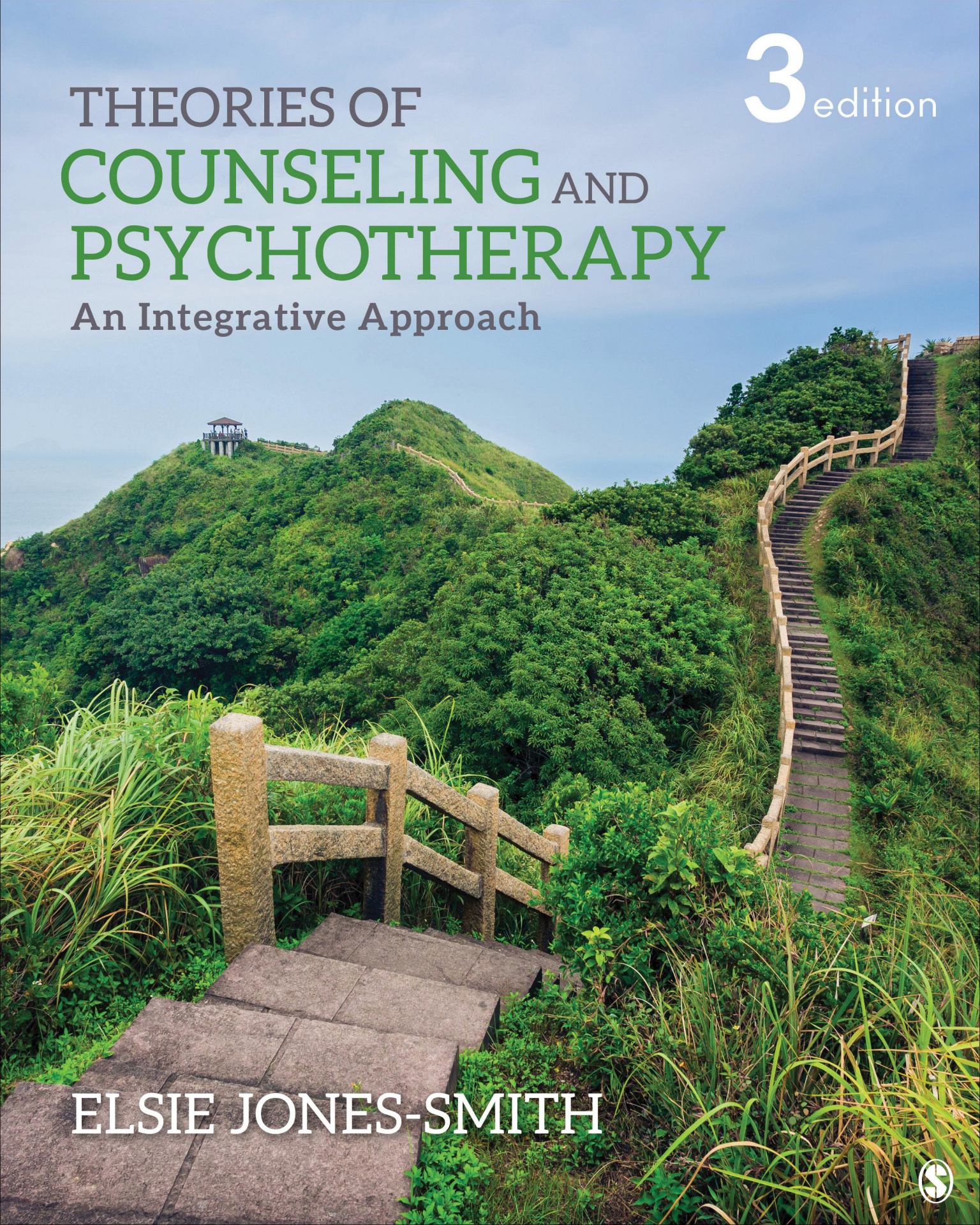
THEORIES OF COUNSELING AND PSYCHOTHERAPY

3 edition

An Integrative Approach



ELSIE JONES-SMITH

Theories of Counseling and Psychotherapy

Third Edition

To Elijah John Jones

This book is dedicated to my loving brother, Elijah, who has enriched my life so much with his deep insightfulness, support, and guidance along the many pathways of my life. I will be forever grateful that God placed you in my life to light my way and to give me so much love. Every time I begin to count the ways that I love you, my list grows longer and longer.

Theories of Counseling and Psychotherapy

An Integrative Approach

Third Edition

Elsie Jones-Smith

Diplomate in Counseling Psychology,
American Board of Professional Psychology

SAGE

Los Angeles | London | New Delhi
Singapore | Washington DC | Melbourne

FOR INFORMATION:

SAGE Publications, Inc.
2455 Teller Road
Thousand Oaks, California 91320
E-mail: order@sagepub.com

SAGE Publications Ltd.
1 Oliver's Yard
55 City Road
London EC1Y 1SP
United Kingdom

SAGE Publications India Pvt. Ltd.
B 1/I 1 Mohan Cooperative Industrial Area
Mathura Road, New Delhi 110 044
India

SAGE Publications Asia-Pacific Pte Ltd
18 Cross Street #10-10/11/12
China Square Central
Singapore 048423

Printed in the United States of America

ISBN: 978-1-5443-8455-9

Acquisitions Editor: Abbie Rickard
Editorial Assistant: Elizabeth Cruz
Production Editor: Andrew Olson
Copy Editor: Megan Markanich
Typesetter: C&M Digitals (P) Ltd.
Proofreader: Heather Kerrigan
Indexer: Marilyn Anderson
Cover Designer: Karine Hovsepian
Marketing Manager: Katherine Hepburn

This book is printed on acid-free paper.

20 21 22 23 24 10 9 8 7 6 5 4 3 2 1

Brief Contents

Sara Miller McCune founded SAGE Publishing in 1965 to support the dissemination of usable knowledge and educate a global community. SAGE publishes more than 1000 journals and over 600 new books each year, spanning a wide range of subject areas. Our growing selection of library products includes archives, data, case studies and video. SAGE remains majority owned by our founder and after her lifetime will become owned by a charitable trust that secures the company's continued independence.

Los Angeles | London | New Delhi | Singapore | Washington DC | Melbourne

Detailed Contents

Preface

The third edition of *Theories of Counseling and Psychotherapy: An Integrative Approach* is designed for undergraduate and master level students in psychology, counselor education, the mental health professions, and human service programs. This book reflects my commitment to provide a comprehensive overview of past and current approaches to psychotherapy and counseling. It distinguishes itself from other books in that it has adopted a more contemporary approach to theories of psychotherapy. Professors and students have said that they liked the fact that my theory book reviews material that others do not cover and that they appreciated the emphasis on neuroscience as the "fifth wave of therapy."

In this third edition, a concerted effort has been made to retain the major positive qualities that students and professors mentioned they liked or found useful, such as good coverage of the theories, the comprehensive nature of the book, the manner in which the book conceptualizes psychotherapy in terms of "forces within counseling and psychology," and the way it integrates the various therapy models and views them as a whole. In keeping with students' requests that additional contemporary approaches to psychotherapy are included, I have updated developments related to neuroscience to include such areas as interpersonal psychotherapy, emotion-focused therapy, interpersonal neurobiology, neurocounseling, and trauma-informed counseling.

Even though I have included new discussions of additional contemporary psychotherapy approaches, the third edition has become more streamlined than the second edition—primarily because I eliminated some of the tables previously included and placed them on the student website. For instance, Chapter 1 now contains a more in-depth discussion of the importance of counselor values, and a new section has been added on ethical codes and the relationship of such codes to counselor competency in integrating theories of psychotherapy. Moreover, throughout the book, references and studies have been updated to reflect the latest developments within the helping professions.

Goals of the Third Edition

The goals of the third edition of *Theories* remain very similar to those expressed in the second edition. The *overarching goal* is to help you learn the basics of major psychotherapy approaches and to assist you in applying such theories in counseling practice.

A *second goal* of this book is to help you to construct your own integrated approach to psychotherapy (Norcross & Goldfried, 2005; Wampold & Imel, 2015; Zarbo, Tasca, Cattafi, & Compare, 2016). Research studies have established clearly that few psychotherapists and counselors have adopted a single theoretical approach to therapy (Tasca et al., 2015). I take the position that effective therapists need to become familiar with and skilled in the conceptual frameworks, techniques, and knowledge base of multiple theories if they are to help diverse clients from different backgrounds who have various presenting issues. It is important for therapists to develop a broad range of therapeutic expertise to meet the needs of a culturally diverse clientele.

In each chapter of this book, I ask you to consider what, if any, parts of the theory presented would you consider integrating into your own psychotherapy frameworks. Moreover, to arrive at a carefully thought-out integrative theory of your own, you are encouraged to consider what you subscribe to from the various theories, including identifying your views of human nature as well as your beliefs about what brings about behavioral change in people who are hurting, in distress, or dissatisfied with some aspect of their lives. Formulating an integrative theory of therapy is a journey that each therapist has to take for himself or herself. Moreover, your integrated theory will change over time, depending on what you find helps people make meaningful changes in their lives.

A *third goal* is to depart from the traditional therapy theory texts by presenting a framework for integrating theories of psychotherapy. In the third edition of *Theories*, I modify Brooks-Harris's model by adding five other dimensions, including spiritual, relational, strengths (internal and external), evidence-based

research, and the change process. Moreover, I offer for research and practice considerations a new neuroscience framework that John Arden (2015) has proposed in his book *Brain 2Brain: Enacting Client Change Through the Persuasive Power of Neuroscience.* Arden (2015), a well-known, eminent neuropsychologist, has postulated that neuroscience will become the framework for all psychotherapies, and that theoretical approaches such as cognitive behavioral therapy (CBT), dialectical behavior therapy (DBT), and eye movement desensitization and reprocessing (EMDR) will be used primarily for their techniques. Arden contends that the 20th century was essentially a "brainless psychology" that focused on specific psychotherapy orientations. He maintains that psychotherapy in the 21st century will be brain-based, with a focus on common factors (essentially Carl Rogers's theory of therapeutic alliance), attachment, memory systems, and research tools such as fMRI and positron emission tomography (PET). Brain-based therapy deals with how the brain works, and it uses common methods from a broad range of theoretical perspectives. Arden said the following:

> The changes happening in the 21st century will dissolve the separate schools of psychotherapy and their special languages accessed only by members. The alphabet soup of special clubs—CBT, ACT, PT, DBT, EMDR, EFT, RET, and so on—needs to be discarded in favor of one model. (Arden, 2015, p. xv)

Despite the third edition's embrace of neuroscience as the fifth force in counseling and psychotherapy, I do not advocate adopting a neuroscience framework or any particular framework—except for an integrative one for therapy. Time will tell if Arden is correct in his new brain-based framework for integrating theories of psychotherapy. Suffice it to say that the new research in neuroscience has shown what brain systems are over- or underactivated in individuals' experiencing of a broad range of disorders (Arden, 2015). Researchers are now considering the relevance of neuroscience on a broad range of disorders. For instance, research is now being conducted on developing a neuroscience framework for addiction diagnosis that capitalizes on the burgeoning knowledge of the neurobiological origins of addiction (Kwako, Momenan, Litten, Koob, & Goldman, 2016). In addition, researchers are now beginning to unravel the neural and genetic components involved in the development of socioemotional functioning and psychopathology (Wiggins & Monk, 2013).

For those counselors who do not claim science and research as their strengths, the chapter on neuroscience might be challenging and may seem irrelevant to everyday therapy or counseling. I can understand such a position. When I initially began to learn about neuroscience, I questioned its relevance to psychotherapy practice. Yet, the purpose of this book is not to develop neuroscience savvy practitioners but rather to provide everyday counselors and therapists with guidelines and ideas about how to become neuroscience-informed counselors—not neuroscience experts in the field. I believe strongly that once you have learned about how the brain functions to produce emotional health or psychopathology, you will not want to go back to earlier days when you did not take into consideration the origins of psychological disorders. Being a neuroscience-informed counselor now means that when you see an out-of-control, angry and shouting client, your first instinct might be to help the client get his or her amygdala under control instead of trying to explain how such anger is linked to what his or her mother did. Such a psychodynamic explanation might come later.

Neuroscience is not a passing phase. Brain-based therapy is here to stay, as evidenced by the fact that the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) Standards address neuroscience, traumatic events, the neurobiology of addiction, and psychopharmacology. It is predicted that in the coming years, the average therapist and counseling student will become conversant with such terms as neuroplasticity, neurogenesis, prefrontal cortex, habit formulation, default mode, and nutritional neuroscience.

