process and outcomes. Practice-based evidence (aka PM) involves collecting data, sometimes every session, pertaining to client symptoms and/or client satisfaction (Meier, 2015). Duncan, Miller, and Sparks (2004) refer to this as **client informed therapy**. Regardless of the terminology, it helps to empower clients to directly share their treatment progress (or lack thereof) with their therapists. This allows therapists to make modifications in their approach as needed (Lambert, 2010).

Additional Ethical Issues

You will face many more ethical issues as you provide mental health services. Most ethics experts consider ethical codes as a rudimentary and surface effort to hold practitioners to higher standards of care (R. Sommers-Flanagan & Sommers-Flanagan, 2007; Welfel, 2016). Ethical codes have become increasingly legalistic and sometimes serve protective rather than proactive or aspirational functions. Being an ethical practitioner requires ongoing attention to the heart of the profession. At a minimum, it includes consultation with colleagues, a good ethical problem-solving model, continuing education, and a willingness to scrutinize your own behaviors.

NEUROSCIENCE IN COUNSELING AND PSYCHOTHERAPY

A recent title search of the PsycInfo database using a combination of "neuroscience" and "counseling" or "psychotherapy" revealed two publications from 1980 to 1999. In contrast, there were 93 published works from 2000 to 2015. This is one indicator of the enthusiasm and excitement surrounding potential integrations of neuroscience and counseling/psychotherapy.

Neuroscientific findings are increasingly recognized as having profound implications for counseling and psychotherapy research and practice. In some cases this recognition comes grudgingly. In others, enthusiasts view neuroscience as transforming everything we know about counseling and psychotherapy. Recently, the new terms "neuropsychotherapy" and "neurocounseling" have been introduced. Given this trend, in chapters where neuroscience research has been applied to specific theories, we've included special coverage in the form of Brain Boxes (see Brain Box 1.1).

Historical Reflections

In 1980, I (John) began my career in mental health as a recreation therapist in a 22-bed psychiatric hospital. The patients were experiencing severe depression, manic episodes, and psychotic symptoms.

There was an intimidating psychiatrist (Dr. M) on the unit who was a fan of biological psychiatry. He would smile as I engaged patients in the "Newlyfriend Game" (like the Newlywed Game, only better), relaxation groups, bowling nights, and ice cream socials. Occasionally Dr. M cornered me, explaining how my recreational programs had no influence on our patients' mental health. He waxed eloquent about brain chemistry. True, the Thorazine and Haldol he prescribed had nasty side effects, but eventually, he claimed, there would be designer drugs that restored neurochemical balance and cured mental disorders. Everything else was irrelevant.

The chemical imbalance theory of mental disorders dominated mental health etiology through the 1980s and 1990s. Etiological explanations focused on too much dopamine (causing schizophrenia) and not enough norepinephrine or serotonin (causing depression). No one knew what caused these so-called imbalances, but biogenetic factors were the prime suspects. Although I kept silent with Dr. M, I held tight to my beliefs that social, psychological, and physical experiences could be therapeutic.

BRAIN BOX

1.1 Three Pounds of Theoretical Elegance

This Brain Box is a brief, oversimplified description of the brain. I apologize, in advance, to you and to brains everywhere for this oversimplification and likely misrepresentation. The problem is that even if I took a whole chapter or a whole book to describe these three pounds of elegance, it would still be an oversimplification. Such is the nature and mystery of the human brain.

You may already be familiar with the concepts described here. If so, it's a review. If you may be less familiar, then it's an introduction. For more information on neuroscience and therapy, we recommend *Neuroscience for Counselors and Therapists: Integrating the Sciences of Mind and Brain* by Chad Luke.

Brain structure: The human brain has indentations, folds, and fissures. It's slick and slimy. Put simply, it's not a pretty sight. However, the brain's form maximizes its function. One example: if you could lay out and spread its surface area onto a table, it would be about the size of two pages of a newspaper. The folds and fissures allow more surface area to fit within the human skull.

Scientists describe the brain as having four lobes: the frontal, parietal, occipital, and temporal (see Figure 1.3). The fissures or sulci of the brain demarcate the four lobes. At the bottom of the brain is the brainstem and cerebellum.

Each lobe is generally associated with different brain functions. I say "generally" because brains are specific and systemic. Although individuals have similar brain structures, individual brains are more unique than a fingerprint on a snowflake.

The **frontal lobe** is primarily associated with complex thought processes such as planning, reasoning, and decision-making (much, but not all, of what psychoanalysts

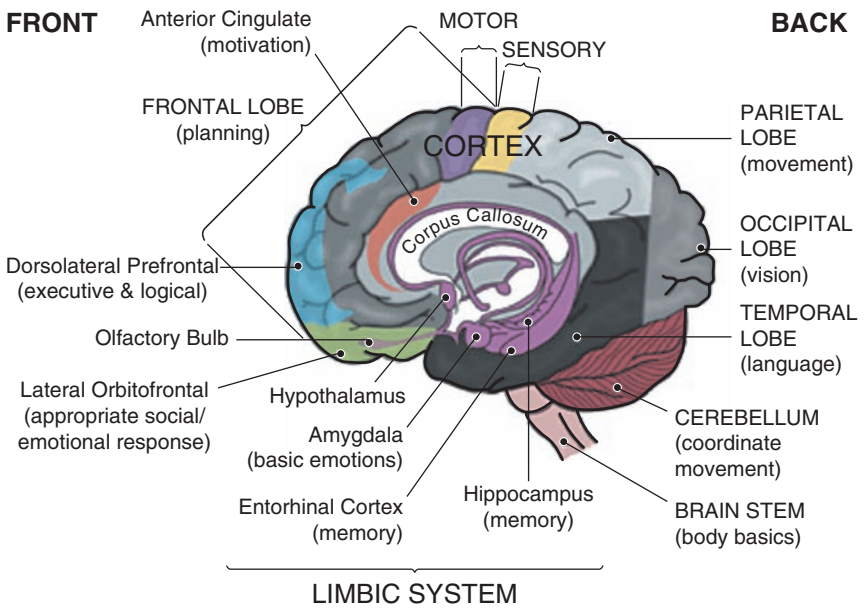


FIGURE 1.3 A Look at the Brain
(*Source:* http://www.brainwaves.com/. Reproduced with permission of Brainwaves)

refer to as ego functions). The frontal lobe also appears involved in expressive language and contains the motor cortex.

The **parietal lobe** includes the somatosensory cortex. This surface area involves sensory processing (including pain and touch). It also includes spatial or visual orientation.

The **temporal lobes** are located symmetrically on each side of the brain (just above the ears). They're involved in auditory perception and processing. They contain the hippocampus and are involved in memory formation and storage.

The **occipital lobe** is located in the back of the brain and is the primary visual processing center.

I'm using all four lobes right now to type, read, edit, re-think, re-type, re-read, shift my position, and recall various relevant and irrelevant experiences. The idea that we only use 10% of our brains is a silly myth. They even busted it on the *Mythbusters* television show.

The brain includes two **hemispheres**. They're separated by the longitudinal fissure and communicate with each other primarily via the corpus callosum. The hemispheres are nearly mirror images of each other in size and shape. However, their neurotransmitter quantities and receptor subtypes are quite different. The **right hemisphere** controls the left side of the body and is primarily involved in spatial, musical, and artistic/creative functions. In contrast, the left hemisphere controls the right side of the body and is involved in language, logical thinking, and linear analysis. There are exceptions to these general descriptions and these exceptions are larger in brains of individuals who are left-handed. Woo-hoo for lefties.

The **limbic system** is located deep within the brain. It has several structures involved in memory and emotional experiencing. These include, but are not limited to, the amygdala, basal ganglia, cingulate gyrus, hippocampus, hypothalamus, and thalamus. The limbic system and its structural components are currently very popular; they're like the Beyoncé of brain science.

Neurons and neurotransmitters: Communication within the brain is electrical and chemical (aka electrochemical = supercool).

Neurons are nerve cells (aka brain cells) that communicate with one another. There are many neuron types. Of particular relevance to counseling and psychotherapy are mirror neurons. **Mirror neurons** fire when you engage in specific actions (e.g., when waving hello) and the same neurons fire as you observe others engaging in the same actions. These neurons are central to empathy and vicarious learning, but many other brain structures and systems are also involved in these complex behaviors (see Chapter 5).

Neurotransmitters are chemicals packed into synaptic vesicles. They're released from an **axon** (a part of a neuron that sends neural transmissions), travel through the synaptic cleft (the space between neurons), and into a connecting **dendrite** (a part of a neuron that receives neural transmissions), with some "leftover" vesicles reabsorbed into the original axon (referred to as "reuptake," as in serotonin-specific reuptake inhibitors).

There are somewhere between 30 and 100 (or more) neurotransmitters (NTs) in the brain, divided into three categories: (a) small molecule NTs (e.g., acetylcholine, dopamine, GABA, glutamate, histamine, noradrenaline, norepinephrine, serotonin, etc.); (b) neuropeptides (e.g., endorphins, oxytocin, etc.); and (c) "other" (e.g., adenosine, endocannadinoids, nitric oxide, etc.). Neurotransmitters are classified as excitatory or inhibitory or both. For example, norepinephrine is an excitatory neurotransmitter,

dopamine is both excitatory and inhibitory, and serotonin is inhibitory. Although several chemical imbalance hypotheses regarding the etiology of mental disorders have been promoted (e.g., "low" serotonin at the synaptic cleft causes depression), when it comes to the brain, I caution you against enthusiastic acceptance of any simplistic explanations. A significant portion of the scientific community consider the dopamine and serotonin hypotheses to be primarily mythical (see Breggin, 2016; Edwards, Bacanu, Bigdeli, Moscati, & Kendler, 2016; Moncrieff, 2015).

