Theories and Applications of Counseling and Psychotherapy: Relevance Across Cultures and Settings

Pages: 640
Publisher: SAGE Publications, Inc; 1 edition (March 22, 2018)
Format: pdf, epub
Language: English

Theories and Applications of Counseling and Psychotherapy

I dedicate this textbook to Jackie Ginter. If truth be told, I would have accomplished very few—more likely none—of my professional achievements without the undying support, vital assistance, insightful opinions, and love that Jackie provided me over the last 43 years of our relationship. Years ago I read in The Bhagavad-Gita: Krishna's Counsel in Time of War (Vyasa, 1986) a passage (repeated below) that relates to clear thinking, strong passion, and inactivity that can comingle in a manner to bring about a "dark inertia." Jackie has always been there to share her views concerning how I could successfully overcome any such problematic dark inertia. Lucidity addicts one to joy, and passions to actions, but dark inertia obscures knowledge and addicts one to negligence. Earl J. Ginter

For my parents, Nepal Chandra and Amita Rai Sircar, who believed in their daughters' educational and professional advancements, which belief I transmit to my granddaughters Josephine Amita, Simone Sangitha, and Katherine Swati. Gargi Roysircar

To my brilliant doctoral program advisors, Wayne Antenen and Abraham Tesser, and my highly talented and creative psychotherapy mentors and teachers: Harry Bates, Insoo Berg, Warren C. Bonney, Steve de Shazer, Helen Kramer, Elizabeth Sheerer, Peter Sherrard, and Elwyn Zimmerman. Lawrence H. Gerstein **Theories and Applications of Counseling and Psychotherapy** Relevance Across Cultures and Settings **Earl J. Ginter***University of Georgia***Gargi Roysircar***Antioch University New England***Lawrence H. Gerstein***Ball State University*

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. 3 Church Street #10-04 Samsung Hub Singapore 049483 Printed in the United States of America *Library of Congress Cataloging-in-Publication Data* Names: Ginter, Earl J., 1950- author. | Roysircar Sodowsky, Gargi, author. | Gerstein, Lawrence H., author. Title: Theories and applications of counseling and psychotherapy : relevance across cultures and settings / Earl J. Ginter, The University of Georgia, Gargi Roysircar, Antioch New England Graduate School, Lawrence H. Gerstein, Ball State University. Description: Thousand Oaks : SAGE, [2019] | Includes bibliographical references and

index. Identifiers: LCCN 2017053991 | ISBN 9781412967594 (pbk. : acid-free paper) Subjects: LCSH: Counseling—Philosophy. | Psychotherapy—Philosophy. Classification: LCC BF636.6 .G56 2019 | DDC 158.301—dc23 LC record available at https://lccn.loc.gov/2017053991 This book is printed on acid-free paper. Acquisitions Editor: Abbie Rickard Content Development Editor: Emma Newsom Editorial Assistant: Jennifer Cline Marketing Manager: Susannah Goldes Production Editor: Veronica Stapleton Hooper Copy Editor: Colleen Brennan Typesetter: C&M Digitals (P) Ltd. Proofreader: Dennis W. Webb Indexer: Jean Casalegno Cover Designer: Michael Dubowe Cover Art: Lawrence H. Gerstein and John Melvin