Moreover, most textbooks on counseling theories omit spiritual approaches to counseling (Plante, 2009). Therefore, a *fourth goal* of this book is to deal with some of the spiritual approaches to psychotherapy. I examine issues surrounding spirituality and the therapeutic process. Rather than teach therapists a formalized theory of spirituality and therapy, this chapter deals with such issues as assessment and spirituality, consultation with religious professionals, and best practices in spiritual approaches to therapy.

A *fifth goal* is to infuse multicultural concepts throughout the book. I examine each psychotherapy approach under consideration in terms of multicultural issues. The chapters focus not only on Western multicultural approaches to psychotherapy but also on Eastern approaches. For instance, I include Naikan therapy, Morita therapy, mindfulness therapy, Arab Muslim approaches to psychotherapy, and one African

approach to psychotherapy (Ma'at). Although many counseling theory texts examine the traditional psychotherapy theories from a multicultural perspective, few deal with multicultural theories, and still fewer present Eastern approaches to psychotherapy.

A *sixth goal* is to present a case study throughout the book that deals with issues that reflect some of the dilemmas of present-day America. Most counseling theory textbooks present case studies dealing with adults. However, increasingly, the typical client seen at agencies is a youth who has been referred to counseling by the courts or by a school guidance counselor or a school social worker. Throughout the book, I present the case study of Justin, a 12-year-old boy of mixed parental heritage (mother, White; father, African American) who has moved from the inner city of Chicago to Utah to escape the gangs. Justin is very real and so are the issues that he faces in living with a single mother in a school struggling to deal with multicultural conflicts and situations. The case study is presented in each chapter so that it is viewed from each of the major theoretical perspectives discussed within this text.

This book represents a step forward from the traditional text on counseling theories. I've made a concerted effort to bridge the traditional approaches to psychotherapy with the newer approaches—to make the study of counseling theories more than just the study of what was and has been but also the study of what is current and relevant—from solution-focused therapy, narrative therapy, and strengths-based therapy, to neuroscience and neuropsychotherapy, to name just a few. I also endeavor to engage the reader in making a critical analysis of the theories that are studied in most graduate-level school programs with neuroscience, which is not taught in most counseling and social work graduate programs of study. This is the first counseling theory book that presents an entire chapter on neuroscience and neuropsychotherapy—the fifth major paradigm shift in psychotherapy and counseling. Neuroscience developments hold the possibility of revolutionizing many of the major theories of psychotherapy. Students will be introduced to some of the outstanding developments in neuroscience, including new psychotherapy approaches based heavily on neuroscience, such as interpersonal neurobiology as developed by Daniel Siegel (2010). They will be introduced to the concept that counseling and psychotherapy build new brain networks in their clients (the concept of neuroplasticity), that therapists and counselors can influence their clients through the practice of engaging mirror neurons, that therapy is primarily a process of right brain to right brain engagement, and that a client's attachment history has a significant influence on his or her brain development as well as his or her mind development. The chapter on neuroscience is truly an exciting and informative chapter.

New to the Third Edition

The book groups theories of psychotherapy under the headings of five major forces in psychology and in psychotherapy: the first force, which includes psychoanalytic and psychodynamic theories; the second force, which contains behavior and cognitive therapy theories; the third force, which includes existential–humanistic theories; the fourth force, which includes social constructivist, postmodern, and integrative approaches to therapy; and the fifth force, which includes neuroscience and psychopharmacology (which is not included in this book). This introductory chapter presents a number of definitions and concepts and it proposes questions that will help guide students in forming their own integrative focuses.

Part I of the book, "The First Force in Psychotherapy: Psychoanalysis and Psychodynamic Theories" contains Chapters 2 and 3. Chapter 2 discusses the theoretical contributions of Sigmund Freud, Carl Jung, Anna Freud, Erik Erikson, and Donald Winnicott (object relations and the good-enough mother) and self psychologists (Heinz Kohut—the narcissistic personality). Chapter 3 explores the contributions of Alfred Adler, an individual who has had a profound influence on psychology; many of his ideas have been incorporated into other theoretical approaches such as solution-focused brief therapy. Recent Delphi polls by therapy experts have suggested that this theoretical approach will continue to see a decline in theory adoption by therapists (Norcross, Pfund, & Prochaska, 2013).

Part II, "The Second Force in Psychotherapy: Behavior Therapy and Cognitive Therapy" includes Chapters 4, 5, and 6. Chapter 4 presents in detail the contributions of John Watson, B. F. Skinner, and Joseph Wolpe. The chapter on behavior therapy has been reduced so that tables related to psychopharmacology have now been placed on the student website. The chapter was simply too long. Because the behavioral movement has now merged with the cognitive approach to psychotherapy, two chapters are devoted to the cognitive movement in psychology. Chapter 5 discusses Albert Ellis's rational emotive behavior therapy (REBT) and Aaron Beck's cognitive therapy. Also covered in this chapter is Albert Bandura, who did not

provide a theory of therapy but whose research findings on observational learning and self-efficacy were so great that they influenced theorists who did develop a specific approach to therapy.

The third edition provides a rather sizable section on what is being called the third-wave CBTs—those cognitive behavioral theoretical approaches that have incorporated Eastern perspectives and mindfulness. Three new cognitive behavioral approaches to psychotherapy are presented in Chapter 5, and these include DBT, acceptance and commitment therapy (ACT), and mindfulness-based cognitive therapy (MBCT). Chapter 5 shows the development of the cognitive school of psychotherapy—from the second-wave approaches of Ellis and Beck to the third-wave theories of Marsha Linehan and Steven C. Hayes. Chapter 6 focuses on William Glasser's reality therapy, a theoretical approach that the recent Delphi poll predicted will continue to decline in the year 2022 (Norcross et al., 2013).

Part III, "The Third Force in Psychotherapy: Existential and Humanistic Theories" contains Chapters 7, 8, 9, 10, and 11. Chapter 7 presents the existential–humanistic theories of Rollo May and Viktor Frankl. Chapter 8 provides in-depth coverage of Carl Rogers and his contribution of client-centered or person-centered therapy. Chapter 8 is changed in the third edition to include small sections on interpersonal psychotherapy and emotion-focused therapy. For the most part, Chapter 9, which features Fritz Perls and Gestalt therapy, remains the same. Chapter 10 on William R. Miller and Stephen Rollnick's motivational interviewing has been modified to include Miller and Rollnick's latest revisions of their theory (Miller & Rollnick, 2013). Miller is placed in the humanistic third force section because he told me personally that he belonged in that section and because his theory is based partly on the work of Carl Rogers. Chapter 11 on expressive arts therapies includes art therapy, music therapy, and drama and play therapy. The section on drama and play therapy is revised and updated with new research studies.

Part IV, "The Fourth Force in Psychotherapy: Social Constructivism and Postmodernism," is conceptualized as the "postmodern and social constructivist movement." Others have termed the *fourth force* as the multicultural movement; however, I maintain that multiculturalism is subsumed under the heading of social constructivist. Although multiculturalism is not conceptualized as the fourth force, its influence on psychology has been profound and widespread.

Part IV is the longest and most varied part of the book. Chapters 12, 13, and 14 constitute a trilogy that deals specifically with multiculturalism. This section of my book is highly responsive to the CACREP (2016) Standards and the need to include cultural diversity across the broad spectrum of counseling and psychology courses. The current CACREP Standards for counseling accreditation place a great emphasis on the value of cultural diversity. The CACREP requirement for including cultural diversity issues in a textbook on theories of counseling and psychotherapy is included under Section 2: Professional Counseling Identity and more specifically under the section on Counseling Curriculum 2, Social and Cultural Diversity. More specifically, the CACREP Standards highlight the importance of having a curriculum (and presumably textbooks) that modify or take into account "(b) theories and models of multicultural counseling, cultural identity development, and social justice and advocacy; (c) multicultural counseling competencies; (d) the impact of heritage, attitudes, beliefs, understandings, and acculturative experiences on an individual's views of others; and (g) the impact of spiritual beliefs on clients' and counselors' worldviews." The third edition of *Theories* continues its strong emphasis on cultural diversity by retaining the three chapters mentioned above and by including a section on cultural positives and cultural blindspots for each major psychotherapy presented.

In using this text, instructors will find that they no longer have to supplement their presentations with outside material on cultural diversity. In addition, Chapter 12 contains the new multicultural competencies from the American Psychological Association (APA, 2017), and it discusses the Cultural Formulation Interview (American Psychiatric Association, 2013) as a framework for counseling culturally diverse individuals.

Chapter 13, titled "Transcultural and International Approaches to Counseling and Psychotherapy: Bridges to Asia, Africa, and the Middle East," examines the international contribution to cultural diversity in psychotherapy. This chapter contains a description of Naikan therapy and Morita therapy—two Japanese approaches. The chapter also reviews mindfulness, which is the Chinese approach to psychotherapy. Currently, mindfulness has been integrated with a number of theoretical approaches to psychotherapy, including CBT, dialectical therapy, and so on. Within the past few years, more than 40 books have been written on mindfulness, integrating it with other theories. The chapter also presents Arab Muslim views on psychotherapy. Typically, even though this population numbers about 1.5 billion strong throughout the world, it is excluded from most counseling theory textbooks. The Arab Muslim view of

psychotherapy should be presented along with the contributions of Japanese and Chinese.

The trilogy on multiculturalism is rounded out with Chapter 14 on feminist therapy and lesbian and gay therapy. This textbook explores such critical issues as gay and lesbian identity development, issues related to coming out, and therapist bias and heterosexism.

The book next navigates to include spiritual therapy. Chapter 15 is titled "Integrating Spiritual or Religious Issues During Psychotherapy." Again, the inclusion of a separate chapter on spirituality and psychotherapy in a counseling theory book is a major milestone. An important theme of this chapter is taken from Steven Covey: "We are not human beings on a spiritual journey. We are spiritual beings on a human journey." In keeping with the theme of psychotherapy integration, this chapter explores how a therapist might integrate spiritual issues into therapy. There's a brief section on "listening for clients' spiritual language." The chapter also provides a section on clinical assessment and questions to bring forth clients' spiritual life: (1) questions designed to evoke clients' past spirituality, (2) questions designed to elicit clients' present or current spirituality, and (3) questions related to clients' future spirituality. In addition, the chapter presents a client intake form that focuses on clients' spirituality.

Next, this section moves to some of the newer social constructivist theories. Except for reference updating and minor revisions, these chapters remain basically the same. Chapter 16 reviews solution-focused therapy and the contributions primarily of Insoo Kim Berg and her husband, Steve de Shazer. Chapter 17 focuses on narrative therapy and the major theoretical offerings of Michael White and David Epston. These theorists maintain that throughout our lives we construct stories about our lives, about who we are and where we either are going or not going. A therapist listens to our stories and helps us rewrite and renarrate them so that we can live more fulfilling lives.

Chapter 18 is devoted to my theory of strengths-based therapy, which is revised to include new research on neuroscience and new strengths-based counseling techniques, such as strengths talk and developing a strengths-based narrative with clients. Strengths-based therapy is an integrative approach that can be traced to several theories, including research on brain development and strength, needs theory, and logotherapy. Chapter 18 offers new practical strengths-based steps and exercises a therapist might use in working with clients.

Chapter 19 deals with several theories from family therapy—the theoretical approaches of Murray Bowen and Bowenian family therapy, Virginia Satir and Carl Whitaker (experiential family therapists), and Salvador Minuchin and structural family therapy.

Part V, "The Fifth Force in Psychotherapy: Neuroscience and Theories of Psychotherapy," is made up of Chapters 20 and 21. During the past several decades, an explosion of knowledge has been witnessed in the field of neuroscience (Cozolino, 2010; Fine & Sung, 2014; Goss, 2016; Russell-Chapin, 2016). Chapter 20 examines the latest developments in neuroscience and neuropsychotherapy. The book's introduction to the fifth force in psychotherapy has been revised to take into consideration the many developments that have taken place in neuroscience. In place of discussing six criteria for arriving at the conclusion that neuroscience is a new major force, I now outline developments within psychology, psychiatry, and counseling that indicate neuroscience has arrived indisputably as the fifth force of psychotherapy.