As I pursued graduate studies, I found evidence to support my beliefs including a study showing that testosterone levels vary as a function of winning or losing tennis matches (Booth, Shelley, Mazur, Tharp, & Kittok, 1989). If our testosterone levels changed based on competitive tennis, what other ways might human experiences influence the brain?

In 1998, while perusing research on serotonin and depression, I discovered that treadmill running increased brain serotonin in rats. The researcher described the complexity of the phenomenon:

> Lipolysis-elicited release of free fatty acids displaces the binding of tryptophan to albumin and because exercise increases the ratio of circulating free tryptophan to the sum of the concentrations of the amino acids that compete with tryptophan for uptake at the blood–brain barrier level, tryptophan enters markedly in the brain compartment. (Chaoeloff, 1997, p. 58)

It seemed possible that physical exercise might increase serotonin in human brains and also help alleviate depression.

Then, along came neurogenesis. **Neurogenesis** is the creation of new brain cells. It has been long known that during fetal development, cells are created and migrate to specific places in the brain and body where they engage in their specific role and function. Cells that become rods and cones end up in the eyes, while other cells become bone, and still others end up in the cerebral cortex. In the 1980s and 1990s, everyone agreed that neurogenesis continued during infancy, but most neuroscientists also believed that after early childhood the brain locked down and neurogenesis stopped. In other words, as adults, we only had neuronal pruning (cell death).

In the late 1980s, neuroscientists began conducting research that shook long-held assumptions about neurogenesis. For example, one research team (Jenkins, Merzenich, Ochs, Allard, & Guk-Robles, 1990) housed adult monkeys in cages where the monkeys had to use their middle finger to rotate a disc to get banana pellets. Even after a short time period (1 week), brain autopsies showed that the monkeys had an enlarged region in their motor cortex. The conclusion: in adult monkeys, repeated physical behaviors stimulate neurogenesis in the motor cortex. This seemed like common sense. Not only do our brains shape our experiences, but our experiences shape the brain (literally).

As it turns out, neurogenesis slows with age, but doesn't stop. It continues throughout the lifespan. New learning stimulates cell birth and growth in the hippocampus (and other areas involving memory processing and storage). This "new brain research" left open the possibility that counseling and psychotherapy might stimulate neurochemical changes and cell birth in the human brain.

As brain research continues to accelerate, implications and applications of neuroscience to counseling and psychotherapy have flourished (Satel & Lilienfeld, 2013). Practitioners have created new marketing terminology like "brain-based therapy," "neuropsychotherapy," "neurocounseling," and "interpersonal neurobiology," despite the lack of clear scientific evidence to support these terms. In some cases, birthing of this new terminology has caused lamentation within the neuroscience and academic communities (Bott, Radke, & Kiely, 2016; Lilienfeld, Schwartz, Meca, Sauvigné, & Satel, 2015).

Appreciating Neuroscience Complexities

Where does all this take us? As Dr. M would say, the brain is central to mood and behavior change. We now know that the reverse is also true: mood, behavior, and social interaction are central to brain development and change. The influence goes in both directions. More importantly, we need to acknowledge that relationships between and among brain structures, neurotransmitters, hormones, other chemicals, and human behaviors are extremely complex and still largely unexplained. The brain is functioning as a whole, as regions, as inter- and intracellular processes, while doing all these activities both sequentially and simultaneously.

Here's an example of the complexities we must take into account as we attempt to use neuroscience findings in therapeutic practice. It appears that meditation and interpersonal empathic experiences stimulate the anterior insular cortex (AIC) and perhaps facilitate neurogenesis! So what does this mean exactly? The following excerpt from the neuroscience literature helps illustrate the difficulty of making direct inferences (Mutschler, Reinbold, Wankerl, Seifritz, & Ball, 2013):

> In summary, we argue that the dorsal AIC plays a pivotal role in empathy (similarly as during emotion processing and pain) by integrating sensory stimuli with its salience,

> possibly via connections to the cingulate cortex.… As mentioned above we assume that the overall role of the morphometrically identified area in the dorsal AIC related to individual differences in empathy which overlaps the DGR might be involved in integrating information which is relevant for socio-emotional and cognitive processing. Thus, we assume that empathy is not (only) related to a specific "socio-emotional" interaction area, but to a superordinate "domain-general" area, in line with concepts of empathy that include not only social and emotional, but also cognitive aspects.… Whether our findings in the dorsal AIC have also a relation to the "von Economo neurons" [VENs,…] remains to be determined. VENs have been hypothesized to play a role in social-emotional processing including empathy.…" (Reproduced under the Creative Commons Attribution License, *Source:* Mutschler, Reinbold, Wankerl, Seifritz, and Ball, 2013, p. 6)

This excerpt should inspire us all to pause with respect for the complexity of neuroscience; it should also slow down simplistic conclusions. If we just focus on empathy and the insula, we can see many sources of potential error: (a) much of the neuroscience empathy research focuses on empathy for physical pain; (b) empathy is hard to measure; (c) it's possible for a human brain to "light up" with empathy, but for the human to not express empathy; (d) while empathy is generally considered a positive quality, some people use empathy to manipulate and hurt others; (e) there is brain structural and functional overlap; and (f) the role of the VENs is unknown.

EMERGENCE OF PERSONAL THEORY

If you want to be an excellent mental health professional, then it makes sense to closely study the thinking of some of the greatest minds and models in the field. This text covers 12 of the most comprehensive and practical theories in existence. We hope you absorb each theory as thoroughly as possible and try experiencing them from the inside out. As you proceed through each chapter, suspend doubt and try thinking like a practitioner from each theoretical orientation.

It's also important for you to discover which theory or theories are the best fit for you. You'll have opportunities to reflect on the content of this text and hopefully that will help you develop your own ideas about human functioning and change. Although we're not recommending that you develop a 13th theory, we are recommending that you explore how to integrate your genuine self into these different theoretical perspectives.

Some of you reading this book may already have considerable knowledge and experience about counseling and psychotherapy theories. However, even if you have very little knowledge and experience, you undoubtedly have some preexisting ideas about what helps people change. Therefore, before reading Chapters 2 through 14, we encourage you to look at your own implicit ideas about people and how they change.

Your First Client and Your First Theory

Pretend this is the first day of your career as a mental health professional. You have all the amenities: a tastefully decorated office, two comfortable chairs, a graduate degree, and a client.

You also have everything that any scarecrow, tin man, or lion might yearn for: a brain full of knowledge about how to provide therapy, a heart with compassion for a diverse range of clients, and courage to face the challenge of providing therapy services. But do you have what it takes to help a fellow human being climb from a pit of despair? Do you have the judgment to apply your knowledge in an effective way?

You walk to the waiting room. She's there. She's your first client ever. You greet her. The two of you walk back to the office.

In the first 20 minutes, you learn quite a lot about your client: she's a 21-year-old college student experiencing apathy, insomnia, no romantic interests, carbohydrate cravings, an absence of hobbies, and extremely poor grades. She's not using drugs or alcohol. Based on this information, you tentatively diagnose her as having some variant of clinical depression and proceed with counseling. But how do you proceed? Do you focus on her automatic thoughts and her core beliefs about herself that might be contributing to her depressive symptoms? Do you help her get a tutor, thinking that improved grades might lift her depressive symptoms? Do you recommend she begin an exercise routine? Do you explore her childhood, wondering if she has a trauma experience that needs to be understood and worked through? Do you teach her mindfulness skills and have her practice meditation? Do you have her role play and rehearse solutions to her problems? Do you focus on listening, assuming that if you provide her a positive therapy environment, she'll gain insight into herself and move toward greater psychological health? Do you help her recast herself and her life into a story with a positive ending with a more adaptive identity? Do you ask her to sit in different chairs—speaking from different perspectives to explore her here and now feelings of success and failure? Any or all of these strategies might help. Which ones seem best to you?

You have many choices for how to proceed, depending upon your theoretical orientation. Here's our advice. Don't get stuck too soon with a single theoretical orientation. It's unlikely that all humans will respond to the same approach. As suggested in Putting It in Practice 1.2, experiment and reflect before choosing your preferred theory. (Complete the ratings in Table 1.2 and then look through Table 1.3 to see which major theoretical perspectives might fit best for you.)

Table 1.2 What's Your "Natural" Theoretical Orientation?