Brief Contents

Detailed Contents

Approaches Introduction The Case of Tim, a Transgender Client Key Players in Feminist Therapy Jean Baker Miller Lenore Walker Laura Brown Historical Context Basic Concepts Gender Marginalization Self-in-Relationship Good Mother/Bad Mother Personal Experience Personal Is Political Integrated Analysis of Oppression and Egalitarianism Important Concepts in Relational–Cultural Therapy Therapeutic Process Goals Therapist's Role Client's Role Assessment Therapeutic Change Techniques and Strategies Multiculturalism and Social Justice Ethical Considerations American Psychological Association Guidelines for Practice With Transgender and Gender Nonconforming People Foundational Knowledge and Awareness Stigma, Discrimination, and Barriers to Care Evaluating Theory Research Support Overall Limitations and Criticisms Relevance of Theory to Current-Day Practice Applying Theory to Practice Returning to the Case of Tim, a Transgender Client Returning to the Multicultural Case of the Sanchez Family Chapter 12. Postmodernism: Constructivism and Social Constructionism Introduction Key Players of Constructivism and Social Constructionism Michael J. Mahoney The Case of Justine Kenneth J. Gergen Robert A. Neimeyer Historical Context Constructivism Social Constructionism Narrative Theory Conclusion About Constructivism and Social Constructionism Basic Concepts Self Meaning-Making Local Knowledge The Therapeutic Process Narrative Therapy Constructivism Techniques and Strategies Social Constructionism Techniques and Strategies Multiculturalism and Social Justice Therapist Cultural Self-Awareness Understanding the Client's Worldview Making Cultural Generalizations Ethical Considerations Evaluating Theory Research Support: Ways of Discovery Limitations and Criticisms of Theory Current Mental Health Delivery System Applying Theory to Practice Returning to the Case of Justine Returning to the Multicultural Case of the Sanchez Family Chapter 13. Family Therapy Approaches Introduction Returning to the Issue of Defining the Word Family Hypothetical Case: A Famous Family Enters Therapy Family Therapy Between Family and Individual Therapy: Differences Family Therapy: Historical Context and Points of Origin General Systems Theory: The Bedrock for Family Therapy Gregory Bateson Contemporary Family Therapy Five Approaches to Family Therapy Cognitive-Behavioral Family Therapy: Rational Emotive Behavior Family Therapy Family Dynamics Therapist's Role and Family's Role Assessment and Goals Techniques and Termination Process of Change Solution-Focused Therapy Family Dynamics Therapist's Role and Family's Role Assessment and Goals Techniques and Termination Process of Change Bowen Family Systems Therapy Family Dynamics Therapist's Role and Family's Role Assessment and Goals Techniques and Termination Process of Change Structural Therapy Family Dynamics Therapist's Role and Family's Role Assessment and Goals Techniques and Termination Process of Change Experiential Approach Family Dynamics Therapist's Role and Family's Role Assessment and Goals Techniques and Termination Process of Change Appropriate Client Populations: Family Therapy Multiculturalism Social Justice Special Ethical Considerations Research Findings Limitations and Criticisms Application: Family Therapy Returning to the Case of a Famous Family Seeking Family Therapy What Famous Family Was Used to Construct the Genogram? The Case of Miguel Sanchez Chapter 14. Multicultural and International Approaches Introduction Key Players Derald Wing Sue The Case of Tyrone Melba J. T. Vasquez Janet E. Helms Paul Bodholt Pedersen Historical Context Deficit or Inferiority Model Fighting the Deficit Model Civil Rights Movement Culturally Deprived Model Culturally Different Model Internationalization of Psychology Basic Concepts Culture Cultural Paranoia Biculturalism Race and Ethnicity Intersectionality Stereotype Threat Racial Microaggressions Implicit Racism Racial Identity "Emic" (Multicultural) and "Etic" (Cross-Cultural) Approaches The Therapeutic Process Goals of Therapy The Therapist's Role The Client's Role Multicultural Assessment Techniques and Strategies Social Justice Ethical Considerations Evaluating Theory Research Support Limitations of the Multicultural Theory Relevance to Current Practice Applying Theory to Practice Returning to the Case of Tyrone Returning to the Multicultural Case of the Sanchez Family Assessment Interventions Chapter 15. Moving Toward a Personal Theory of Counseling and Psychotherapy A Wealth of Theories and Therapies The Journey to Find One's Own Theoretical Approach Elements That Make a Theory a Theory: A Much Maligned Term Defined The Tangible Value of Operating From a Theoretical Position Boxing Differences Among the Theories Covered Common Factors: Corralling Similarities Among the Theories The Master Therapist: A Blending of Science and Art Integration's Role in