Neuroscience has changed our knowledge about the human brain, mind, nervous system, and psychotherapy. I maintain that the developments in neuroscience as they relate to psychotherapy are revolutionary and that neuroscience changes the current cognitive behavioral paradigm in psychology and psychotherapy such that it creates a fifth force. Neuroscience is helping scientists and practitioners to understand the human attachment and motivational systems. Neuroscientists assert that human emotions and motivations develop from distinct systems of neural activity. Why should knowing and learning neuroscience matter to psychologists and helping professionals? According to Cozolino (2010),

> On a practical level, adding a neuroscientific perspective to our clinical thinking allows us to talk with clients about the shortcomings of our brains instead of the problems with theirs. The truth appears to be that many human struggles, from phobias to obesity, are consequences of brain evolution and not deficiencies of character. (p. 356)

The integration of neuroscience into counseling practice has become an important emerging trend in the mental health field (Beeson & Field, 2017). During 2014, *The Journal of Counseling Psychology* published a special issue on neuroscience, with a total of seven articles on such topics as "Neurosciences of Infant Mental Health Development" (Sampaio, 2014) and the "Neuroscience of Child and Adolescent Health Development" (Fine & Sung, 2014). In April 2016, the

Journal of Mental Health Counseling published a special issue on neurocounseling that contained six articles that demonstrated how neuroscience concepts could be incorporated into counseling practice. Writing the lead article, Lori A. Russell-Chapin (2016) defined neurocounseling as "the integration of neuroscience into the practice of counseling by teaching and illustrating the physiological underpinnings of our many mental health concerns" (p. 93). Russell-Chapin emphasized the significance of providing clients with psychoeducation regarding the relationship between their brain and body. According to her, dysregulation between the brain and body may result in physical and mental health problems.

In the third edition of *Theories*, Chapter 20 has been revised to include sections on Siegel's (2010) framework for interpersonal neurobiology, Arden's (2015) neuroscience framework for integrating counseling or psychotherapy theories, and recent articles and research in neurocounseling as well as a brief overview of anxiety disorders, depression, and obsession disorders from a neuroscientific perspective. In the past, these disorders have been addressed primarily from the framework of intrapsychic or interpersonal issues and rarely from the perspective of brain functioning.

The third edition has condensed former Chapters 21 and Chapter 22 into one chapter, "Integrative Psychotherapy: Constructing Your Own Integrative Approach to Therapy," which is now Chapter 21. I combined the chapters because I wanted to provide both a means for students to compare each of the theories for possible integration and to present frameworks for doing so. The chapter reviews all the theories using a consistent set of dimensions, such as worldview, key concepts, goals of therapy, role of the therapist, and techniques of therapy. This chapter is, however, much more than just a comparison of key points among the counseling theories. This chapter includes a section that provides a multicultural conceptualization framework for clients that is based on the theories examined throughout the book.

Chapter 21 offers a wealth of information and a new approach to theoretical integration. After tracing psychology's emphasis on a single approach to psychotherapy, I direct the readers' attention toward psychotherapy integration. After reading this chapter, students will be able to construct their own integrative approach to psychotherapy, using the framework they desire.

Because I have chosen to discuss each of the theories in terms of the forces that they represent, the order of the chapters here is not the same as one finds in typical textbooks on theories of psychotherapy. Most such textbooks present the existential and humanistic school right after the psychoanalytic and psychodynamic theories. The world was talking first about B. F. Skinner and then about Carl Rogers. Clearly, the behavioral school had developed approaches to therapy long before the existential–humanist theorists had made their mark on the world. Therefore, this book presents the cognitive behavioral school immediately following the psychoanalytic and psychodynamic schools. I hope that my presentation of the theories will motivate people to discuss theories in terms of the forces that they represent in psychotherapy. And in presenting some of the more recent theories of psychotherapy, I hope to make my psychotherapy text more relevant to the lives of people living in the 21st century.

Acknowledgments

In writing this third edition of *Theories of Counseling and Psychotherapy: An Integrative Approach*, I wish to acknowledge and to thank the many professors who have adopted this textbook. Your insightful comments about new theoretical approaches and revisions to this text have been extremely helpful and encouraging for me. Many of you indicated that you wanted to have new theories reviewed, including interpersonal psychotherapy and emotion-focused therapy. The third edition includes these newer theoretical approaches because I believe strongly that a textbook on counseling theories should do more than just present a historical review of the major counseling theories that were created decades ago. We must go forward. Just as life is forever changing, our theories of counseling and psychotherapy are also evolving.

The suggestions and recommendations of professors and students have improved greatly this third edition of *Theories*. For instance, professors who adopted this text recommended that I continue the focus on neuroscience and that I update it with sections on interpersonal neurobiology, neurocounseling, and trauma-focused counseling. These new sections have also been included to expand our thinking about how neuroscience might be used to help counselors and therapists better serve their clients. It is simply amazing to realize that few of our theories have even taken into account the role of a person's brain in creating, sustaining, and maintaining his or her problems. Most of our theories have dealt with the role of the mind in developing the problems that bring people to therapy. Yet, few have even conceptualized or mentioned the well-traveled neural pathways of the brain that play a role in feelings of low self-esteem, anxiety, and depression.

I also want to thank the students who indicated that they used my text to study successfully for their licensing examinations in counseling, psychology, and marriage and family therapy. Others told me that they appreciated the intimate detail that I provided on the theorists, their struggles, and their construction of their counseling and psychotherapy approaches. Thanks for the encouragement and confirmation that spending those long hours researching the background of the theorists was well worth it. Students' comments and recommendations led me to revise the section on cultural diversity in counseling theories, and therefore, one will find new multicultural approaches from India and Africa are included in this third edition of *Theories*.

My deepest appreciation also goes out to SAGE for their decision to publish a third edition of my book. Abbie Rickard deserves my deepest gratitude and heartfelt appreciation. Thanks are also extended to Andrew Olson, Elizabeth Cruz, and the reviewers:

Lesley L. Casarez, Angelo State University

Danica Harris, Texas Woman's University

Pamela Danker, Blackburn College

Lynn Boyd, Troy University

Finally, I wish to thank my brother Elijah Jones, who gently confronted me with the fact that although I was saying that I wanted to write a book on theories of counseling and psychotherapy, I was spending my time doing other things. He helped me to close the gap between what I was saying I wanted to achieve and what I was actually doing with my life. I shall ever be grateful to you, Eli, for helping me to face my truths, and that is why I have dedicated this book solely to you.

I hope that the readers of this book should be so lucky to have an Eli in your life who will be truthful with you, even when the truth might feel like a thorn gently pricking your finger from touching a beautiful rose. I also hope that this book helps you to find your own truths about who you are and how you want to work with people during counseling and psychotherapy. Life is not easy, but it is sure worth living. Each one of us has to be determined to construct our own rose garden and in doing so, be willing to take the risks of pricking your finger as you prune off those dried flowers that at one time blossomed beautifully and played an important role in your life.

About the Author

Elsie Jones-Smith is a licensed psychologist, a certified school psychologist, and the president of the Strengths-Based Institute. She holds two PhD degrees, one in clinical psychology from Michigan State University and the other in counselor education from the University at Buffalo. She is a fellow in two divisions of the American Psychological Association (APA), Division 17, the Society of Counseling Psychology, and Division 45, the Society for the Psychological Study of Culture, Ethnicity, and Race. She is a diplomate in counseling psychology (American Board of Professional Psychology, or ABPP), a fellow of the Academy of Counseling Psychology, and a prior Distinguished Visitor for the APA.

Dr. Jones-Smith has extensive experience in strengths-based therapy, graduate level teaching, program evaluation (Head Start, Title –Chapter 1), tests construction, and psychological consultation with schools. Her clinical orientation is strengths based. She has currently expanded her clinical work to include cultural neuroscience.

She is the author of six books, including the recently published *Culturally Diverse Counseling: Theories and Practice* (SAGE, 2019); second edition of *Theories of Counseling and Psychotherapy: An Integrative Approach* (SAGE, 2016), which presents a chapter on neuroscience and describes it as the fifth force in psychology); *Spotlighting the Strengths of Every Single Student: Why U.S. Schools Need a New, Strengths-Based Approach* (ABC-CLIO, 2011); and *Nurturing Nonviolent Children: A Guide for Parents, Educators, and Counselors* (Praeger, 2008).

Two of her articles ("The Strengths-Based Counseling Model" (which was nominated as the outstanding article in *The Counseling Psychologist* for 2006) and "Ethnic Minorities: Life Stress, Social Support and Mental Health Issues" (1985) have been cited by *The Counseling Psychologist* as major contributions to the field of psychology. She has served on numerous editorial boards, including *The Counseling Psychologist*, *The Journal of Counseling Psychology*, and *Counselor Education and Supervision.*

Dr. Jones-Smith has developed and published two theories in psychology: *Strengths-Based Therapy* and *Ethnic Identity Development*. In addition, she has developed a strengths-based educational approach for working with youth in schools and several instruments that measure ethnic identity development, students' strengths, and teachers' strengths.

1 Introduction

JOURNEY TOWARD THEORY INTEGRATION

Identify the role and purpose of counseling theory in working with clients.

Understand the author's philosophical stance on integrative counseling.

Understand the role of diversity in counseling and psychotherapy.

Explain how a counselor's values are to be considered in the counseling relationship.

Describe the characteristics of an effective counselor.

Explain the role of ethics in counseling practice and theory integration.

Identify central issues regarding the case of Justin.

Brief Overview

Most graduate-level students are required to develop knowledge of the theories of therapy as part of their educational and professional development. Typically, they are introduced to at least 10 theories from the major schools of psychotherapy, such as psychoanalysis, behavior, cognitive, learning, or client-centered therapy. The heart of this book is about choosing a theoretical orientation—meaning either a single theory or an integrated psychotherapy approach. A therapist without a theoretical approach to psychotherapy is like Alice in Wonderland asking the Cheshire cat which way she should go.

> Alice came to a fork in the road.
> "Which road do I take?" she asked.
> "Where do you want to go?"
> responded the Cheshire cat.
> "I don't know," Alice answered.
> "Then," said the cat, "it doesn't matter."
>
> —Lewis Carroll,
> *Alice in Wonderland*

Theories of psychotherapy are like the Cheshire cat. They provide a road map for us when we work with clients. Without such a map, therapists are only winging it. They're like Alice, wanting to go somewhere but not knowing where they want to go with a client. Effective therapists establish theoretical road maps or treatment plans for their clients.

Do you see any similarities between you and Alice? Any differences?

Would you be able to tell the Cheshire cat where you are going? Where would that be?

The Role of Theories of Psychotherapy

A **theory** may be defined as a set of statements one uses to explain data for a given issue. Theories help people make sense out of the events that they observe. A theory provides the means by which predictions can be made, and it points out the relationships between concepts and techniques. A psychotherapy theory supplies a framework that helps therapists understand what they are doing (Norcross, Pfund, & Prochaska, 2013). It is a systematic way of viewing therapy and of outlining therapeutic methods to intervene to help others. It provides the basis for a therapist's deciding what the client's problem is, what can be done to help the client correct the problem, and how the relationship between the therapist and the client can be used to bring about the desired or agreed-on client change.

In psychotherapy, a theory provides a consistent framework for viewing human behavior, psychopathology, and therapeutic change. It supplies a means for therapists to deal with the impressions and information they form about a client during a therapy session. A psychotherapy theory helps therapists describe the clinical phenomena they experience, and it helps them to organize and to integrate the information they receive into a coherent body of knowledge that informs their therapy (Wampold, 2018).

A theory influences which human capacities will be examined and which will be ignored or reduced in importance. Therapists develop treatment interventions based on their underlying conceptions of pathology, mental and physical health, reality, and the therapeutic process (Tasca et al., 2015). A psychotherapy theory deals, either explicitly or implicitly, with the theorist's view of the nature of people, human motivation, learning, and behavioral change. Does the theorist believe that people are basically good or evil?

Theories may be measured against several criteria. The first criterion is clarity. Is the theorist clear in his or her outline of the basic assumptions that underlie the theory? Second, the various parts of a theory should be internally consistent and not contradict one another. Third, a theory should be comprehensive and explain as many events as possible. It should be precise, parsimonious, and contain testable hypotheses or propositions. Fourth, a theory should be heuristic and serve to promote further research. As additional research evidence is accumulated, the theory is further substantiated, revised, or rejected. As you review the theories presented in this text, evaluate how well each adheres to these criteria.

A sample of how theory works in therapy can be illustrated by examining a therapy interview. A client comes to a therapist for assistance in dealing with a problem. The therapist begins the interview with some observations and thoughts about the client's problem and some possible interventions that might help to resolve the client's issues. The therapist's initial thinking or hunches serve as a hypothesis about what goals, interventions, and outcomes may reduce the client's symptoms. The therapist's hypothesis about the client's issues and needs is supported or rejected by his or her experience with the client.

The therapist's next step in theorizing is to have additional sessions with the client during which he or she observes what takes place in the interactions with the client. Based on his or her observations, the therapist formulates hypotheses about what is happening with the client. These hypotheses form part of the therapist's theory. For instance, a therapist may observe that it is important to use the first session to establish a working alliance with the client rather than to ask too many questions. That is, he or she observes the various conditions under which the client responds positively or negatively, and from such observations, he or she formulates generalizations that result in mini-theories about what is working with the client.

List three ways that a theory of psychotherapy might be useful to you in your work with clients.

In the best of all possible worlds, how do you see yourself using a theory of psychotherapy?

This book subscribes to the prevailing view that no one therapy theory has a stronghold. Instead, there are many roads to client change.