Instructions: Use the following scale to rate each statement under each theory heading:
0 - - - - 1 - - - - 2 - - - - 3 - - - - 4 - - - - 5 - - - - 6 - - - - 7 - - - - 8 - - - - 9 - - - - 10
0 = Completely Disagree 5 = On the Fence 10 = Completely Agree

Theory 1	1. Most client problems consist of repeating dysfunctional relationship patterns; these patterns are very difficult to change unless clients can become more aware of where their patterns come from. RATING _____ 2. Because clients bring developmental baggage into therapy with them, they invariably project their old child–caretaker (parent) relationship dynamics onto the therapist and repeat or reenact their child–parent or child–caretaker relationship patterns. RATING _____ 3. The main job of the therapist is to remain quiet and listen for the client's unconscious patterns of dealing with inner conflict or unhealthy relationship patterns and then to interpret or share these patterns with the client in an effort to increase client awareness. RATING _____
Theory 2	1. An unhealthy individual who needs counseling or psychotherapy typically feels discouraged in his/her efforts to face the major tasks of life (this also might involve a lack of courage to face the demands of life). RATING _____ 2. People are built to strive forward in their lives toward future goals, seeking to improve themselves and seeking purpose and meaning. RATING _____ 3. The relationship between therapist and client should be like that of a friendly teacher with one's student. RATING _____
Theory 3	1. The inevitable conditions humans face during life, such as death, responsibility, freedom, and meaning or purpose, can and should be a primary focus of counseling and psychotherapy. RATING _____ 2. When clients are troubled by anxiety or guilt they're better served by embracing and seeking to understand the meaning of these emotions than they are by learning skills for avoiding their emotional reactions. RATING _____ 3. Therapy works best when therapists are fully present and engaged in a relationship with the client and, at the same time, are, when appropriate, both empathic and confrontational. RATING _____
Theory 4	1. The client is the best expert on the direction therapy should go and consequently therapists should trust their clients to lead them to the most important topics to talk about. RATING _____ 2. Clients (and all people) have within them a deep actualizing or formative tendency. If this force is activated it can pull or push clients toward positive growth and development. RATING _____ 3. Successful therapy occurs because the therapist has established a relationship with clients based on authenticity, respect, and empathic understanding. This is the foundation for change and sometimes may be all that's needed for therapy to succeed. RATING _____
Theory 5	1. The most important focus for therapy is on client self-awareness in the present moment. This awareness should include physical and sensory awareness; intellectualizing or thinking should be de-emphasized. RATING _____ 2. The main purpose of therapy techniques is to bring unfinished business from the past into the present so it can be dealt with more directly and effectively. RATING _____ 3. In therapy clients should be pushed to stay in touch with their feelings and take responsibility for all of their behaviors. RATING _____
Theory 6	1. Therapy interventions should be based on solid scientific evidence (i.e., laboratory experimentation). RATING _____ 2. Adaptive and maladaptive human behaviors are acquired and maintained in the same way: through learning. RATING _____ 3. Successful therapy does not require clients to change their thinking. In fact, trying to change clients' thinking is often irrelevant. Instead, successful therapy only requires that clients change their behavior. RATING _____
Theory 7	1. It's not what happens to individuals that causes them misery; it's what they think about what happens to them. RATING _____ 2. Therapy should be an educational process, with therapists teaching and clients learning. RATING _____ 3. For therapy to result in a positive outcome, therapists need to challenge or question the irrational or maladaptive thinking that's linked to the client's problems. RATING _____
Theory 8	1. Humans act, not on the basis of external rewards and punishments, but based on internal values and things we want or wish for. RATING _____ 2. The only person whose behavior you have complete control over is your own. Moreover, the only person's behavior that you should seek to control is your own. RATING _____ 3. Therapy involves detailed planning for how clients can achieve what they want. A good plan is very specific and doable. RATING _____

(continued)

Table 1.2 What's Your "Natural" Theoretical Orientation? *(continued)*

Theory 9	1. Raising client consciousness of social oppression and gender-based limits is a crucial part of effective therapy. RATING _____ 2. Psychopathology is primarily caused by gender and social-related norms that inhibit and oppress women and minorities. RATING _____ 3. The therapy relationship should be mutually empathic and egalitarian. RATING _____
Theory 10	1. It is crucial for therapists to help clients apply whatever strengths they bring with them into the therapy office to their personal problem situations. RATING _____ 2. Sometimes only a very small change is needed to address very big problems. RATING _____ 3. Client resistance is natural and not the fault of the client. RATING _____
Theory 11	1. In most cases, the proper focus of therapy is the family system and not the individual. RATING _____ 2. Individual problems are created and maintained by the family and serve a purpose within the family. RATING _____ 3. Therapy that focuses on family systems, community systems, and other factors outside the individual constitute some of the most powerful approaches to human change. RATING _____
Theory 12	1. Ethnically diverse clients are better served by ethnically specific therapy, services oriented to the cultural needs of clients. RATING _____ 2. To work effectively with minority clients, therapists need specific training in multicultural sensitivity and knowledge. RATING _____ 3. Psychopathology is not a problem existing within individuals; instead, psychopathology is usually created by oppressive social forces outside individuals. RATING _____
Theory 13	1. There is no single best or right theory of counseling or psychotherapy. RATING _____ 2. Therapy is most effective when there's a good match between the client's problem, the specific technique, and the therapist's style. RATING _____ 3. Effective therapy involves an emotionally charged relationship and a process that includes a socially sanctioned myth (about the cause of the problem) and an appropriate ritual that enhances positive expectations. RATING _____
Scoring Instructions: Add up your scores for each theory. The lowest possible score is 0; the highest possible is 30. The theories linked to your highest scores are your natural theoretical inclination. Those linked to your lowest scores are inconsistent with how you think about therapy now. Check Table 1.3 for brief descriptions of each theory.	

Table 1.3 An Overview of 13 Theoretical Perspectives

Theory 1: Psychoanalytic or psychodynamic theory (Chapter 2). Psychoanalytic theories hold the common belief that early childhood relationships shape personality and behavior. The main goal of psychoanalytic therapies is to bring maladaptive unconscious relationship dynamics into consciousness. This involves an exploration of past relationships, development of insights into current relationship dynamics, and an application of these insights to contemporary relationships.

Theory 2: Adlerian or individual psychology (Chapter 3). Individual (Adlerian) psychology views each client as a unique, whole individual who strives toward improvements and idiosyncratic personal goals. Psychopathology develops when people become discouraged due to belief systems that interfere with their ability to face and deal with the tasks of life. Therapists help clients have insight into the "basic mistakes" imbedded in their belief systems. Therapy is effective because of a friendly, collaborative relationship, insight into maladaptive aspects of the lifestyle, and education about how to remediate the maladaptive lifestyle.

Theory 3: Existential (Chapter 4). Existential approaches are derived from existential philosophy. Individuals must grapple with core life issues such as death, freedom, isolation, and meaninglessness. Anxiety is part of normal human experience. Psychopathology arises when individuals avoid, rather than confront and cope with, life's core issues. Existential therapists can be gentle or confrontational and strive to develop a deep and authentic relationship with clients. Preplanned techniques are generally not used. Therapy is effective when clients are able to face their ultimate concerns and constructively embrace anxiety in ways that enhance personal meaning.

Theory 4: Person-centered (Chapter 5). Person-centered therapy is an optimistic, humanistic, and phenomenological approach to therapy. Person-centered theory posits that individuals have within themselves a capacity for dramatic and positive growth. This growth is stymied and psychopathology arises when clients, usually in childhood relationships, begin to believe they are not worthwhile or lovable unless they meet specific behavioral conditions (i.e., conditions of worth). In person-centered therapy, clients can talk about whatever they believe is important, especially whatever is emotionally significant. Person-centered therapy is effective when therapists are genuine, accepting and respectful, and empathic.

Theory 5: Gestalt (Chapter 6). Gestalt theory views humans as having both natural growth potential and natural defensiveness from experiential contact. Gestalt therapy focuses on developing an I–Thou relationship between client and therapist and then works in the here and now to deal with unfinished emotional and behavioral experiences from the past. Intellectualization is discouraged and action within the session is encouraged. Gestalt therapists don't engage in authoritative interpretation, but instead confront clients to come to their senses and make their own interpretations via Gestalt experiments.

Theory 6: Behavioral (Chapter 7). Behaviorists believe in basing all therapy approaches on scientific research. Behaviorists view humans as a function of their environment. Psychopathology is directly caused by maladaptive learning, either from classical or operant conditioning models. Behavior therapy consists of relearning; the focus of therapy is primarily on the present. Therapy is effective when therapists teach clients to apply basic behavioral learning principles within and outside therapy.

Theory 7: Cognitive behavioral (Chapter 8). Cognitive theory and therapy are usually used in combination with behavioral approaches. Cognitive approaches emphasize vicarious learning and that it's not what happens to individuals that causes them distress but what they think or believe about what happens to them that causes distress. Maladaptive or irrational thinking styles and beliefs about the self and maladaptive inner speech produce psychopathology. Therapy is effective when clients are taught new and more adaptive or rational ways of thinking about themselves and their lives.

Theory 8: Reality therapy/choice (Chapter 9). Choice theory holds that individuals are responsible for choosing their thoughts and behaviors; thoughts and behaviors directly influence feelings and physiology. All humans are motivated to satisfy one or more of their five basic needs: survival, love and belonging, power, freedom, and fun. Psychopathology develops because clients choose to restrain anger, want to receive help from others, or are choosing to avoid important issues. Therapy focuses on the present and is effective because the therapist forms a positive therapy relationship with clients and then teaches choice theory from within the context of that relationship.

Theory 9: Feminist (Chapter 10). Feminist theory was developed to address the social and cultural oppression and unequal treatment of women. Feminists view psychopathology as arising from social, cultural, and masculine-based power inequities and oppression. Feminist therapy involves recognizing inequities and empowering women and minorities. Therapy is based on a strong, mutual, supportive, and empowering relationship between therapist and client. When therapy is effective, clients are empowered to use their strengths to further and deepen mutual relationships in their lives.

Theory 10: Constructive (Chapter 11). Constructive theory emphasizes the power of language, information processing, and cybernetics in influencing human behavior and change. Psychopathology is a function of each individual client's construction of reality. The focus is on the future, solutions, and reshaping the narrative or story the client is living. Therapy is effective when the therapist and the client have a conversation or dialogue and co-create a reality wherein clients engage in positive, solution-focused strategies for constructing and maintaining their world.