approach in mental health settings, client populations generally served), an example of how the theoretical approach covered might be applied when working with actual clients (including the role of multiculturalism), the role of social justice, summary comments by the chapter's author(s), and recommended publications. The authors made a concerted effort to describe each of the theories and approaches in a manner that offers a "balanced, deliberate, and judicious coverage of the various theoretical approaches." My evaluation of their effort to do so exceeded my expectations. According to the authors, this textbook was designed to provide a comprehensive overview of those therapeutic approaches that emerged from what was to become a multitheoretical system whose origin could be traced to the late 1800s. This textbook was also designed for readers who seek an introduction to the world of therapy, especially those enrolled in introductory undergraduate courses offered through counselor education, psychology, social work, and criminal justice programs. Further, this textbook is appropriate for advanced curriculums, which reacquaint students with previously studied theories. This reviewer fully agrees with the recommended users of the text and is unequivocal in his recommendation! George M. Gazda, EdD Research Professor of Education, Emeritus College of Education, University of Georgia Past President of American Counseling Association Past President of American Psychological Association Division 17 (Society of Counseling Psychology) **Preface T**he decision to write this textbook began when Lawrence (Larry) Gerstein, who had just published the ***Handbook for Social Justice in Counseling Psychology: Leadership, Vision, and Action,*** was approached by Kassie Graves of SAGE Publications and asked if he would consider co-authoring a theories of counseling and psychotherapy textbook. After Larry agreed to take on the proposed project he subsequently contacted Earl Ginter and Gargi Roysircar and invited them to participate. Before the writing phase of this collaborative effort started the three authors decided that a critical first step was to compile a list of strengths and weaknesses found in various theory textbooks that were used in psychology and counseling programs. In addition to the weaknesses and strengths the authors were personally aware of in a number of existing textbooks, they approached veteran teachers of theory courses at several universities to elicit what these professors considered to represent common problematic features and inherent assets of the textbooks they had adopted for use in their theory course(s). The authors pooled their own and the consulted professors' assessment of negative and positive qualities. A larger number of weaknesses than strengths were identified that everyone agreed posed problems that hindered, to varying degrees, what students needed to learn by the end of an academic term. The authors of this textbook made a concerted effort to avoid and/or address the weaknesses uncovered while also incorporating the strengths identified. **Goals for this Textbook** The authors believe they have written a textbook that offers both upper level undergraduates and beginning graduate students in counseling and psychology a comprehensive, readily attainable examination of essential theories that support and guide the therapeutic approaches relied upon by practitioners. The authors also believe that persons pursuing a career in another of the mental health fields, for example, social work, psychiatric nursing, criminal justice, paraprofessional jobs focused on alcohol and substance abuse, and so forth would find this textbook invaluable for broadening their understanding of how certain treatment approaches might interface with their treatment responsibilities. The optimum depth and width of coverage that characterize this textbook, believed by the authors to be necessary for a theory course, was accomplished using a style of presentation that would appeal to present day students. The authors purposely sought clarity of content by avoiding the use of needless jargon that might make a topic area needlessly difficult, if not unintelligible, for readers who were new to the field. The primary aim was to expose readers to enough specialized terminology to allow them to differentiate among the various approaches to therapy and to comprehend the unique contributions made by each of the theories to the practice of therapy. (The term "therapy" is used throughout this textbook to refer to the wide array of existing mental health practices.) Whenever technical terms, and concepts tied to those terms, were introduced in one chapter they were used in a consistent manner throughout the remainder of this textbook. In addition to these characteristics, there are several other special features of this textbook that should be emphasized. **Features of this Textbook Guides for Summarizing the Various Theories** The authors included an ongoing