From what you know about theories of psychotherapy, do you believe that "the long-term dominance of major theories is over"?

It is not easy choosing a single therapy orientation, let alone an integrative therapy approach.

What, if any, concerns do you have about finding a personal theory approach that works for you?

How do you plan to deal with those concerns?

There are ample reasons to examine your theoretical orientation in terms of ethical issues. In fact, if the shift toward evidence-based and manualized treatment (treatment following a psychotherapy manual) continues, clients may soon begin to sue their therapists on ethical grounds of failing to provide a basic standard of care because they failed to use the treatment approach that has been found empirically to be the most efficacious. Moreover, ethical codes transcend the various theoretical schools. You cannot just dismiss a standard of professional practice because your theoretical school endorses a certain practice. Ethical codes not only provide guidelines but also establish consequences for therapists' and psychologists' behavior.

Integrative Psychotherapy: The Focus of This Book

A major contribution of this text is that it acknowledges from the beginning that the average practitioner will probably pick and choose from the various therapies what works for her or him. Oftentimes, however, a therapist might evidence scant theoretical rationale for selecting certain elements of a particular theory. There are pathways to psychotherapy integration; the picking and choosing that practitioners engage in does not have to be haphazard. To develop an integrated therapy perspective, one must have an in-depth knowledge of psychotherapy theories; a therapist cannot integrate what he or she does not know.

There has been a recurrent, 40-year finding that therapy theories and their related techniques have a limited influence on therapy outcome (Lambert, 1992). The majority of client improvement is attributable to factors common to the various psychotherapeutic approaches and not to factors specific to individual therapy theories. There is also a large body of research that shows that the personal qualities of the therapist contributed almost 3 times more to the variance of psychotherapy outcome than did the therapy theory framework used (Norcross et al., 2013).

This book provides guidelines for constructing an integrative psychotherapy practice. It encourages the therapist to ask certain questions of himself or herself, such as "What have I learned about my own values, my own culture and its influence on my behavior? How might my attitudes and beliefs promote or retard the establishing of an effective therapy relationship?"

Definition of Integrative Psychotherapy

What is integrative psychotherapy? Integrative psychotherapy involves an attitude toward the practice of psychotherapy that affirms the underlying factors of different theoretical approaches to therapy (Stricker, 2010). Integrative psychotherapy takes into consideration many views of human functioning, including the psychodynamic, client-centered, behavior, cognitive, family therapy, Gestalt therapy, object relations, and psychoanalytic therapy. Therapists subscribe to the view that each theory is enhanced when integrated with another.

Psychotherapy integration has been conceptualized as an attempt to look beyond the confines of single-therapy approaches for the purpose of seeing what can be learned from other theoretical therapy schools (Stricker, 2010). It represents openness to different ways of integrating diverse therapy theories and techniques. Psychotherapy integration is not a particular combination of therapy theories; rather, it consists of a framework for developing an integration of theories that you find most appealing and useful.

Moreover, psychotherapy integration is based on several key beliefs. First, all theoretical therapy and personality models have limited applicability to clients in therapy. Second, the therapeutic relationship is much more important than any specific expert therapy or theoretical technique. Third, what clients think, feel, believe, and desire is more significant to therapy outcome than any academic or theoretical conceptualization (Hubble, Duncan, & Miller, 1999).

Psychotherapy integration is a process to which therapists must decide whether or not they want to commit themselves. This approach to therapy emphasizes the personal integration of theories of psychotherapy. Integrative psychotherapists maintain that there is an ethical obligation to dialogue with colleagues of diverse theoretical orientations and to remain informed of the developments in the field.

Psychotherapy integration is based on the belief that no one theory of psychotherapy has all the answers for all clients. Each theory conceptualizes human motivation and development with its own particular slant.

Dattilio and Norcross (2006) maintained that most clinicians currently acknowledge the limitations of basing their practices on a single theoretical system and are open to integrating several theories. Practitioners may find that several theories play crucial roles in their therapeutic approaches. As therapists accept that each theory has strengths and limitations, they become open to integrating different theoretical approaches into their clinical practices. To construct an integrative approach to therapy, you need to be very familiar with several theories and open to the idea that you can unify them in some kind of meaningful way. It is important to recognize that an integrative perspective to therapy requires a great deal of reading, research, clinical practice, and theorizing.

The Need for Cultural Diversity and Psychotherapy Integration

I advocate taking an integrative perspective for theories of psychotherapy for other reasons. The world is changing rapidly. We have moved toward a global economy and a global workforce. Many countries in the world have experienced an influx of people from diverse nations. The United States, for instance, is becoming increasingly diverse, with citizens who have immigrated from all over the world. Understanding cultural differences is not just politically correct. It is absolutely necessary if therapists are going to be able to work with all Americans and not just those whose origin is Western countries.

For the most part, theories of psychotherapy are based on a Western view of life. It is only relatively recently that non-Western healing methods have been explored for the purpose of integrating them into Western psychotherapy. Moodley and West (2005) provided a rich description of a large number of psychotherapeutic healing methods from culturally diverse contexts that can be integrated into the current largely Western theories of psychotherapy. They contended, in part, that their review of non-Western healing approaches is necessary because Western psychology and psychotherapy have failed to address the needs of culturally diverse clients. They recommended that various culturally diverse approaches to healing be integrated into Western psychotherapy. Similarly, Wong and Wong (2006) discussed a number of culturally diverse approaches to be taken into account when managing stress.

While the broader world is moving toward psychotherapy integration, most textbooks on counseling theory are still stuck in the past. There have been at least 40 books published on Buddhist mindfulness, yet few psychotherapy theory textbooks contain a section on mindfulness therapy. Clearly, the Western paradigm in psychotherapy is inadequate in addressing the needs of a culturally diverse population. The Western paradigm in psychotherapy is ethnocentric because it restricts the field to only those approaches that it defines as part of the helping profession. It eliminates most non-Western approaches by labeling them as belonging in the realm of the spiritual, philosophy, or superstition. Non-Western approaches are considered to be unscientific.

The major challenge is to find areas of commonality between Western psychotherapy and non-Western approaches. According to Santee (2007), the teachings of Buddhism, Daoism, and Confucianism are basically stress management programs. The Chinese believe, as do many Western therapists, that psychological disorders are caused by the chronic and repeated activation of the stress response. Given that the point of commonality between Western and Chinese approaches is stress management, there is room to integrate the culturally different approaches to healing. Santee (2007) has stated,

> Once the commonality is established, theory and practice from non-Western approaches can be integrated for the purpose of informing, enhancing, and expanding the Western paradigm of counseling and psychotherapy. This being the case, it is necessary to build a bridge, if you will, between Western counseling and psychotherapy and non-Western approaches to allow for the transference of theory and technique. This bridge will allow for a solution to the previously noted problems of (1) the restrictive paradigm in Western counseling and psychotherapy and (2) the removal of ethnocentric bias. (p. 3)

Even though most counseling theory textbooks endorse multicultural competencies, very few consider non-Western approaches to psychotherapy. It might be more accurate to label such texts as describing Western approaches to psychotherapy (Ishii, 2000; Maeshiro, 2005; Yoshimoto, 1983). Your need to integrate theories of psychotherapy goes beyond just integrating Western theories. Consideration must also be given to integrating Eastern and Western approaches to psychotherapy.

Integrative psychotherapists maintain that there is an ethical obligation to dialogue with colleagues of

diverse theoretical orientations and to remain informed of the developments in the field. Psychotherapy integration is usually the end point of therapist training. To reiterate, before you can integrate your own therapy theory, you must know yourself as a therapist and understand your values, beliefs, and culture as well as the cultures of others.

Do you think therapists should try to integrate theories of psychotherapy from the East and the West?

To what extent is it feasible to use Buddhist concepts in therapy for the average American?

Are the theories that we study in counseling theory courses culturally bound and Eurocentric?

Psychotherapy Integration: Position or Process?

A therapist who is on an integrationist journey is confronted eventually with the question of whether or not psychotherapy integration is a position, process, or a combination of the two. Therapists who see psychotherapy integration primarily as a position to be arrived at tend to emphasize bringing together two or more theoretical approaches to produce a new integrative theory that stands on its own. Some individuals who advocate that psychotherapy integration is primarily a position may even push for a single paradigm that will define the psychotherapy profession.

The average integrationist will take the route of bringing together two or more existing approaches to create new integrative models. This approach to psychotherapy integration is open to criticism because it proliferates therapy approaches, and it does little to eliminate or reduce the number of therapies that already exist. Therapists who view integration as primarily a process view it as a quest that does not end. It is viewed as an ongoing process in a continual state of development and evolution.

Forming an integrative theory of psychotherapy is not an easy task. For most therapists, it takes years to become comfortable with an integrative way of providing therapy services. In developing such a perspective, it is important that you understand your own worldview, the worldviews of your clients, human development, characteristics of effective therapists, and your views on the process of psychotherapy and ways of intervening. Each theory presents a different perspective from which to look at human behavior. If you are currently a student, it will take a while for you to develop a well-defined integrative theoretical model. This goal can be accomplished with much experience as well as reading and studying. Your first challenge is to master one or two theories of psychotherapy that resonate with you and that meet the needs of those with whom you work. Before mastering 20-plus counseling or psychotherapy theories, it is important that you take time to look inward to your own reasons for choosing to become a counselor, that you consider the characteristics of effective counselors, that you take an inventory of your values and cultural background, and that you become aware of basic ethical principles for counseling. You need to know and understand the differences between counseling and psychotherapy as well as counseling and advice-giving.

Professional and Personal Issues for the Journey Toward Psychotherapy or Counseling Integration

Definitions of Counseling and Psychotherapy

Counseling and psychotherapy may be conceptualized as overlapping areas of professional competence. Typically, **counseling** is conceived as a process concerned with helping normally functioning or healthy people to achieve their goals or to function more appropriately. In contrast, **psychotherapy** is usually described as reconstructive, remedial, in-depth work with individuals who suffer from mental disorders or who evidence serious coping deficiencies.

Historically, counseling has tended to have an educational, situational, developmental, and problem-solving focus. The helping professional concentrates on the present and what exists in the client's conscious awareness. Counseling may help people put into words why they are seeking help, encourage people to develop more options for their lives, and help them practice new ways of acting and "being in the world." Therapy is more a process of enabling a person to grow in the directions that he or she chooses.

In comparison to counseling, psychotherapy is considered a more long-term, more intense process that assists individuals who have severe problems in living. A significant part of the helping process is directed

toward uncovering the past. Typically, counseling is focused on preventive mental health, while psychotherapy is directed toward reparative change in a person's life. Whereas the goals of counseling are focused on developmental and educational issues, the goals of psychotherapy are more remedial—that is, directed toward some significantly damaged part of the individual. In general, counseling denotes a relatively brief treatment that is focused most on behavior. It is designed to target a specific problematic situation. Psychotherapy focuses more on gaining insight into chronic physical and emotional problems.

Usually, psychotherapy requires more skill than simple counseling. It is conducted by a psychiatrist, trained therapist, social worker, or psychologist. While a psychotherapist is qualified to provide therapy, a counselor may or may not possess the necessary training and skills to provide psychotherapy. Throughout this book, the terms *counselor*, *psychotherapist*, *helper*, *clinician*, and *mental health therapist* are used interchangeably; I acknowledge at the outset that there are differences among these terms.

Some individuals initially decide to enter the counseling profession because they have enjoyed giving advice to their friends about a number of issues. It is important to distinguish between advice-giving and counseling. Oftentimes, clients come to therapy because they are experiencing psychological pain in their lives, and they want that pain to stop. Wanting to stop their pain, some clients ask the counselor or therapist for advice. They approach the counselor with some variant of this statement: "Just tell me what to do to deal with this mess. I'm so confused. Anything you could tell me would be helpful."

Psychological pain may blur temporarily a person's ability to solve what others might view as a simple problem. That is, emotional pain assumes a role in making individuals feel vulnerable and incapable of solving their own problems. Counselors who want to help a hurting client should avoid falling into the trap of advice-giving because advice-giving is not therapy. The therapy hour is a place where you can explore your feelings and learn all about those things you have struggled to hide from yourself and others. People come to therapy to achieve a better understanding of their inner world and their relationships with others. Advice-giving is a quick fix that makes you feel better for a short time period. Conversely, therapy takes time because it involves periods of deep reflection, insight, and change. Sometimes the best a counselor can do is just to sit with a client and to listen empathically to the deep psychological hurts a client has endured. I remember sitting with one client who cried and cried and cried. Each time I offered her a tissue to wipe her eyes, she just took it and continued to cry without saying a word. Finally, after an extended period of crying, the client looked up at me and said, "Thanks, I needed someone to hear my tears. I've been wanting to cry for a long time, but there was no one to listen to my tears. You listened. Thanks." That client helped me to understand the value of silence in therapy.