Theory 11: Family systems (Chapter 12). Family systems theorists view problems as emanating from dysfunctional family processes, rather than being owned by individuals. Psychopathology is viewed as a function of interpersonal transactions and interactions within the family context. Interventions focus on changing family dynamics or behaviors within the family, rather than on changing individuals. Therapy strategies range from being strategic and paradoxical to straightforward and behavioral.

Theory 12: Multicultural (Chapter 13). Multicultural theory focuses on the power of culture in influencing human behavior, emotions, and values. Psychopathology is a product of social and cultural oppression. Many multicultural approaches acknowledge and embrace religious and spiritual perspectives. Clients benefit from therapy when they are accepted and empowered to behave in ways consistent with their culture.

Theory 13. Integration/eclectic (Chapter 14). No single theory is viewed as more correct or inherently better than any other. Diverse theoretical perspectives are woven together with common factors, technical eclecticism, and theoretical integration. There are several evidence-based, new generation integrative approaches to counseling and psychotherapy. The nature of humans, psychopathology, and theoretical constructs shifts, depending upon the specific approaches employed. Effective therapy involves applying different approaches that best fit clients and their problems.

OUR BIASES

Good qualitative researchers try to acknowledge their personal biases when reporting their research results. We think the same should be true for textbook authors. We therefore provide you with a brief overview of some of our main biases.

Our Theoretical Roots

In a sense, we were born and raised eclectic. Our graduate program at the University of Montana in the 1980s included a psychoanalytic/hypnoanalytic professor, a cognitively oriented professor, a person-centered professor, and two behaviorists. John went to a strictly psychoanalytic predoctoral internship at a medical center in New York in 1985 and Rita went to a family systems child and family clinic in Oregon in 1988. After licensure, John spent time teaching, working as a health psychologist in an industrial setting, in private practice, and as director of a parent education program. Rita has consulted with two different Veteran's Centers, established a part-time private practice, and taught 24 years as a professor of counselor education. During this time, we lived in Montana, New York, Washington, Oregon, Central America, and Northampton, England.

John's favorite theoretical figures are Carl Rogers, Alfred Adler, and Irvin Yalom. Rita's are Jean Baker Miller and the feminists, Alfred Adler, and Viktor Frankl. John loves to quote Freud and Rita loves to dethrone Freud, considering him overrated and antithetical to her feminist beliefs.

Our generalist background makes us slow to jump on contemporary bandwagons. We're especially cautious of new theories or techniques that claim remarkable recovery rates for distressed clients. Hopefully, this doesn't

PUTTING IT IN PRACTICE

1.2 Your Emerging Personal Theory

Reproduced with permission of Dr. Kurt Kraus

Dr. Kurt Kraus of the Department of Counseling and College Student Personnel at Shippensburg State University shares his thoughts on theories:

> I am afraid that students are encouraged to identify their emerging theoretical identity way too early. Students write papers for professors of Introduction to Counseling and Survey of Theoretical Approaches espousing their growing theoretical identities. Nonsense! Take time to learn about mental health professionals who have practiced for many years, study their contributions, write about them and their experiences, their beliefs, their skills, the benefits and liabilities inherent in their practices. Only after you have explored the journeys of many others can you really begin to make a decision about your own. Heck, you are only beginning; how dare we imply that you should know where you want to be? (K. Kraus, personal communication, August 2002)

Another colleague who teaches theories of counseling and psychotherapy to graduate students, **Janice DeLucia-Waack** of the State University of New York, Buffalo, gives the following advice to her students (reproduced with permission of Janice DeLucia-Waack):

> I tell my students that I don't expect or even want them to marry any particular theory while they're taking my course. However, I *do* tell them that I expect them to spend at least a week dating each theory before the semester ends. (J. DeLucia-Waack, personal communication, April 2002)

mean we're not open to new ideas. We're just reluctant to believe that having clients pop a pill or hum a few tunes will cure their longstanding problems.

Balance and Uncertainty

We have a strong bias against certainty. Several years ago we attended a workshop conducted by the great structural family therapist and theorist Salvador Minuchin. The subtitle of his presentation was "Don't be too sure." We agree. No theory holds the key to all problems. No theory entirely explains what it means to be human. When we get too sure about our theory, we close ourselves off to different perspectives; even worse, being too sure places us in danger of forcing the client to fit our theory, rather than the other way around.

We're skeptical about empirical research. The biggest problem with research is that it's tremendously difficult to conduct studies that reflect what happens in the therapy offices of practitioners around the world. As W. Silverman (1996) wrote, "Efficacy studies do not reflect models and they do not represent psychotherapy as practiced in the field" (p. 210).

However, we also deeply value counseling and psychotherapy research. Good research is essential to guiding mental health professionals. When a particular form of treatment makes great claims of effectiveness in the absence of empirical research, we become very suspicious.

The Zeitgeist, Ortgeist, and Poltergeist

The **zeitgeist** is defined as "the spirit of the time." It explains why several individuals can, without consulting each other, make a significant discovery at around the same time. This spirit of the time explains why Pierre Janet and Sigmund Freud, in France and Austria, could both independently begin suspecting that working directly with client unconscious processes might help resolve longstanding and troublesome symptoms. In the late 1890s the time was right to begin working with the unconscious.

The **ortgeist** refers to the "spirit of the place." It explains why people in close proximity often move toward similar discoveries. Perhaps the ortgeist spirit was operating in Europe in the late 1890s. Bankart (1997) speaks of the zeitgeist and ortgeist in relation to Freud: "A genuine understanding of Freud's psychoanalysis, for example, requires (and at the same time provides) a reasonably deep understanding of middle-class life in turn-of-the-century Europe" (Bankart, p. 8).

Similarly, National Public Radio's show "The Writer's Almanac" featured a quotation on Freud from the plain-spoken philosopher Eric Hoffer:

> Ah, don't talk to me about Freud. Freud lived in a tight little circle in Vienna, and inside that tight little circle was another tight little circle, and inside that tight little circle was still *another* tight little circle. What applies to that poor man, Freud, does not necessarily apply to me. (Keillor, 2002)

A **poltergeist** is a mischievous spirit or ghost. We reference poltergeists because, in our experience, conducting psychotherapy or counseling sometimes includes mysterious and mischievous surprises. An example of a poltergeist is given in the famous Harry Potter book series:

> Peeves the Poltergeist was worth two locked doors and a trick staircase if you met him when you were late for class. He would drop wastepaper baskets on your head, pull rugs from under your feet, pelt you with bits of chalk, or sneak up behind you, invisible, grab your nose, and screech, "GOT YOUR CONK!" (Rowling, 1997, p. 132)

We're not big believers in ghosts, but the idea of mischievous spirits is one way to bring your attention to the fact that you should prepare for the unexpected. Sometimes clients will say and do outrageous things. Other times, you'll suddenly feel the urge to say or do something inappropriate. For whatever reason, sitting privately with another individual for long periods of time can produce unusual and profound experiences. Just when you least suspect it, your videorecording equipment will malfunction or you'll feel like crying or you'll want to fidget or want to leave the room or the clock hanging on the wall in your office will stop or your client will tell you something shocking. Our point: be ready for surprises.

REFLECTIONS

Keeping the zeitgeist, ortgeist, and poltergeist in mind, what spirits of time, place, and mischief are operating in counseling and psychotherapy right now? What will be the next big discovery or controversy?

CONCLUDING COMMENTS

In this chapter we've taken you on a quick tour of major issues in counseling and psychotherapy. From historical context to contemporary research to ethical essentials, the field of counseling and psychotherapy is filled with amazing and interesting information. We wish you the best as you explore the main theories of therapy in greater depth.

CHAPTER SUMMARY AND REVIEW

Theories are central to the understanding and effectiveness of counseling and psychotherapy. Theories are important because they provide mental health practitioners with direction and guidance on how to practice. This book reviews many different traditional and contemporary theoretical perspectives, all of which have some research support and have made efforts to address unique issues salient to diverse populations.

Counseling and psychotherapy theories involve the gathering together and organizing of knowledge about how people develop emotional or behavioral problems, what can help them make positive changes, and how they're likely to respond to therapeutic interventions. All theories develop within a particular context. Most people consider modern theories of psychotherapy to have started with Sigmund Freud, but many other people and contextual factors were operating in combination.

At least four different cultural and historical perspectives have shaped the development of counseling and psychotherapy. These included: (1) biomedical, (2) religious/spiritual, (3) psychosocial, and (4) feminist/multicultural.

Many different definitions for counseling and psychotherapy have been offered over the years. Psychotherapy tends to be seen as a longer, deeper, and more expensive process as compared to counseling. The definition of counseling and psychotherapy is complex, including at least 12 different dimensions.

In 1952, Hans Eysenck conducted a review of psychotherapy outcomes and concluded psychotherapy was less effective than no treatment whatsoever. This finding was controversial and stimulated substantial research on psychotherapy outcomes. Currently, most researchers and practitioners agree that counseling and psychotherapy are very effective, but there are still heated arguments over which approaches are more effective with which problems.

There are two main positions constituting the *great psychotherapy debate*. One position claims that specific therapy procedures are superior to other procedures and therefore should constitute most of what therapists provide. The other position claims that there are common factors within all approaches that account for the fact that research generally shows all therapy approaches have equal efficacy or effectiveness.