Effective therapists avoid the advice-giving role because it may deny a client the opportunity to work through personal thoughts and feelings about a situation. Advice-giving can also lead to the counselor's lecturing to the client (Evans, Hearn, Uhlemann, & Ivey, 2011). Moreover, giving advice to clients fosters their dependence on you as therapist. A major goal of counseling or psychotherapy is to help clients make their own independent choices and to accept the positive and negative consequences of their choices.

Am I Suited for Becoming a Counselor?

I can remember the first day I sat in an Introduction to Counseling class. Even though I had registered and paid for the course, I was sitting in the class wondering if counseling were the correct profession for me. Did I want to become a counselor because I was tired of correcting stack loads of English papers, or was it because I enjoyed talking to many of my students after class?

One experience was important in helping me to make the shift from teaching to school counseling. I loved teaching literature—especially poetry and short stories. And sometimes the poems and short stories we discussed in class raised some issues that the students themselves were grappling with. For instance, students seemed to like the poem "Richard Corey," who "glowed" when he walked. Everyone in the town wanted to be like Richard Corey, but one cool night, Richard Corey went home and put a bullet in his head. Students were responsive to the notion that they wish they could be like other people, but maybe everything is not as glamorous as it seems on the other side. One student responded that she felt a lot like the townspeople who wanted to be like Richard Corey. "It's like I have my face pressed against the window pane of life, and everyone is having fun but me," she said. Class discussion revealed that there were many students in the room who felt the same way as she did. We talked after class, and I suggested that she meet with the school counselor—just to have someone to talk with about things in her life.

Gradually, I began to understand that I wanted to be a counselor whom students could turn to discuss whatever was going on in their minds and lives. Still, as I sat in my first class on Introduction to Counseling, I wondered if I had what it would take to become a counselor. So I sat in class, with half of my attention on what the professor was saying and half on my own inward questioning about whether or not I had made the right decision to become a school counselor. Looking back, I believe that I made the right choice to become a school counselor.

If truth were told, many students taking their first courses in counseling wonder if they would make a good counselor, which leads me to the question that I have often been asked in class, "Do you think I would make a good counselor, or should I choose some other profession?" Usually I remain silent with some sort of quasi Rogerian response like, "I can't make that decision for you. Perhaps as you find out more about what counselors do in their job, you'll be in a better position to answer that question for yourself."

I remember one student who asked me this question. Instead of answering her question directly, I asked, "Tell me what you think about people and the issues they might bring to counseling/therapy? Do you think people really can change their behavior and the way that they feel?"

The student responded to me, "I don't think people can or really want to change. They might say they want to change, but deep down inside, they're comfortable in their own mess, and they don't want to change."

Our class discussion gravitated to what I considered a basic counselor value—the belief and value that human beings can and do want to change, even though such change might be difficult to embrace. By the end of the year, that student conveyed to me privately that she had decided not to become a counselor. "Change," she said. "I still believe what I said in the beginning of the semester. I don't believe people actually want to change. They just pretend they want to change."

Negative and Positive Reasons for Becoming a Counselor

There are both positive and negative reasons given for becoming a counselor. Sometimes students are attracted to professional counseling because they have serious personality and adjustment problems (Nassar-McMillan & Niles, 2011). Some enter counseling because they want to provide "self-help" for their own personal problems. They believe that taking counseling courses will enable them to help both themselves and others in solving life's challenges. Others enter the counseling profession because they like the position of power and control they might assume over clients. Another negative motivator is that students enter the counseling profession because they have a need to be loved and adored by others—especially those who are experiencing difficulties and need their help.

Positive motivators for becoming a counselor include a person's desire to help and empower others. Counselors-in-training might consider examining their best and worst qualities as well as their developmental histories and patterns of interpersonal relationships to determine if they are good candidates for becoming effective counselors.

Should I Seek Therapy Before Becoming a Counselor or Therapist?

Individuals seeking to become counselors and therapists often raise this question: Should I get counseling for myself before trying to help others? Sometimes underlying this question is the nagging feeling that "there is something wrong with me" or "maybe I'm a little crazy myself." There used to be a time when therapist training programs routinely recommended that psychologists and therapists obtain therapy for themselves. In many psychoanalytic training programs, therapy was required for all trainees. There are both advantages and disadvantages of obtaining in-depth therapy before one engages in psychotherapy. On the negative side, one therapist told me that he felt "drained" and "overexposed" from his psychoanalysis.

There are, however, some advantages of seeking psychotherapy for yourself before going out in the world to practice therapy. Sometimes therapists who have been through therapy themselves may be in a good position to empathize with their clients; they know what it feels like to be sitting in the chair opposite a therapist. After all, most professionals in a given area use the services of other professionals in their fields. Lawyers hire other lawyers, doctors have their own doctors, and so forth. Moreover, both the ethical codes for counselors (American Counseling Association [ACA], 2014) and psychologists (APA, 2017) recommend that therapists seek supervision under certain situations and guidelines. For instance, it is recommended that psychologists obtain supervision when the psychologist may be experiencing **countertransference** or legal issues, or when client's issues exceed the psychologist's level of competency. Psychologists who have experienced serious emotional trauma in their lives should seek therapy to ensure that their own trauma issues do not surface and

get out of hand when they are working with clients—especially those who have experienced similar trauma. There is no shame in seeking the services of another therapist. In fact, doing so may help one avoid ethical violations and lawsuits (Corey, Corey, Corey, & Callahan, 2015; Herlihy & Corey, 2015).

Therapist Beliefs and Values: Relationship to Choosing a Theory

Therapists need to understand their beliefs, attitudes, and values prior to the end of their formal training. A *belief* can be defined as a judgment of relationship between an object and some characteristic of the object. Beliefs are cognitive constructs that can be distinguished from *attitudes* (positive or negative feelings toward an object) and *behavior* (action toward an object). Furthermore, beliefs can be distinguished from *values* because beliefs merely represent how an individual perceives the world. In contrast, values contain propositions about what should be. A **worldview** is a general outlook that a person has about life.

Therapists do not simply abandon their own values or worldview during the therapeutic process. It is impossible to work value-free with clients. Moreover, value clashes may occur when there are recognized cultural differences intruding in the therapy relationship. Values that have a potentially negative impact on the therapy relationship are those that deal with clients' and therapists' morality, ethics, and lifestyles. Sometimes counselors impose their values on clients when they exert direct influence over their beliefs, feelings, attitudes, and behaviors. Counselors impose their values on clients when they make direct statements designed to influence their clients through verbal or nonverbal means, such as looking away when a client talks or crossing one's arms when a client espouses values different from theirs.

Counselor self-awareness is an important tool to prevent imposing one's values on clients. Most ethical codes for helping professionals indicate that clinicians should not impose their values on clients. For instance, the 2014 *ACA Code of Ethics* states this in Section A.4.b. Personal Values:

> Counselors are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors. Counselors respect the diversity of clients, trainees, and research participants, and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature. (ACA, 2014)

Therapists need to learn how to manage their values so that they do not interfere with the counseling process; that is, they must engage in what Kocet & Herlihy (2014) termed "values bracketing." To work with a broad range of diverse clients, counselors set aside their own personal values. Counselors need to learn how to communicate their values without imposing them on clients. They should seek to maintain a neutral position—that is, they should ask themselves the following question: Have my values and beliefs influenced the manner in which I help my clients set goals? Counselors should seek clinical supervision when there are value conflicts between them and their clients (Herlihy, Hermann, & Greden, 2014).

Imagine that you were told that you were going to be one of the lucky ones to build a 21st-century Walden Pond. The problem is that you can take only three of your values with you to this new community.

What three values would you take, and why?

How might these three values influence your practice of psychotherapy?

Some Common Therapist or Counselor Values

A national survey of therapists and mental health practitioners found that certain values are held widely by practitioners. These values include assuming responsibility for one's actions; having a deepened sense of self-awareness; having job satisfaction; demonstrating the ability to give and receive affection; having a purpose for living; being open, honest, and genuine; and developing appropriate coping strategies for stressful life situations (Wampold, 2011).

One value that most therapists share is a respect for their clients. The therapist seeks to do no harm (Wampold, 2011). Therapy is not a neutral process. It is for better or for worse. Moreover, therapists do not look down on their clients because their clients have problems. They respect their clients as human beings who are searching for solutions to their problems and

pain. Psychotherapy involves a basic acceptance of the client's perceptions and feelings, even if they are at odds with the therapist's values. You must first accept the client where he or she is before you can contemplate who the client might become.

Therapists do not rush to judgment about people and their issues. You are not there to judge your clients or to give them your values. Instead, you are there to help them identify, explore, and find solutions to the values they have adopted. As a therapist, you neither judge nor condone a client's values; instead, you understand the client's point of view and let him or her know that you understand his or her point of view (Egan, 2002). Good therapists challenge clients to clarify their values and to make reasonable choices based on them. When you respect your clients, you are willing to enter their worlds to help them with their presenting issues.

Therapists also have a value of adopting a neutral posture. Being a therapist suggests that one has a dedication to helping other people without having a vested interest in the directions they choose to take. Therapists work toward helping clients make decisions without having investments in those decisions. They devise ways to avoid thinking about client problems during the times they are not in session with their clients.

The value of being neutral in the helping process allows therapists to establish boundaries between themselves and their clients. In learning to become a therapist, you learn how to become comfortable in the presence of others' discomfort. Clients may come to the therapy session full of rage and hurt. They may cry and scream. Therapists learn how to step back and assume a neutral posture, all the while taking the full force of the client's emotional energy. As helping professionals adopt a neutral position, they avoid getting caught up in the client's behaviors and dysfunctional communication patterns. Therapists who are neutral do not allow themselves to be manipulated by clients who try to get them to rescue them. Moreover, providing therapy to individuals from different ethnic, gender, and socioeconomic backgrounds requires therapists to transcend their internalized cultures.

Characteristics of Effective Therapists or Counselors

What does it take to become an effective counselor? What kinds of specific attributes and skills should one have if he or she is considering becoming a counselor? Effective counselors tend to be those who have excellent communication skills. They have a good ability to communicate their ideas and feelings to others and a natural ability to listen to others. Effective therapists are nonjudgmental and accepting of others; they need to have the ability to establish rapport with others, to communicate client acceptance with warmth and understanding, and to be capable of giving their undivided attention to clients so that they cultivate clients' trust.

Wampold (2011, 2018) has posited that effective therapists or counselors have 14 qualities and actions. Some theoretical approaches emphasize some of these qualities more so than others. Nine of Wampold's list of 14 qualities for effective counselors are as follows:

1. Effective therapists/counselors have a broad range of interpersonal skills, among which include: (a) good communication style and verbal fluency; (b) interpersonal perception or the ability to discern what is taking place in people's interactions with each other; (c) ability to express themselves and to modulate their affect; (d) warmth and acceptance; (e) empathy; and (f) focus on other.
2. Effective therapists/counselors are capable of forming a working therapeutic alliance with a broad range of clients.
3. Clients of effective therapists/counselors feel that their therapist understands them, and trust is established between the two.
4. Effective therapists/counselors give the client an acceptable and adaptive explanation for his or her psychological distress such that the client feels that he or she can overcome or resolve the difficulties. Clients who accept therapists' explanations for their distress are inclined to engage in collaborative work with their therapists.
5. Effective therapists/counselors provide an acceptable standard of care, as well as an acceptable treatment plan that is consistent with their explanations of clients' problems.
6. Effective therapists/counselors communicate hope and optimism to their clients. They help clients mobilize their strengths so that they can solve their problems. They are able to deal with client silence and to tolerate ambiguity.

7. Effective therapists/counselors become aware of their own countertransference issues. *Countertransference* may be defined as any of a therapist's projections that influence the manner in which they view and respond to a client. Countertransference occurs when a therapist's own issues become involved in the counseling relationship. Effective therapists do not inject their own psychological material into the therapy process unless such actions are therapeutic. They avoid countertransference issues and seek supervision when such issues arise during therapy.
8. Effective therapists/counselors are aware of the best evidence-based research related to their clients' problems or life challenges. They understand the biological, social, and psychological bases of the disorder or problem their clients are experiencing.
9. Effective therapists/counselors engage in continual professional development and improvement and they achieve what might be called the expected or the more than expected progress with their clients.

From my own strengths-based theory perspective, the effective therapist is one who helps clients recognize and marshal their strengths to deal effectively with their life challenges. Effective counselors help clients manage their weaknesses so that their shortcomings do not interfere with or prevent them from achieving their desired life or perceived purpose in living. Moreover, my view is that all therapy should be about helping clients connect with the feeling that there is hope for them, that their problems can be solved, and that they have the ability to achieve a better life for themselves. If therapy is designed primarily to tell a client what is wrong about him or her rather than what is right or good, then, in my opinion, that is not therapy.

Looking at your life now, where would you place yourself in the journey toward finding your personal theory of therapy? Are you as far along as you would like to be? What is pushing you forward, and what is holding you back?

Ethical Issues in Starting Your Journey Toward Developing an Integrative Counseling Theory

Regardless of what theory or set of theories you adopt, it is important to understand ethics. Usually counselors take an entire course on ethical issues in counseling. This section is not intended to replace or to compete with the in-depth coverage of an ethics course. Instead, it is intended primarily to review key ethical issues that you should take into consideration as you start your journey to develop an integrative theory of counseling or psychotherapy.

Each helping profession adopts its own mandatory ethical codes. Mandatory ethics outline a profession's minimum level of acceptable practice and standard of care. Professional **codes of ethics** inform both practitioners and the general public about the responsibilities of the profession; they outline a standard against which practitioners can be held accountable, and they protect clients from unethical practices (Herlihy & Corey, 2015). Unethical counselors sometimes become the target of lawsuits. Clients who sue clinicians often cite the ethical and legal codes they have violated in their practice with them. Therapists should be aware of ethical issues related to clients' right of informed consent, the limits and exceptions of confidentiality regarding clients' records, the use of technology in working with clients, multicultural ethical issues, ethical issues in assessment and diagnosis, **evidence-based practice (EBP)**, and **dual or multiple relationships**. The sections that follow provide only a brief description of ethical issues related to the designated areas. A discussion of ethics and theories of psychotherapy is presented first.

Ethics and Therapist Competency Related to Theories and Therapy Techniques

Virtually all codes of ethics for helping professions address the issue of professional competency. The issue of professional competency has a direct bearing on a counselor's or therapist's adoption and integration of theories of psychotherapy. Before adopting a theory of psychotherapy, therapists need to ask themselves if they are integrating theories within their boundaries of professional competence. The 2014 *ACA Code of Ethics*, Section C.2.a. Professional Responsibility delineates

Boundaries of Competence, the areas in which a counselor should consider practicing. It states,

> Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Whereas multicultural counseling competency is required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions , and skills pertinent to being a culturally competent counselor in working with a diverse client population. (p. 8)

Before adopting a theory as part of your counseling practice framework, you need to ask yourself the following questions: What steps do I need to take to become adequately trained within this theoretical perspective? Have I had sufficient practice in using this therapy approach? Am I competent in using the therapy techniques associated with my chosen therapy schools? What additional training or education do I need to become proficient in practicing my chosen therapy approach?

Therapists should not claim that they are experts in a particular psychotherapy approach without having adequate training in that orientation. Section C.2.b. New Specialty Areas of Practice of the 2014 *ACA Code of Ethics* states,

> Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and protect others from possible harm.

Moreover, Section C.2.d Monitor Effectiveness requires counselors to monitor their effectiveness in using a theoretical orientation, and where necessary, they seek peer supervision to evaluate their efficacy as counselors. Counselors should be careful of trying to integrate theories that might have incompatible theories of human nature and possible change mechanisms.

Theory Choice and Ethical Issues in Evidence-Based Practice

During the past several decades, psychologists have placed an emphasis on a sound scientific basis. The desire to make therapy more scientific led to **empirically supported therapies**. Proponents of empirically supported therapies maintain that each psychotherapeutic approach should be tested in carefully controlled experimental research. Such research would demonstrate what psychotherapy approaches work and which do not, or worse yet, may even be harmful to clients. Managed health care companies have been in the forefront of the empirically supported therapy movement because they maintain that it will lead to the improved cost effectiveness of psychotherapy.

Evidence-based practice (EBP) is practice based on the belief that solid, empirical research as well as clinical experience should inform therapy and professional decision making regarding interventions to use. One criticism of the EBP movement is that it has been spurred on primarily by managed care (Deegar & Lawson, 2003), which is concerned primarily with efficiency and low cost for treatment for mental disorders. Another objection to EBP is that it is too mechanistic and leaves little room for considering individual differences and the relational aspects of psychotherapy. Despite these challenges to EBP, Norcross, Hogan, and Koocher (2008) maintained that EBP requirements are here to stay and that the basic goal of EBP is to increase the effectiveness of client treatment.

What do ethics have to do with EBP? Within the past few decades, there has been an increasing demand that counselors and therapists use evidence-based approaches in working with clients (Norcross & Lambert, 2011). EBP, sometimes also called **empirically supported treatments (ESTs)**, supports the view that therapists need to have up-to-date information on what treatments have been found to work with specific psychological disorders or problems (Edwards, Dattilio, & Broomley, 2004). The APA Presidential Task Force on Evidence-Based Practice (2006) defined EBP as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273). Norcross et al. (2008) have outlined three cornerstones of EBP, and these are that therapists should (1) look for the best available research regarding treatment of their client's disorder or problem; (2) rely on clinical expertise in delivering treatment; and (3) consider the client's characteristics and culture.

There has been steady support for clinicians' use of ESTs. In general, clinicians are encouraged to use therapy techniques that have empirical evidence to support their efficacy in client treatment (Norcross, Beutler, & Levant, 2006). For instance, Cukrowicz and her colleagues (2005) found that ESTs resulted in

better treatment outcomes than did non-ESTs. They reported that "patients who received ESTs not only got better than those who did not but they also got better with comparatively less therapeutic contact" (p. 335). Cukrowicz et al. (2005) concluded that "clinicians are well advised to use ESTs as a frontline treatment for their patients in order to remain consistent with ethical practice" (p. 336).

In choosing what theories you wish to include in your integrative theoretical framework, you might want to consider first the degree to which there is empirical support for its efficacy with clients who evidence a given psychological disorder. Next, evaluate your knowledge and competency related to the theory of psychotherapy. Do you have the skills and expertise to use effectively the techniques associated with the theoretical approach? Finally, is the theoretical approach compatible with your client's cultural background as well as your own cultural and personal values?

Ethics and Clients' Right to Informed Consent

Regardless of what theoretical orientation a therapist chooses, clients have the ethical right of **informed consent**. That is, clients have a legal right to be informed about their therapy and the qualifications and techniques their therapist uses so that they can make decisions pertaining to it. Both professional counselors and psychologists are ethically bound to provide clients with informed consent (see ACA, 2014; APA, 2016). Informed consent ethical issues usually take place within the first session and as frequently thereafter as necessary to ensure that clients understand their rights and responsibility in the counseling relationship.

A number of counselor or therapist activities are involved in ensuring that clients have been given informed consent. For instance, the therapist informs the client the fee that he or she charges for services, when payment is to be made, and whether or not insurance payment will be processed and accepted (Berger & Newman, 2011). The therapist also discusses client appointments, the procedure for making them, and the length of a session.

The informed consent process entails having clients become aware of their therapists' academic and professional credentials, their therapy theoretical orientation, and the types of interventions they will use during therapy. Other features of the informed consent process include the goals of therapy, the therapists' responsibilities toward the client, the clients' responsibilities, and the limits and exceptions to client confidentiality as delineated in the particular state's mental health laws and the relevant association's ethical codes (Corey et al., 2015).

It is recommended that informed consent information be provided in written form and that therapists reserve time to discuss the document with clients (Nagy, 2011). A written informed consent protects both therapists and clients. It is recommended that students be required to construct an informed consent document at the conclusion of the psychotherapy theory course.

The Limits and Exceptions of Confidentiality and Client Records

Confidentiality is an important pillar of therapy, and it is what distinguishes therapy from advice-giving. Confidentiality may be defined as a client's right to privacy; it helps to create a sense of trust between therapist and client. Confidentiality is owned by the client and not by the counselor. It is the client who has the right to waive confidentiality or to permit information to be shared with another person or third party.

Although often confused with confidentiality, **privileged communication** is a legal concept that protects clients from having their confidential communications revealed in court proceedings without their permission (Corey et al., 2015). It is a legal term used to describe the degree to which communications made between client and therapist are private. Clients have an ethical right to confidentiality but a legal right to privileged communication as specified in federal, state, and local statues. Whether or not the communications between a client and therapist are designated as privileged communications varies across different states and jurisdictions. Not all therapists and counselors are treated the same with regard to privileged communication. While the communications between client and therapist in a private practice setting might be termed *privileged communications*, a different situation might exist for school counselors who generally are not included in the privileged communication arena.

Sometimes professional counselors ask what they should do if parents ask about their working with their minor child. Each state has minor consent laws that permit to obtain treatment for conditions such as substance abuse, mental health, and some reproductive health areas. The ACA code related to parents and confidentiality still leaves the issue of parental right to know about the progress of their kids in counseling. Section B.5.b.

Responsibility to Parents and Legal Guardians of the *ACA Code of Ethics* (ACA, 2014) states the following:

> Counselors inform parents and legal guardians about the role of counselors and the confidential nature of the counseling relationship. Counselors are sensitive to the cultural diversity of families and respect the rights and responsibilities of parents/guardians over the welfare of the children/charges according to the law. Counselors work to establish, as appropriate, collaborative relationships with parents/guardians to best serve clients. (p. 7)

The duty to warn doctrine also places limitations on therapists' ability to keep matters related to clients confidential. The doctrine was established with the 1976 *Tarasoff* case in California (*Tarasoff v. Regents of the University of California*, 1976). In this case, a client who was a graduate student told his psychologist that he intended to kill a girl named Tatiana Tarasoff because she had rejected his advances. Although the psychologist informed the campus police and his supervisor, he did not warn the intended victim or her family. The graduate student murdered Tarasoff. The Tarasoffs sued the University of California Board of Regents and others for failure to notify Tatiana and her parents. After several years of appeal, the majority judges ruled that the psychologist had a duty to warn and protect an identifiable victim from the student's violence. That court's decision established the legal basis for duty to warn and protect. According to the *ACA Code of Ethics* (ACA, 2014), Section B.2, "the general requirement that counselors keep information confidential does not apply when the disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed" (p. 7).

Remley and Herlihy (2016) have enumerated a number of exceptions to confidentiality and privileged communication. In general, therapists and counselors are bound by law to break confidentiality in cases that show child abuse, elder abuse, disability abuse, and danger to self or others. In these circumstances, therapists have a duty to report or a duty to inform when such harm and danger to self and others takes place.

Ethical Issues in Assessment and Diagnosis

The theories differ in their emphasis on the role of assessment either before or during therapy. Therapists engage in assessment to identify problems and themes in a client's life. After therapists have engaged in a thorough assessment process, they make a diagnosis, which describes the mental disorder a client has in terms of a pattern of symptoms. The reader will find that cognitive behaviorists tend to emphasize assessment more so than theorists in the humanistic or constructivistic schools.

The *Diagnostic Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013; also referred to as the *DSM–5*) is the defining book for making diagnostic assessments. Therapists are expected to diagnosis clients using the framework provided in the *DSM–5*. As you study the therapeutic models presented in this book, review how assessment and diagnosis are used. Therapists are to become aware of how their own cultural background influences their assessment and diagnostic procedures.

There are both benefits and disadvantages of assessment and diagnosis. The benefits of diagnosis are that the *DSM–5* provides a common language for professionals and clients to describe disorders and that based on the list of symptoms identified, a framework may be developed that is helpful in treatment planning and that promotes health insurance reimbursement (Christensen, 2013).

In contrast, one of the drawbacks of diagnosis is sometimes clients are identified primarily by their diagnoses rather than on their uniqueness as human beings. Clients are discussed primarily in terms of their pathology rather than their strengths. Welfel and Patterson (2005) have pointed out that therapists tend to make three kinds of mistakes in the assessment and diagnosis phase of therapy. The first mistake takes place when the therapist mistakenly attributes social justice issues to mental health issues or when the therapist fails to diagnosis medical issues that are causing the problems. The second error occurs when the therapist maintains that there is only one acceptable diagnosis. The third error takes place when the therapist views clients only in terms of their diagnosis, as if the diagnosis is an absolute reality rather than an abstraction of reality. Therapists need to become familiar with the *DSM–5* in order to become skilled, ethical diagnosticians.

Ethical Issues in Multicultural Counseling

Most ethical codes within the helping professions require that therapists and counselors take into consideration the client's cultural background during counseling. The theories presented in this book vary in the extent to which they address multicultural issues.

The APA (2017) published its own guidelines for evidencing cultural competency in working with culturally diverse clients. As you choose the theories to become a part of your integrative framework, examine how the theorist viewed culture. What steps will you take to modify any multicultural limitations that the psychotherapy theory might have? For the most part, I examine each major therapy theory discussed in terms of the theory's multicultural positives and blind spots.

Research studies have found that members of ethnic and racial minority groups are inclined to receive more serious psychological diagnoses than are those from majority ethnic groups (Jones-Smith, 2019). Ethical violations can take place when therapists attempt to counsel individuals without taking into account their cultural background. Therapists should seek supervision or consider referral when they believe that they do not have the cultural competency to work with their clients. I recommend that therapists engage in a continual process of learning about people from different cultures in order to develop a sense of cultural humility, which is discussed in more detail in Chapter 12.