Counseling and psychotherapy approaches are evaluated in either highly controlled research protocols or real-world settings. Tightly controlled research protocols are called treatment efficacy studies; research in real-world settings are called effectiveness studies.

Counselors and psychotherapists are required to abide by professional ethics. Essential ethical topics include: (a) competence and informed consent; (b) multicultural sensitivity, competence, and humility; (c) confidentiality; (d) multiple roles; and (e) beneficence. It's important for

counseling and psychotherapy professionals to be aware that some treatment approaches are potentially harmful. To avoid harming clients, therapists should focus on establishing a strong therapy alliance, integrate empirically supported treatments, use evidence-based principles, individualize therapy, and use culturally sensitive assessments to monitor client progress.

Neuroscience is increasingly seen as having significant implications for how counselors and psychotherapists practice. New terms integrating neuroscience into therapy have been introduced. Over time, neuroscientific findings have supported the ideas that counseling and psychotherapy relationships and techniques cause changes in the brain that contribute to positive outcomes.

As you read this book you will have a chance to explore your own ideas about counseling, psychotherapy, and human change. This will help you integrate your own ideas, values, and ways of being into existing therapy approaches. As authors, we have our own biases. These include a preference for having broad theoretical roots, recognizing that even scientific research leaves room for uncertainty, and the importance of recognizing that the spirit of the time, place, and other mysterious forces will continue to influence counseling and psychotherapy theory and practice.

INTRODUCTORY KEY TERMS

Axon
Beneficence
Biomedical perspective
Common therapeutic factors
Competence
Confidentiality
Context
Corpus Callosum
Dendrite
Dodo bird effect
Effect size
Effectiveness research
Efficacy research
Empirically supported treatment (EST)
Empirically validated treatment
Evidence-based principles
Expectancy
External validity
Extratherapeutic factors
Feminist/multicultural perspective
Frontal lobe
Great psychotherapy debate
Hemisphere
Informed consent
Internal validity
Left hemisphere
Limbic system
Meta-analysis
Mirror neurons
Multicultural competencies
Multiple roles
Negative outcomes
Neurogenesis
Neurons
Neurotransmitters
Nonspecific factors
Occipital lobe
Ortgeist
Parietal lobe
Poltergeist
Potentially harmful therapies (PHTs)
Practice-based evidence
Primum non nocere (first, do no harm)
Progress Monitoring (PM)
Psychosocial perspective
Randomized controlled trials (RCTs)
Religious/spiritual perspective
Right hemisphere
Temporal lobe
The talking cure
Theory
Therapeutic relationship
Trephining
Working alliance
Working definition of counseling and psychotherapy
Zeitgeist

CHAPTER 2

Psychoanalytic Approaches

LEARNER OBJECTIVES

- Define psychoanalytic psychotherapy and its variants
- Identify historical dynamics in Freud's development of psychoanalysis
- Describe core psychoanalytic theoretical principles
- Outline the evolution and development of psychoanalytic theory
- Describe and apply psychoanalytic psychotherapy principles, strategies, and techniques
- Analyze cases that employ psychoanalytic approaches
- Evaluate the empirical, cultural, gender, and spiritual validity of psychoanalytic psychotherapy
- Summarize core content and define key terms associated with psychoanalytic theory and therapies

A famous psychotherapist once wrote, "There are many ways and means of conducting psychotherapy. All that lead to recovery are good."

Surprisingly, this broadly accepting statement came from Sigmund Freud. As you'll see in this chapter, Freud's reputation wasn't one of flexibility and openness. Psychoanalysis was a rigid and tightly controlled process. When you think of Freud and psychoanalysis you might have images come to mind of patients lying on couches with their analysts behind them. These analysts would speak only occasionally and mysteriously, guiding their patients toward important insights into the deep (usually sexual) meaning underlying their behaviors. However, as you'll learn, psychoanalytic and psychodynamic psychotherapies have morphed far from Freud's original theorizing.

Freud's approach established the headwaters from which all contemporary psychotherapies and counseling have flowed. This chapter is the story of psychoanalysis and its evolution.

INTRODUCTION

Contemporary psychoanalytic psychotherapy is based on the writing and theories of Sigmund Freud. However, beyond Freud, many other writers, practitioners, and clients have contributed to the vastly different ways in which psychoanalytic psychotherapies are practiced today.

What Is Psychoanalytic Psychotherapy?

This is a question with many answers.

Sigmund Freud developed psychoanalysis and psychoanalytic theory. Although he had stimulating discussions of his theory and approach with others while he was alive, Freud had the final word. **Psychoanalysis** is the term used to describe Freud's approach and classical Freudian psychoanalytic theory is his theoretical model. **Classical Freudian psychoanalytic theory** is a one-person intrapsychic model where the psychotherapist acts as a blank slate and listens for unconscious conflicts and motivations that underlie repetitive, maladaptive patterns of behavior.

Many other psychoanalytic and psychodynamic psychotherapies developed from Freud's original theorizing. These include, but are not limited to: (a) ego psychology, (b) object relations, (c) self psychology, and (d) relational (or two-person) psychoanalysis. These are broadly referred to as **modern psychoanalytic approaches**. Modern psychoanalytic practitioners generally treat therapy as a two-person field, where the psychotherapist's and client's unconscious, intrapsychic, and relationship interactions are used to shed light on interpersonal patterns that are troubling the client (Bass, 2015; Renik, 1993; Wachtel, 2010).

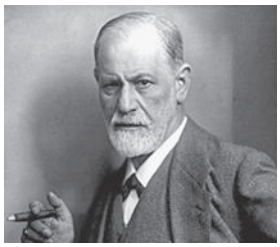
The most general term is psychodynamic psychotherapy. **Psychodynamic psychotherapy** refers to approaches that emphasize unconscious behavior patterns and use insight as a primary therapeutic tool for psychological change.

Counseling and Psychotherapy Theories in Context and Practice: Skills, Strategies, and Techniques, Third Edition. John Sommers-Flanagan and Rita Sommers-Flanagan. © 2018 John Wiley & Sons, Inc. Published 2018 by John Wiley & Sons, Inc.
Companion website: www.wiley.com/go/sommers-flanagan/theories3e

Sigmund Freud has maintained his place as the central figure in psychoanalytic theory since the early 1900s. Some contemporary theorists and practitioners view him as an inspiration. For others, he's almost reflexively seen in a negative light and his ideas are ignored or unfairly criticized. The fact that speaking his name in public still produces strong emotional and intellectual reactions is a testament to his widespread influence. We begin with a brief examination of his childhood and personal history, because, frankly, Freud himself wouldn't have it any other way.

Sigmund Freud

> A man like me cannot live without a hobby-horse, a consuming passion—in Schiller's words a tyrant. I have found my tyrant, and in his service I know no limits. My tyrant is psychology.
>
> —Sigmund Freud, 1895, in a letter to W. Fliess



Sigmund Freud

Sigmund Freud was born in Freiberg, Moravia, in 1856. He was the firstborn of the union between his father, Jakob, and his mother, Amalie (Jakob's second wife). Although Jakob had two children from a previous marriage, Sigmund held the favored position of eldest son in a family with three boys and five girls. Jakob, a wool merchant, was authoritarian, while Amalie was protective and nurturing. Due to financial constraints, the family lived together in a small apartment.

Freud's intellectual potential was obvious early on. For example, he and a friend taught themselves Spanish because they wanted to read *Don Quixote* in its original language. His parents supported his intellectual appetite as much as they could. Freud obtained a medical degree from the University of Vienna with the goal of becoming a research scientist. Given his later fascination with psychosexual development and the unconscious sexual meaning of many behaviors, it's especially interesting that his first major research project involved a search for the testes of the eel.

Freud was unable to continue his research career due to financial needs. Instead, he went into the private practice of neurology.

As a neurologist, Freud worked with patients diagnosed with hysteria. **Hysteria** included various unexplained symptoms, including, but not limited to, numbness, paralysis, and tremors. Many European women in the late nineteenth century were afflicted with hysteria.

During a visit to France, Freud became familiar with the work of Jean Charcot. Charcot was a French neurologist who was using hypnosis to *produce* hysterical symptoms. Charcot's work convinced Freud that he also might use hypnosis to treat hysteria. Freud began using hypnosis to get patients to talk about important incidents that they couldn't typically recall.

After experimenting with hypnosis and reporting that it made him feel like "a miracle worker," Freud began working alongside Viennese physician Josef Breuer. Breuer was successfully treating hysteria symptoms—without hypnosis—simply by having patients talk about emotionally laden childhood experiences. In the early 1880s Breuer worked extensively with a patient named *Anna O.* (a pseudonym for Bertha Pappenheim), discussing her hysteria symptoms and treatment in great detail with Freud. Together, they published *Studies in Hysteria* (Breuer & Freud, 1895). Eventually, Freud became impressed with this "talking cure" and stopped using hypnosis. The rest, as they say, is history.

REFLECTIONS

Psychoanalysis has come to be a controversial approach and Freud is a controversial figure in psychotherapy history and practice. Nevertheless, Freud (and John and Rita) are interested in your first thoughts and emotions as you begin to read about psychoanalysis and Freud. What are your preconceptions? Be honest, just like you would be with your analyst.

HISTORICAL CONTEXT

As noted in Chapter 1, psychological theories are reflective of the culture and historic period in which they were developed. Freud was obsessed with the sexual origins of mental disorders (Bankart, 1997), but he also lived in Vienna in the late 1800s, a reputedly extremely sexually repressed society. No doubt, Freud's Viennese culture and personal history influenced his theory.

A good illustration of psychoanalytic historical context is Freud's development and subsequent recanting of his **seduction hypothesis** (the hypothesis that repression of early childhood sexual abuse caused hysteria). Interestingly, there's conflict over the truth of this story. As you read about the seduction hypothesis, keep in mind that certain points have been contested, but the unfolding of a spectacular drama around sexuality, sexual fantasy, and sexual abuse in a sexually repressed society appears accurate.

The Seduction Hypothesis

In 1885, Freud went to France to study with Jean Charcot. According to Jeffrey Masson, former projects director of the Freud Archives, it's likely that Freud visited the Paris

Morgue, observing autopsies of young children who had been brutally physically and sexually abused (Masson, 1984). Masson speculated that Freud's exposure to the grisly reality of child abuse combined with his patients' stories of abuse led him to believe that child sexual abuse caused hysteria.

Later, Freud presented a paper titled "The Aetiology of Hysteria" at the Society for Psychiatry and Neurology in Vienna (Freud, 1896). He presented 18 cases (12 women and 6 men), all of which included childhood sexual abuse. Freud's critics contended (then and now) that Freud never provided the facts of his case histories (Wilcocks, 1994). They have also noted that he may have constructed the sexual memories by pressuring patients and by distorting what he heard to fit with his preexisting ideas (Esterson, 2001).

Freud's (1896) seduction hypothesis included the following components:

1. Very early "premature" sexual experiences cause symptoms of hysteria.
2. At the time of the abuse, there are no hysterical symptoms; the sexual memories are repressed.
3. Unconscious memories are "aroused after puberty."
4. Hysterical symptoms (e.g., fainting, paralysis) are manifest.
5. Psychoanalysis can address symptoms of hysteria.

Freud apparently believed in this etiological foundation and treatment process, as well as the reality of his clients' sexual abuse stories, until the late 1800s or early 1900s (Ahbel-Rappe, 2009).

Recanting the Seduction Hypothesis

Imagine yourself alone with a profound and horrible insight. In Masson's version of the seduction hypothesis story, this was Freud's situation. Masson (1984) described the reception Freud received after presenting his hypothesis (there is no dispute over this part of the seduction hypothesis story):

> The paper … met with total silence. Afterwards, he was urged never to publish it, lest his reputation be damaged beyond repair…. But he defied his colleagues and published "The Aetiology of Hysteria." (pp. xviii–xix)

Five days after presenting his paper, Freud wrote about the experience to his friend and otolaryngologist (ear, nose, and throat physician) Wilhelm Fliess. Freud's anger was obvious:

> [My] lecture on the aetiology of hysteria at the Psychiatric Society met with an icy reception from the asses, and from Kraft-Ebing [the distinguished professor and head of the Department of Psychiatry at the University of Vienna] the strange comment: "It sounds like a scientific fairy tale." And this after one has demonstrated to them a solution to a more than thousand-year-old problem, a "source of the Nile!" They can all go to hell. (Schur, 1972, p. 104)

Although it's clear that Freud's lecture received "an icy reception" it's less clear why the audience was unimpressed. According to Masson, the reception was icy because Freud was bringing up sex and sexual abuse and that most professionals and citizens at the time were uncomfortable with this topic. Others have suggested that Freud's arrogance along with an absence of scientific rigor, moved the audience to rebuke him. Wilcocks (1994) wrote:

> The inferential support offered—without detail, of course—is that in eighteen cases out of eighteen, Freud has "discovered" the same etiological factors. But since neither we nor his audience are/were privy to the circumstances of any of his cases, this claim—whatever it's other inferential mistakes—is simply useless. (p. 129)

Freud's life during the years following the "Aetiology of Hysteria" lecture were difficult. His private practice was in decline and his professional life in shambles. This is when Freud embarked on "his lonely and painful self-analysis" (Prochaska & Norcross, 2003, p. 29). His 2-year self-analysis included uncovering memories of yearning for his mother and equally powerful feelings of resentment toward his father (Bankart, 1997).

Eventually, Freud discarded his seduction hypothesis in favor of the Oedipus complex (wherein a boy holds unconscious wishes to have sexual relations with his mother). Some suggest this was because he began noticing seductive patterns in so many parent–child interactions that it was unrealistic to assume that child sexual abuse occurred at such a high rate. Others believe Freud was ahead of his time in discovering child sexual abuse, but buckled under the social and psychological pressure, abandoning the truths his patients shared with him. Still others contend that while Freud was constructing his theoretical principles, he was projecting and mixing his own fantasies into his clients' stories. This appears to be the case in the following passage:

> I found in myself a constant love for my mother, and jealousy of my father. I now consider this to be a universal event in childhood. (R. A. Paul, 1991)

In 1925, long after he recanted the seduction hypothesis, he reflected on how he was naïve to have believed his patients:

> I believed these stories, and consequently supposed that I had discovered the roots of the subsequent neurosis in

> these experiences of sexual seduction in childhood.… If the reader feels inclined to shake his head at my credulity, I cannot altogether blame him.… I was at last obliged to recognize that these scenes of seduction had never taken place, and that they were only fantasies which my patients had made up. (Freud, 1925, cited in Masson, 1984, p. 11)

The creation and recanting of the seduction hypothesis offers a glimpse into Viennese culture, Freud's personal psychology, and the challenge of discerning fact from fantasy. Were Freud's patients recalling real memories or reporting fantasies? Did Freud finally discern the truth or did he unconsciously mix (or project) his own personal issues into the plot? This process, sorting out our own ideas from the facts of what clients tell us, remains a challenge to all professional helpers. In the end, it may be that we create Kraft-Ebing's "scientific fairy tale" or something with lasting and meaningful significance. More likely, we create a combination of the two.

REFLECTIONS

What's your impression of Freud's struggles with the seduction hypothesis? How might "hysteria" back then be related to post-traumatic stress disorder now?

THEORETICAL PRINCIPLES

Freud's theory is one of the "giant theories" of developmental psychology (P. Miller, 2010, p. 108). One of our psychoanalytic colleagues refers to classical Freudian theory as a "museum theory," not so much because it belongs in a museum (although a case can be made for that as well) but because, as noted previously, classical Freudian theory is a one-person intrapsychic model that treats clients as separate, individual artifacts to be objectively examined. Classical Freudian theory includes several models or "approaches."

The Dynamic Approach

Freud's dynamic approach forms the foundation of his overall theory. Other names for the **dynamic approach** include **drive theory** or **instinct theory**. Freud posited that mental or psychic energy fills and energizes humans. This energy comes from two sources: **eros**, defined as energy associated with life and sexual instincts, and **thanatos**, defined as externally and internally directed aggression (Freud, 1964).

Freud used physical models to describe drive theory. He believed that psychic energy could be built up, transformed, connected to certain images, distributed, and discharged. Sometimes he wrote about searching for concrete, physical manifestations of his theoretical speculations. Nevertheless, psychic energy was and is a distinctly psychological force. Although parallel physical processes may exist, they have not been identified (Brenner, 1973).

Psychic determinism is foundational to the dynamic approach. Freud believed that nothing that occurs within the mental realm is random. Instead, preceding physical and psychological events link to and determine all subsequent psychological experiences (Brenner, 1973).

If psychic determinism exists, that means there's an underlying psychological motivation or explanation for every emotion, thought, impulse, and behavior. If you oversleep, you're probably avoiding something or someone. If you party too hard, maybe you're expressing antagonism toward your parents' demands for responsible behavior. If you forget your professor's name, perhaps you're experiencing an unconscious aggressive impulse toward that professor. Or perhaps that professor reminds you, in some unconscious way, of someone you felt sexual feelings for and not recalling the name is one way to defend against your sexual impulses.

Freud referred to eros-related energy as **libido**. Thanatos or destructive energy was unnamed. Based on Freudian drive (dynamic) theory, every impulse has an origin, aim, object, and intensity. An impulse originates from some place in the body. For example, in very young children, most pleasure (or libidinal) impulses arise from the oral region. This is why young children put everything into their mouths. Their aim (or goal) is oral gratification.

If we stay with a small child example, the dynamic approach might look like this:

- *Origin of impulse*: baby experiences physical hunger sensations.
- *Aim of impulse*: get food! (gratification).
- *Object of impulse*: breast or bottle (caregiver).
- *Intensity of impulse*: strength of hunger sensation varies.

One of the easiest ways to understand the contemporary relevance of the dynamic approach is to think about it with the help of a case example.

As a baby and toddler, Katie was consistently deprived of food and repeatedly experienced hunger and distress. Often, she had to wail and cry very loudly and forcefully to have her oral needs for sustenance fulfilled. This pattern involved her (a) physical need for food, (b) impulse (and strategy) to obtain impulse gratification, and (c) eventual gratification. This pattern was repeated so many times that it became internalized. For Katie, it became an internal working model for how relationships and gratification patterns work around hunger and

food. An **internal working model** is a repetitive impulse–energy–relationship pattern that informs individuals about what to expect and how to react to the world.

When, at age 22, Katie arrives for psychotherapy, she's experiencing distress over the **repetition compulsion** of the pathological impulse–relationship cycle that's continuing to manifest itself in her life. Several of her hunger/food-related behaviors are causing problems in her new romantic relationship. Among other patterns, to avoid experiencing intense distress, Katie began hoarding food. Her food hoarding behavior is minor, but her emotional distress to having it interrupted is extreme. Given her current life situation, her response to lack of food availability constitutes an over-reaction; she recognizes this, but feels unable to break the pattern … and the pattern is causing conflict in her relationship. In psychoanalytic therapy, Katie comes to understand these patterns and their origins. She is then able to develop more positive coping responses.