Ethical Issues in Dual or Multiple Relationships

Virtually all ethical codes within the helping professions state that therapists should avoid dual or multiple relationships. The ethical principle of dual or multiple relationships refers to the fact that therapists should hold only one type of relationship with their clients—therapist–client. Sometimes, however, therapists try to blend their professional relationship with a client with another type of relationship. For instance, they may combine being a therapist with that of a lover, or being both a counselor and teacher, or friend and therapist.

Ethics and the Use of Technology

The digital age has brought to the forefront ethical concerns with the use of technology in counseling and psychotherapy (Jencius, 2015). Currently, counselors and psychologists run hundreds of websites advertising their services and communicating with their clients. The practice of cyber counseling—where the counselor might be hundreds of miles away from the client—is plagued by many ethical considerations around issues of client confidentiality as well as other matters. Technology-assisted counseling involves telephone, e-mail, and video services between clients and therapists.

In *Guidelines for the Practice of Telepsychology*, the APA (2013) has stated,

> Telepsychology is defined, for the purpose of these guidelines, as the provision of psychological services using telecommunication technologies. Telecommunications is the preparation, transmission, communication, or related processing of information by electrical, electromagnetic, electromechanical, electronic means. . . . Telecommunication technologies include but are not limited to telephone, mobile devices, interactive videoconferencing, email, chat, text, and Internet (e.g., self-help websites, blogs, and social media). (p. 792)

The APA guidelines identified two important components of telepsychology, involving (1) the psychologist's competency in the use of the telecommunications being used and (2) the need to ensure that the client fully understands the increased risks to loss of security and confidentiality when using telecommunication technologies.

Based on the previously given APA guidelines on telepsychology, counselors and therapists need to be concerned if a desktop or laptop computer containing confidential information is stolen from an office or car. Ethical issues are also raised when other individuals hack into therapists' computers that are connected to the Internet, and confidential information related to a client is stolen. There are numerous ways therapists might become embroiled in ethical issues using telephones and faxes. For instance, a therapist and client might discuss confidential information over the telephone, unaware that their conversation is being overheard by someone close by because one of them is using a cell phone in public. Another problem also takes place when a therapist faxes confidential information to a client or a supervisor, unaware that the fax machine is shared by others. Clients and therapists should take into account privacy issues before agreeing to send e-mail messages to each other. It is recommended that e-mail messages be restricted to technical information, such as appointment times.

Jurisdictional and licensing issues may surface when therapists and clients live in different states with different licensing regulations for therapists. It is important to note that some state regulatory boards require counselors to hold licenses in both the states in which they practice and the locations in which their clients live. The National Board for Certified Counselors (2012) has published useful guidelines and standards related to the counseling relationship and client confidentiality in telecounseling services.

CASE ANALYSIS

JUSTIN

Justin is currently under PINS (Persons in Need of Supervision) with the Utah District Family Court because he has repeatedly gotten into trouble at school and because he was with some boys who stole items from the local Walmart. Justin denied that he stole anything, but because he was with the boys who did steal, he was given a citation for appearance in family court. The court has informed Justin that he must meet with it periodically and that he must not get into any more trouble; otherwise, he may be placed in a residential treatment facility that has a school for young boys. The family court judge has specifically stated that Justin must improve his grades in school and that he must not get into any more fights in school. The judge will obtain periodic reports from his school to see whether Justin is acting responsibly.

The judge has also indicated that if the school and Justin's mom, Sandy, can come up with a workable plan to improve Justin's grades, this will serve as a mitigating factor in the judge's decision to let Justin remain at home or to send him to a residential treatment facility. Furthermore, Justin must be on time for all court appearances, because he was late for the past two appearances. The court has also assigned Justin a probation officer who will gather the material from his school and mother for the purposes of reporting back to the judge and giving his recommendations for Justin. The judge has placed the question on his file: What will it take to save Justin? Can he be helped?

Justin could achieve much higher than what he has performed academically in school. He complains that he can't seem to remember all that he reads and that he can't focus his attention on reading an entire chapter. Justin has asked for a tutor, but his school has been unable to provide one for him on a personal basis. Justin sometimes acts up in his class. While everyone else is reading or working on an assignment in class, Justin gets up and starts walking around the classroom. Sometimes he pokes a student or makes fun of one of the smarter students in the class. He has gotten into several fights at school and has been suspended for fighting at least three times. The principal has indicated that if he gets into another fight in school, he may be expelled.

Despite these observations, Justin's art teacher seems to believe in him. She has indicated that Justin has a lot of raw talent for painting. Despite his considerable talents in painting, Justin paints very little. Last year, he won the school's artistic award for painting.

Except for standardized tests, Justin has not been tested in school. He has met the guidance therapist and psychologist on only two occasions. This semester he has received three Ds and two Cs; he is in a regular seventh-grade class. Justin told his mother that he did not like the psychologist or the guidance therapist because they seemed to act like they thought he was crazy or mentally challenged. Both the psychologist and the guidance therapist read the riot act to Justin, and they tried to impress on him the seriousness of his behavior. Also, they informed him that if he ever wanted to talk about what was going on, their doors would be open. Neither the guidance therapist nor the psychologist has contacted his mother. Justin's teachers have called her at home about his acting-out behavior in class and his dismal academic performance. Sandy has visited the school about Justin on at least three occasions, but each time, she felt unwelcome.

Justin believes that, for the most part, he is on his own—that is, except for his brother, mother, and "homeboys." According to his philosophy, you have to get someone before he gets you.

He was glad that he had his homeboys to back him up. His homeboys were his real family. He could trust them because they would not leave him, and they would fight for him if anyone tried to jump him.

Although Justin is biracial, he hangs out primarily with African American kids. He does have a few White friends, but two of these individuals shy away from him because they are performing reasonably well in school, and Justin gets into so much trouble that the two do not want to be associated with him. Justin hangs out with kids older than he is. For instance, the third White kid he hangs out with is 16 years old, and he is a member of a gang.

Justin's older brother, James, has been in repeated trouble with the law. Just this past semester, he dropped out of school after completing the 10th grade. James smokes pot on a regular basis. Most of James's friends are in a gang. Justin looks up to his older brother. In a surprising admission, James said that he wanted things to be better for Justin than what he has experienced in his life. Sometimes James would make Justin complete his homework. It's clear that there is a strong bond between Justin and James.

For the most part, Justin hangs around with a small group of people who seem to look up to him for leadership. Justin "gets over" in part because of his good looks. He has curly brown hair, green eyes, and his skin color is of a caramel hue. He is slender and agile. Justin has evidenced only passing interest in girls.

Justin suffers from feelings of inferiority because of his mixed racial parents. Students at school sometime refer to him as half-breed, and that is one of the reasons that he got into a fight. People at the mall and other places ask him where his mom is, even when she is near him. When he points to his White mother, they say something like, "Oh, I'm sorry. I didn't know that she was your mother."

In addition, Justin has inferiority feelings about the low grades he has received in his courses. Sometimes, he feels just like hauling off and hitting a couple of the bright kids—just because they think that they are all that much. On his standardized IQ test, Justin scores within an average range; however, his performance IQ component score is higher than his verbal IQ score. Except for art class, many of the so-called bright students mock him in class—not so much with words but by their looks to each other whenever he is called on by the teacher. They expect that he either won't have the right answer or that he will say something really stupid. Justin won an award for having the best artwork for a seventh grader.

Justin's relationship with his mother is tumultuous. One day he loves her, and the next day he is cursing and yelling at her, especially if she disciplines him. Sandy loves Justin very deeply; she calls him her baby. When Sandy becomes angry with Justin, she curses him out and sometimes hits him. Sandy has said that Justin is all that she has left. In addition, Sandy needs some training in parenting because sometimes she hosts pot parties in her home with Justin and James present. She excuses this with the explanation that pot helps her to cope, and her kids should do as she says, not as she does.

Sandy can't seem to get a handle on understanding Justin and his needs. One minute he is smoking like an adult and cursing, and the next minute he is crying like a little baby. For instance, he cried in court and in the car on the way home because the judge told him that if his behavior did not change he was going to send him to the county's residential treatment center for wayward and out of control boys. As if to encourage him, the judge did praise the residential treatment center and noted that several of the boys he sent there to get their lives straight came out and did well. These boys completed college and obtained good jobs.

(Continued)

(Continued)

Justin's mother has attended 1 year of community college. She said that she breastfed Justin and that she used to read stories to him at night. At best, however, Sandy belongs to a lower socioeconomic group. She says that as soon as the court gets out of her life, she is going to get a full-time job. She keeps a neat house, but she is challenged in doing so. Justin and James provide little assistance in keeping the house clean and organized. In addition, Sandy is challenged when setting up structure for her children to follow. For instance, Justin and James eat whenever they want, with no set time for dinner or for getting up and completing homework or chores.

Justin's response to the court has been mixed. He has arrived more than 20 minutes late on two occasions. His mother has to call him repeatedly to get out of bed so that he wouldn't be late for court. Justin has struck up a positive relationship with his probation officer. For the most part, Bob, the probation officer, has given encouraging reports to the presiding judge. One consequence of these reports is that they have kept Justin from being sent to the residential treatment facility. Bob is concerned, however, that Justin is not going to make it. He points to Justin's brother, James, and the life of crime he has lived.

Justin is terrified that the court will take him away from his mother and place him in the residential treatment facility for boys. Most of the time, he covers up this fear with a great deal of posturing and bravado. Justin says that he is going to do better in school, but thus far, he has not achieved very much. Moreover, he and his mother have failed to come up with a workable plan for the improvement that the judge indicated he would consider a favorable action in Justin's case. Every time Sandy mentions creating a plan, Justin says that he will do it tomorrow. The truth of the matter is that Sandy has few clues regarding how to go about creating a plan for helping Justin to deal successfully with his issues at home and at school.

When the therapist asked Justin about his earliest memories, he first said that he couldn't remember anything when he was very young. "It's all kind of like nothing is there. It's as if my entire life did not happen when I lived in Chicago. I keep trying to remember what my house looked like, but I can't remember anything." The therapist paused for a few moments.

"Tell me about your father. What do you remember about your father?"

Justin's eyes began to fill with tears, and he began fidgeting in his chair, signaling that he was uncomfortable with the therapist's line of questioning. The therapist reached over and handed Justin a tissue to wipe his watery eyes. "My question has resulted in your tears, Justin. Can you tell me about those tears? What are they saying to you? "

"Tears can't talk. You know that."

"But sometimes they provide a signal to us that we are experiencing pain. I sometimes cry when I am sad. I also cry sometimes when I am very, very happy."

In response to his therapist, Justin added, "My mom cries when my brother and I get into trouble. She says that we are trying to send her to the crazy house."

"We laugh at her. She's supposed to be a grown-up, but she cries when things don't go the way that she wants them to be."

"So, how do you feel Justin, about your tears as we are talking together?"

"Embarrassed . . . like I'm a baby or something. I'm no baby. I know how to take care of myself."

Justin went on to discuss his relationship with his father, whom he barely remembered.

His earliest memory of his father was with his mother and father arguing loudly in the kitchen. Justin tried to get in between his parents with a plea that they not fight anymore. First, his father knocked him to the floor, but when he began crying his father picked him up and said, "Hey, Champ, big boys don't cry." Then, seemingly catching himself from this outburst of anger, he said, "Come on," cajoling Justin, who was still crying, and he took his fist and he playfully touched him a couple of times with fake punches.

Justin said that this was his last memory of his father—asking him to be strong when he really just wanted to be comforted by his father. For Justin, the memory of his father was both positive and negative. He could never understand why his father was not like the fathers he had seen on television. Justin's family was at war then—much in the same way that it is now embroiled in turmoil.

SUMMARY

This chapter has introduced you to the concept of theories in psychotherapy. A theory can be a good thing if it provides a well-thought-out, organized way of conceptualizing human development and behavior.

Emphasis was placed on the idea that therapists must consider integrating Eastern and Western approaches to psychotherapy. Currently, there is evidence of a movement to incorporate Eastern approaches to psychotherapy as evidenced by the fact that three relatively new cognitive behavioral therapies (CBTs; dialectical behavior therapy [DBT], acceptance and commitment therapy [ACT], and mindfulness-based cognitive therapy [MBCT]) have incorporated mindfulness and other Asian approaches to psychotherapy.

Counselors' values have an important influence on their choice of a therapy theoretical framework and on their interactions with clients. Counselors need to become aware of their values and the impact that they have on the counseling relationships. Counselors respect the right of their clients to hold values different from theirs. They should avoid value imposition on clients, defined as counselors' attempt to define a client's values. Both the ACA and the APA maintain that it is unethical for counselors to engage in value imposition toward their clients.