The Topographic Approach

Freud described the topography of the mind:

> Let us … compare the system of the unconscious to a large entrance hall, in which the mental impulses jostle one another like separate individuals. Adjoining this entrance hall there is a second, narrower, room—a kind of drawing-room—in which consciousness, too, resides. But on the threshold between these two rooms a watchman performs his function: he examines the different mental impulses, acts as a censor, and will not admit them into the drawing-room if they displease him. (Freud, 1963, p. 295)

The psychoanalytic mind is divided into three interrelated regions: (a) the **unconscious** (the relatively large space where mental impulses outside of awareness are jostling one another); (b) the **preconscious** (where both consciousness and unconsciousness reside with the "watchman" sorting out unacceptable thoughts and tossing them back into the unconscious); and the (c) **conscious** (the narrow and relatively small drawing room where conscious thoughts reside). According to the theory, human consciousness constitutes only a small portion of this psychological topography; there's much more activity happening at the unconscious level than at the conscious level.

The main **purpose of psychoanalysis** is to make the unconscious conscious. Psychoanalysts help clients gain insight of unconscious impulses or maladaptive internal working models. By bringing these unconscious dynamics into awareness, clients are better able to manage them, because when existing outside awareness, primitive impulses can become indirect and destructive influences.

For example, if a young man has an unresolved Oedipus complex, he may become overly aggressive and competitive. His lack of awareness of the origin, aim, intensity, and object of these impulses allows for their escalation. As a consequence, one night while out with friends, he becomes belligerent toward a police officer (whom he unconsciously views as a substitute for his father) and ends up in jail. If the young man had received psychoanalytic therapy, he might recognize this pattern, manage his competitive and combative impulses, and avoid jail time. Note that, loosely associated with the Greek myth, the **Oedipus complex** involves a male child's sexual attraction and wish to possess or marry his mother. This conflict emerges at the phallic stage (see below) and is resolved when the boy identifies with his father (and the police officer). Freud thought that resolution of this conflict led to development of the superego. C. G. Jung postulated a similar dynamic involving female development, referring to it as the **Electra complex**.

The Developmental Stage Approach

Over the past decade, early brain development has been emphasized in the popular press and in the schools (Olson, 2014; Siegel & Bryson, 2015). For many, this emphasis seems like common sense, but in the early 1900s, the idea that adult functioning was shaped by early childhood experiences was groundbreaking. Freud was the first to outline an extensive developmental theory explaining how early childhood experiences influence later adult functioning.

Freud's **developmental stage approach** is a psychosexual developmental model; it involves an integration of psychological and sexual or sensual concepts. Each developmental stage focuses on a part of the body linked to gratification or pleasure.

- *Oral*: birth to 1 year old.
- *Anal*: 1 to 3 years old.
- *Phallic*: 3 to 5 or 6 years old.
- *Latency*: 5 or 6 to puberty.
- *Genital*: puberty to adulthood.

During the first five or six years of life, the drive for pleasure shifts from oral to anal to phallic regions of the body. How children get these needs met is both physical and interpersonal. Consequently, interpersonal patterns and emotions linked to need gratification in childhood eventually form the psychological foundation for later (adult) need gratification.

Progress through stages is driven by biological maturation—which forces individuals to confront demands inherent to each stage. At each stage, if parents are overly indulgent or withholding, children can end up with

fixations or complexes. A **fixation** or **complex** is an unresolved unconscious conflict (aka dysfunctional internal working model).

Some contemporary psychoanalysts remain interested in Freud's developmental stages, but others are not. Nevertheless, most contemporary developmental theories grew, in one way or another, from Freud's original theorizing. Overall, Freud's general premise that individuals have developmentally based dysfunctions that can be treated via analysis remains alive and well within psychoanalytic circles. Beyond Freud, contemporary analysts consider a variety of developmental theories when working with clients (Erikson, 1963; Loevinger, 1976; Mahler, Pine, & Bergman, 1975; Stern, 1985).

The Structural Approach

Freud's **structural approach** to human personality involves interrelationships among the id, ego, and superego. As discussed previously, powerful, unconscious forces flow through the body and mind. If not for the system's structural components, sexual and aggressive forces or drives would directly dictate human behavior. However, because these primal forces flow through the id, ego, and superego, humans can constructively manage their urges; we learn to wait, watch, and control ourselves.

The *id* is the seat of biological desire. As a structural entity within the person, it functions on the pleasure principle. Freud (1964) described the id as "a chaos, a cauldron full of seething excitations" (p. 73). The **pleasure principle** is an instinctive drive toward pleasure; it represents hedonistic impulses and the desire for immediate gratification.

Id impulses are primarily unconscious. However, it's possible to glimpse these impulses—as in cases when individuals seek immediate sexual or aggressive gratification. Additionally, we can view id impulses within ourselves via dreams, fantasies, and powerful pleasure-seeking urges. **Primary process thought**, another facet of id functioning, is characterized by hallucination-like images of fulfilled sexual or aggressive desires.

The id is mother of the ego. Constant gratification is impossible, so you must learn to wait for what you want. This is how the ego develops. The **ego** represents the individual's conscious decision-making processes; these processes steer behavior in more safe and adaptive directions. To accomplish this "steering," the ego has resources of its own. Ego functions include memory, problem-solving abilities, and logical thought. These functions are labelled **secondary thought processes** and help us cope with sexual and aggressive drives. The ego operates on the **reality principle**—the realities associated with the external world.

The **superego** develops when children resolve their Oedipus (or Electra) issues and begin identifying with same-sex parents and parental demands or expectations. There are two parts of the superego: there is the **conscience**. The conscience develops from parental prohibitions. When mom, dad, or caregiver says, "No!" or "Stop that!" or administers punishment, these admonitions are internalized within the child's psyche and later used as a means of self-punishment or prohibition. The conscience becomes an inner source of punishment.

The superego also includes the ego-ideal. In contrast to the negative, punishing conscience, the **ego-ideal** is positive, and consists of a desire to emulate adult standards or operate on moralistic standards. When parents model healthy and rational behaviors, children strive to behave similarly. Using the language of behavioral psychology, the conscience is the "stick" or punishment motivator, while the ego-ideal is the "carrot" or reinforcement motivator.

Overall, the ego acts as mediator within the human personality. It mediates and settles conflicts between and among (a) the id's primitive impulses, (b) admonitions and expectations of the superego, and (c) realities of the external world. This is no easy task; therefore the ego often uses defense mechanisms to deal with anxiety linked to internal battles among these intrapsychic forces.

Defense mechanisms are designed to ward off unpleasant anxiety feelings associated with internal conflicts among the id, superego, and reality. Defense mechanisms have four primary characteristics:

1. They are automatic: individuals use them reflexively.
2. They are unconscious.
3. They ward off unacceptable impulses.
4. They distort reality (to a greater or lesser extent, depending upon the defense mechanism employed).

From an applied perspective, most therapies are ego supportive; they help the ego—a rational and logical entity—deal more effectively with primitive desires, internalized parental and societal standards, and the real world. Eight common ego defense mechanisms are described in Table 2.1.

Psychopathology and Human Change

Psychoanalytic theorists view psychopathology as arising from early childhood experiences. Freud believed in a **normal–abnormal continuum**, with healthy individuals showing occasional signs of pathology. Miller (1983) summarized:

Table 2.1 Ego Defense Mechanisms

Defense mechanism descriptions and examples
Repression involves forgetting an emotionally painful memory. When clients repress a memory, there may be behavioral evidence that it exists, but there's genuine absence of recall: "Nope. I don't remember anything unusual about my childhood."
Denial is expressed more forcefully than repression. Shakespeare's famous line about protest[ing] too much captures its essence. Clients using denial might say, "No way, that's not true" and repeat their denial forcefully.
Projection occurs when clients push unacceptable thoughts, feelings, or impulses outward, onto another person. Clients may accuse another person of being angry, instead of owning their anger: "Why are you so angry?"
Reaction formation occurs if it's dangerous to directly express aggression, and so the opposite behavior (obsequiousness) is expressed instead. Instead of expressing sexual attraction, individuals might act disrespectfully toward whomever they're feeling attracted.
Displacement occurs when the aim of sexual or aggressive impulses is shifted from a dangerous person to a less dangerous person. Aggressive displacement involves the proverbial "kicking the dog." Sexual displacement occurs when sexual feelings toward a forbidden person are displaced on to a more acceptable person.
Rationalization occurs when clients use excessive explanations to justify their behavior. Students who make a hostile comment in class might overexplain and justify their comment.
Regression involves reverting to less sophisticated methods of doing things. Traumatized children may regress to wetting the bed or pooping their pants rather than using more advanced toileting skills. Adults who are skillful communicators may regress to shouting rather than logical argument.
Sublimation occurs when sexual or aggressive energy is channeled into positive loving or vocational activities. Sexual energy is thought to be sublimated into creative tasks and aggression into hard work (e.g., house cleaning, yard work).

Note: Several more defense mechanisms have been identified and described, including regression, dissociation, acting out, introjection, identification, compensation, and compartmentalization. Also, depending on the extent to which they distort reality, defense mechanisms may be more adaptive or more maladaptive.