This chapter has reviewed important ethical issues that most counselors and therapists will have to take into consideration in their practice. Therapists need to become aware of the ethical codes that guide their profession. Some basic ethical issues involve informed consent, client confidentiality, assessment and diagnosis, multiculturalism, multiple relationships in the counseling process, and EBP.

The process of choosing a theory can be described as a long process, and for some individuals, it can be a lifelong process that involves continually evaluating, incorporating, and fine-tuning one's practice to conducting psychotherapy. Psychotherapy integration has become the norm rather than the exception. Most therapists are choosing to incorporate aspects of several theoretical models in their therapy practice. Ethical codes for counseling and psychology maintain that therapists should be competent in their use of theories of psychotherapy.

"Why I want to become a therapist": Divide into groups of four or five people. Designate one person as the group recorder. Each student writes down and describes three reasons why he or she wants to become a counselor or a therapist. The group's recorder keeps track of these reasons. What common themes came forth from the group? What differences did you find in the reasons that people gave for wanting to choose the helping profession? Each group reports back to the class as a whole so that students will be able to examine their own reasons for becoming a counselor or a therapist as well as the reasons that their classmates give.

Discuss five values you have that might have an impact on how you would approach psychotherapy with a client.

Discuss three reasons why you either would or would not choose to enter psychotherapy for yourself before conducting psychotherapy with a client.

What factors are important in choosing a theoretical orientation? Discuss at least three factors that you will take into consideration when you choose your own integrative approach to psychotherapy.

Discuss the level of activity you think you would be comfortable with in conducting therapy: high, medium, or low activity in counseling. Explain.

GLOSSARY OF KEY TERMS

codes of ethics Designed to provide formal statements for ensuring protection of client rights while also enumerating standards of competency for counselors and psychologists. Ethical codes provide guidelines for the professional conduct of its members.

counseling A process concerned with helping normally functioning or healthy people to achieve their goals or to function more appropriately.

countertransference A therapist's unconscious wishes and fantasies toward a client or any therapist's projections that influence the manner in which they view and respond to a client.

dual or multiple relationships Take place when a therapist combines his or her role as a therapist with another role, such as a teacher or friend. These multiple roles may conflict with each other.

empirically supported treatments (ESTs) Psychological treatments designed for a specific disorder, such as panic disorder, that have been shown to be effective in controlled research. Empirically supported therapies are those that have been found to be effective in scientific studies that meet rigid criteria of randomized clinical trials (RCTs). The designation of empirically supported therapy means that treatment must have been found to be better off than clients who received no treatment and that outcomes are at least equal to those reached by alternative therapies that have been found to be helpful.

evidence-based practice (EBP) Practice based on the belief that solid, empirical research as well as clinical experience should inform therapy and professional decision making regarding interventions to use.

informed consent The right of clients to be informed about their therapy (theoretical orientation, techniques, length of therapy, and so forth) so that they can make autonomous decisions related to it. Informed consent is a client right provided for in counseling and psychological codes of ethics.

privileged communication Legal term used to describe the privacy of counselor–client communication. Which professionals are given privileged communication varies by state.

psychotherapy A long-term, intensive helping process that assists individuals who have severe problems in living—usually described as reconstructive, remedial,

in-depth work with individuals who suffer from mental disorders or who evidence serious coping deficiencies.

psychotherapy integration An approach to psychotherapy integrating, in a meaningful way, two or more theories of psychotherapy for the expressed purpose of meeting the needs of a therapist and his or her clients.

theory Set of statements one uses to explain data for a given issue; provides the means by which predictions can be made and points out the relationships between concepts and techniques. A psychotherapy theory supplies a framework that helps therapists understand what they are doing.

worldview May be defined as the way in which he or she constructs meaning in the world. A worldview contains the different beliefs, values, and biases a person develops as a result of having been raised in a given culture.

Additional exercises, journals, annotated bibliography, and more are available on the open-access website at

.

PART I

The First Force in Psychotherapy

PSYCHOANALYSIS AND PSYCHODYNAMIC THEORIES

Psychology's Indebtedness to Sigmund Freud

Psychology is deeply indebted to psychoanalysis and to Sigmund Freud for ushering in the development of a psychotherapeutic treatment known as the "talking cure," and it is this treatment approach and conceptual model that constitutes the "first force" in psychotherapy. Freud popularized the talking cure. Most of psychotherapy is based on the treatment approach that Freud developed. Psychoanalysis consists of a number of theoretical approaches to psychotherapy. Some of the prominent theorists that emerged out of Freud's early work include Carl Jung, Erik Erikson, members of the object relations school, the self psychologists, and Alfred Adler. Chapters 2 and 3 discuss these theorists and their work.

Psychoanalytic theories are those that posit unconscious processes, psychosexual stages of development, and a tripartite personality structure labeled the *id*, *ego*, and *superego*. Psychoanalytically oriented therapies adopt many of Freud's treatment techniques, such as free association and interpretation. Psychoanalysis is generally considered to be a depth psychology, and therapists who subscribe to this theoretical school maintain that human behavior is mainly influenced by what takes place in the unconscious mind. Sessions may take place three to five times a week, and it is long term rather than short term. Psychoanalysis proper is usually conducted with the analyst sitting behind the client, who reclines on a couch. What is often called psychoanalytic therapy is, in reality, psychoanalytically oriented therapy instead of analysis proper.

Some Distinctions Between Psychoanalysis and Psychodynamic Theories

The line of demarcation between psychoanalytic and psychodynamic theory is fuzzy at best. In general, however, psychodynamic therapy has come to signal a much broader view of treatment. It includes psychoanalysis as well as object relations theory and psychoanalytic self psychology. There are some fruitful ways of comparing a classical psychoanalytic (Freudian) approach and a psychodynamic one. Classical psychoanalysis emphasizes the id (or what is commonly referred to as "drive theory"). In contrast, the psychodynamic school highlights the ego instead of the id. The ego psychologists are the leaders within the psychodynamic school in underscoring the importance of the ego. Whereas Freud was concerned primarily with intrapsychic conflicts (psychological conflicts within an individual), psychodynamic therapists focus on interpersonal conflicts or conflicts between individuals. The object relations schools continue the interpersonal focus of psychodynamic theory by proposing the concept of objects or significant people in a person's life. Psychodynamic therapy helps clients describe and put into words feelings that are troubling, threatening, or contradictory. Psychodynamic approaches help clients identify and explore recurring themes and patterns in their lives. Therapy focuses on past experiences and on the therapy relationship.

Integration of Freudian Concepts: The Unconscious and Transference

In Chapter 2, I focus first on Freud's psychoanalytic approach to therapy. Freud's writings are prolific; therefore, I review only some of his essential concepts, including Freud's theory of personality, his psychosexual stages, and phases of psychotherapy. Next, I examine the contributions of Jung, who was Freud's chosen successor (once called the "crown prince" of psychoanalysis) and heir apparent to lead the psychoanalytic movement. Jung adopted Freud's emphasis on the unconscious and the use of dream interpretation during therapy. He also proposed his own analytic psychology, which he put forth when he could no longer accept Freud's all-embracing concept of the libido.

Jung is remembered most for his concepts of the collective unconscious and archetypal patterns and images that are associated with it. For instance, he proposed the archetype of the Wise Old Man, the Great Mother, and the lion. Jung maintained that archetypal images are universal and that they can be found in the religions and mythologies of diverse cultures. Jung also stressed the persona, the social role, or mask that individuals assume and wear; the anima–animus (which is the unconscious opposite or other sex side of a man's or woman's personality and a concept that was later incorporated in Sandra Bem's sex role, feminist theory); the shadow (the unconscious features of our personality that we reject); and the self (which Jung saw as the center of an individual's personality). Some of Jung's concepts, such as his constructions of personality types (introversion–extraversion, thinking–feeling, and sensing–intuiting), have been widely accepted.

New Forms of Psychoanalysis

Other followers of Freud, such as Anna Freud (ego defense mechanisms) and Erikson (psychosocial stages of development), have emphasized the role of the ego more so than the id, and they have highlighted the role of social factors. The impact of Anna Freud and her list of ego defense mechanisms has been widespread. Most therapists acknowledge in some form that people adopt various strategies to protect the ego or the self. Individuals use a number of defense mechanisms to protect the ego, including regression and denial.

Erikson's theory of psychosocial development is currently taught in most child development courses across the world. In contrast with Freud, he considered the social factors that influence a person's development and a person's interpersonal interactions within a given culture. Erikson, himself, however, had his own identity issues as an adopted child.

Object relations theory (proposed by Donald Winnicott) is a newer form of psychoanalytic therapy that explores a person's internal, unconscious identifications and internalizations of external objects, usually described as significant people in their lives. For instance, individuals internalize a view of their mothers (mother object) and fathers (father object). Object relations theorists have focused on early childhood development, the way that young children relate to their mothers, and how disruptions in the mother–child relationship can lead to later childhood and adult psychological disorder. The basic task of human development is conceptualized as one of differentiation and integration with the final emergence of a sense of identity.

Clients who are experiencing issues with separation and individuation or dependency versus independency may find the work of ego psychologists and object relations theorists quite useful. Self psychologists such as Heinz Kohut have also provided significant contributions to psychotherapy, primarily in terms of treatment of specific disorders, such as narcissism.

Relational analysis is one of the newer derivatives of the psychoanalytic school. Theorists within this school emphasize the importance of the therapeutic relationship within an analytic framework. Adherents of this approach renounce the role of the therapist as a blank screen, and they offer a brief form of psychoanalytic or psychodynamic therapy. Relational analysis is based on the fundamental human desire for and defenses against deep emotional connection with others, rather than on the classical psychoanalytic emphasis on conflicts regarding infantile drives for sex and aggression. The relational analyst engages the client as an active coparticipant in the therapeutic process. Hence, a client's experience in a relational analysis is quite different from being in a classical Freudian analysis, in which the therapist seeks to function as a blank screen onto which the client projects.

Currently, some practicing psychoanalysts and psychodynamic therapists continue to use many of Freud's concepts—all the while incorporating concepts of later theorists. For instance, some theorists make use of Freud's constructs of conscious and unconscious, and others use his personality constructs of id, ego, and superego. Other pivotal concepts in psychotherapy, such as transference and countertransference, have been adopted across many theoretical lines. Freud's conceptualization of psychosexual stages—oral, anal, phallic, latency, and genital—are not so widely accepted. Psychoanalysis continues to reformulate and re-create itself using concepts from the offshoots of classical analysis.

Chapter 3 is entirely focused on Adler because of his profound influence on psychotherapy. Most of Adler's ideas have been relabeled and incorporated in many other theories of psychotherapy. For instance, Adler proposed an early form of the "miracle question" long before solution-focused therapy ever arrived on the scene. Adlerian concepts such as inferiority and superiority complexes, mistaken goals of children (negative attention getting), and the power of helping others in reducing psychological problems (social interest) have

been widely adopted without acknowledging the early contributions of Adler. Adler conducted seminal work on the family, the family constellation, and birth order research, and his child guidance clinics may be considered an early forerunner of family therapy.

As can be gleaned from examining some of the contributions of the leading psychoanalytic and psychodynamic theorists presented in Chapters 2 and 3, the first force in psychotherapy has had a powerful influence on psychotherapy.

2 Psychoanalytic and Psychodynamic Theories

Understand the Freudian view of human nature, personality, and psychosexual stages of development.

Identify critical similarities and differences between classical psychoanalysts, ego psychologists, and object and self psychologists.

Describe the major tenets of Jungian personality therapy and the five different archetypes.

Explain the differences between classical psychoanalytic therapy and dynamic therapy in terms of approaches to therapy, the roles of the client and therapist, and the techniques used.

Identify some of the multicultural positives and blindspots of classical psychoanalysis and a broad range of psychodynamic therapies.

Understand the research evidence to support the efficacy of psychoanalysis and psychodynamic approaches to therapy.

Evaluate the primary contributions and limitations of classical psychoanalysis and psychodynamic approaches to therapy.

Brief Overview

The primary focus of this chapter is on Sigmund Freud's contributions to psychoanalysis. Freud's view of human nature, the structure of personality that he proposed, and his pivotal contribution about the conscious and unconscious are examined. Levels of consciousness and psychosexual phases are also covered. I present in brief summary the contributions of some of the offshoots of Freud and psychoanalytic theory. The work of Carl Jung, one of Freud's important disciples, is reviewed. I discuss ego psychologists (Anna Freud and Erik Erikson), object relations psychologists (Donald Winnicott), self psychologists (Heinz Kohut), and relational psychoanalysis.

Would you ever consider integrating psychoanalytic therapy into your integrative approach?

If yes, what parts of this theoretical approach would you choose to integrate?