> In an abnormal personality, psychological processes are exaggerated or distorted. A melancholic patient has an overly strong superego. A sadistic killer has a strong, uncontrolled aggressive drive. An amnesiac must repress all of a painful past. Yet every normal personality has traces of melancholia, sadism, and unaccountable forgetting. (p. 128)

Several key issues pertaining to psychopathology and human change have remained relatively constant in psychoanalytic theory and therapy. First, therapy focuses on psychopathology that arises from internalized, dysfunctional childhood experiences. Second, dysfunctional childhood experiences are not completely understood, recalled, or dealt with consciously. Consequently, repetitive maladaptive behavior and thinking patterns exist; changing these patterns can feel beyond the client's control. Third, a cornerstone of human change involves insight (a consciousness-raising experience). Fourth, human change isn't instantaneous; it requires a working-through process where practicing new ways of understanding and dealing with inner impulses and human relationships occurs.

EVOLUTION AND DEVELOPMENT IN PSYCHOANALYTIC THEORY AND PRACTICE

Despite Freud's charismatic appeal, two prominent members of his inner circle had deep conflicts with him. First, Alfred Adler stepped away (see Chapter 3) and later Carl Jung broke from Freud (see Putting It in Practice 2.1 and online at www.wiley.com/go/counselingtheories). Both Adler and Jung developed their own insight-oriented approaches to psychotherapy. This fragmentation of the psychoanalytic inner circle is part of what makes the evolution and development of psychoanalysis complex and multifaceted.

One way of understanding how psychoanalysis has evolved is to follow Pine's (1990) four stages of psychoanalytic theory development. Pine described the evolution of psychoanalytic thinking as a progression of focus from (a) drive to (b) ego to (c) object to (d) self.

Pine's first stage was drive theory. Drive theory is the foundation of Freudian psychoanalysis. Having covered that in the preceding sections, we now move on to an

PUTTING IT IN PRACTICE

2.1 The Former Heir Apparent: Carl Gustav Jung

Carl Gustav Jung was born in Kesswil, Switzerland, in 1875. He died in Zurich in 1961. At one point, Freud, Adler, and Jung were personally and intellectually close. Freud considered Jung to be his heir apparent, at least briefly, but this was before Jung began questioning Freud's ideas and formulating new concepts.

For instance, Jung redefined libido as creative life energy, rather than exclusively sexual energy. He also didn't view the unconscious as a bubbling cauldron of primitive impulses, but as a source of both peril and wisdom. Jung believed our psyches were self-regulating systems, seeking balance between opposing forces and impulses.

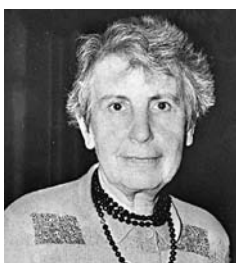
Jung divided the unconscious into the personal unconscious and the collective unconscious. The personal unconscious is unique to individuals and the collective unconscious is a shared pool of human inherited motives, urges, fears, and potentialities. Jung believed the collective unconscious was far larger than the personal unconscious and that it was universally shared by all members of the human race.

Although Jungian therapy and analysis are less common, some of Jung's concepts have become part of our modern lexicon. Many people speak of archetypes, complexes, shadows, and collective knowing.

Jung also believed that certain mental functions and attitudes organize our personalities and determine how we habitually or preferentially orient to the world. Along with the attitudes of introversion and extraversion, Jung identified four functions: the perceptional functions, sensation or intuition, and the rational functions, thinking or feeling. These concepts were used in developing the Myers–Briggs Type Indicator (Myers, 1995), a popular psychological questionnaire.

Many Jungian ideas are widely known, but perhaps not fully appreciated nor understood as Jung intended. This short box cannot do justice to Jung's ideas or their potential applications. We encourage you to read our online Jungian chapter to further expand your understanding of this important early figure (url: www.wiley.com/go/sommers-flanagan/theories3e).

early psychoanalytic innovator—who also happened to be named Freud. This is the story of Anna Freud (Sigmund's youngest daughter) and her influence on ego psychology.



Anna Freud
(photo reproduced under CC BY-SA 3.0 NL)

Anna and the Ego: Psychoanalytic Ego Psychology

Sigmund Freud controlled psychoanalytic theory and psychoanalysis. Part of his control included the insistence that his disciples submit to a course of psychoanalysis by the master. During this time, there were no state licensing boards or professional ethics codes. Thus, Freud was able to take what we would now consider a most unusual and unethical step of accepting his youngest daughter, Anna, into analysis. As Bankart (1997) wrote, Anna was barely out of her teens when she began analysis, and "From those days until the end of her life, Anna had room for only one man in her life, and that man was her father" (p. 183).

Anna was one of the few practicing psychoanalysts without an official professional degree. Essentially, she was "home schooled" with an experiential apprentice approach.

Anna Freud ushered in a new generation of psychoanalysis. As you may recall, Sigmund Freud based his theoretical propositions about child development on his intensive study of adults through psychoanalysis. In contrast, Anna Freud studied children directly. She listened as children shared their dreams and fantasies. Perhaps more importantly, she discovered how to observe children's unconscious mental processes through play. Although she never directly disputed her father's belief in the dominance of id impulses in human development and functioning, she helped shift the psychoanalytic focus from the study of instinctual drives to **ego psychology**—the study of ego development and function.

Beginning in about the 1930s, ego psychology began claiming a portion of the psychoanalytic landscape. These theorists didn't completely break with Freud; rather, following Anna Freud's lead, they extended his ideas, emphasizing that certain ego functions were inborn and autonomous of biological drives (Hartmann, 1958; Loevinger, 1976; Rapaport, 1951). These ego functions included memory, thinking, intelligence, and motor control. As Wolitzky and Eagle (1997) wrote, "Following … ego psychology, there was now room in psychoanalytic theory for behavior and functions relatively autonomous of the vicissitudes of drive" (p. 44). The greater emphasis on ego functioning as separate from id impulses brought the interpretation of ego defenses to the forefront.

The new focus on ego had ramifications for both psychoanalytic theory and practice. A profound development during this period came from one of Anna Freud's analysands and followers, Erik Erikson.

Like Anna Freud, Erikson had little formal academic training. Nonetheless, he outlined and described a highly regarded theory of human development. In his **eight-stage epigenetic psychosocial theory of development**, Erikson (1963) deviated from Freudian developmental theory in two key ways: he emphasized psychosocial development instead of psychosexual development and he emphasized the continuous nature of development into old age, rather than ending his theorizing in early adulthood. Erikson's eight stages of development are summarized in most introductory and developmental psychology textbooks. For a glimpse into the ever-evolving nature of developmental theories, we recommend Joan Erikson's (Erik's wife) video on the ninth stage of human development (F. Davidson, 1995).

Object Relations

In the 1950s, object relations theorists began conceptually reformulating Freudian psychoanalytic theory. Whereas traditional Freudian theory focused primarily on parent–child dynamics during the Oedipus crisis, **object relations theory** focuses on the dynamics and motivation captured within the context of earlier parent–child relationships. These dynamics are referred to as pre-oedipal. Keep in mind that *objects* are not things; they are internalized versions of people.

The most profound object relations shift in psychoanalytic thinking is captured by Fairbairn's (1952) famous statement:

> Libido is object seeking, not pleasure seeking. (p. 82)

Fairbairn was emphasizing that human behavior is not fueled by instinctual (libidinal) drives for sexual and aggressive gratification; instead, behavior is influenced and motivated by desire for human connection. Wolitzky and Eagle (1997) wrote, "In contrast to Freud's psychic world which is populated by unconscious wishes and defenses against those wishes, Fairbairn's psychic world is populated by internalized objects and internalized object relations" (p. 56).

Object relations theorists believe that humans mentally internalize a representation of self and a representation of early caretaker figures (Scharff & Scharff, 2005). These self and other representations are carried within the individual into adulthood. If early childhood interpersonal relationships included trauma or repeating destructive patterns, remnants of these early self-other relationship patterns can dominate contemporary relationships. A major goal of object relations therapy is to "exorcise" the old maladaptive internalized representations and "replace the 'bad object' with a 'good object'" (Fairbairn, 1952; Wolitzky & Eagle, 1997, p. 59). This process is similar to Alexander and French's (1946) concept of the **corrective emotional experience**, which was defined as: "Re-exposing clients, under more favorable circumstances, to emotional situations which" they couldn't "handle in the past" (p. 66). Therapists act as good objects and through this experience clients can replace their original bad internalized objects.

The focus of interpretive work in object relations therapy is different from traditional Freudian analysis. In particular, whereas Freudian analysis focused on Oedipal conflicts and sexual and aggressive wishes and drives, object relations therapy focuses on relationship wishes and pre-Oedipal interpersonal dynamics as played out in the regressive analytic situation. As a "good object," the therapist makes efforts to respond empathically to client struggles (Horner, 1998).

Self-Psychology

Pine's (1990) fourth phase of psychoanalytic evolution centers on Heinz Kohut's (1971, 1977, 1984) writings. In contrast to the preceding theoretical perspectives, Kohut considered needs for self-cohesiveness and self-esteem to be the overarching motivations that fuel human behavior. His **self-psychology** focused not on instincts, ego, or even object relations, but instead on the development of healthy narcissism within individuals.

Kohut also focused on self-defects and the noncohesive self. He believed self-defects and noncohesion stemmed from early childhood experiences. In particular, he emphasized that the development of a "cohesive self requires the parental provision of empathic mirroring and the later availability of a parental figure permitting idealization" (Wolitzky & Eagle, 1997, p. 67). In contrast to his psychoanalytic predecessors, Kohut's approach emphasized psychoanalyst empathy and authenticity in therapy relationships.