student exercise that is explained at the end of Chapter 1 and concludes in Chapter 15. This exercise prepares students to write six specific summaries for each of the theory chapters by utilizing a template provided at the end of Chapter 1. The exact procedure students are to follow was illustrated via a completed template that corresponded to six critical elements that are covered in each of the twelve theory chapters. In Chapter 15, students receive further instructions that outline the steps to take and the questions to answer so they can correctly utilize their personal summaries to isolate those aspects of the various theories that they find most helpful to create their own personal theoretical approach to counseling or psychotherapy. **Professional Organizations, Ethical Codes, Stresses Encountered, and Self-Care** The content found in Chapter 2 is especially valuable for readers to consider since it focuses on the development of the person as a professional and it reviews important features of two prominent associations (i.e., American Counseling Association and American Psychological Association) in the mental health field. The chapter also covers ethical and legal requirements associated with professional practice, licensure and certification, and the issue of self-care to prevent the kind of burnout associated with the exhaustion of physical, emotional, and motivational resources that can result from prolonged exposure to stress. **Authorsâ€™ Use of Cultural Artifacts** A unique feature of this textbook resulted from the authors deciding to explain certain theoretical concepts or intervention strategies by incorporating dialogues and characters from movies and TV shows, paintings, drawings, quotations, poems, short stories, lyrics, news articles, photographs, or comics. The authors have found in their own classes that such an approach heightens students' attention to and interest in a textbook's content even when that content can prove a challenge to those unfamiliar with the various theories. For example, the well-known painting by Edvard Munch, "The Scream," portrays a strong felt experience without using a single word (see Figure 1). The image created by Munch resonates with viewers of his painting, an image that immediately communicates the horrible anguish felt by the depicted figure. The quality of certain images, such as this one, have the power to persist and retain their effect long after a student moves on to consider something else. Without a doubt Munch's painting can be relied on to convey the type of potentially life changing experience often referred to by existential therapists. If one looks carefully at "The Scream" one begins to see the high-pitched wail of someone who realizes he or she is nothing more than a speck in an immense universe that is bone-chilling cold and uncaring. A universe that does not provide any ready-made, universally applicable reason for living. According to existential theory, this represents the turning point where a client can either give in to the overwhelming pain, grief, and anger associated with such a horrifying realization or the client can seize the situation as an opportunity to create his or her own meaningful purpose and reason for living.

Figure P.1 Edvard Munch's Painting *The Scream* **Focus on Multicultural and Social Justice Issues** Multicultural and social justice principles and therapeutic strategies were also incorporated by the authors throughout this textbook. This was done to help students understand the interaction between diversity, social justice, and how to conceptualize, assess, and intervene with clients from various racial and ethnic backgrounds. In addition, the textbook features two client cases for each of the theory chapters. One case is introduced once and not used elsewhere in the textbook, and the other one is a multicultural client case (i.e., the case of Miguel Sanchez) that is reintroduced in each of the twelve theory chapters to illustrate how different therapists, operating from different therapeutic approaches, are likely to conceptualize and approach the same case. The repeated use of the latter client case serves to educate students about how the same exact client can receive treatment using a different theoretically based approach. The case of Miguel Sanchez allowed the authors to explicitly demonstrate how each theory motivates a therapist's actions and thoughts during therapy sessions and guides the therapist in ways to gauge the degree of progress made by a client and when it is appropriate to terminate therapy. Returning repeatedly to the Miguel Sanchez case also enables students to acquire a fuller understanding of how various theoretical approaches function toward solving clients' problems which lies at the heart of comprehending more completely the different forms of therapy practiced today.

Practice Implications Additionally, each theory chapter also informs students about how the marketplace perceives a particular theory (e.g., whether it receives insurance reimbursement), the type of service delivery setting where it is applied (e.g., private practice, community mental health centers, psychiatric hospitals, health care settings), populations it serves (e.g., children, youth, adults, couples, families, groups), type and severity of presenting problems it handles well, whether it is adapted for short term treatment, and if certification in the approach is offered. Each theory chapter includes current research on the effectiveness of the theory's applications which serves to indicate the strengths and limitations of using a particular approach with certain presenting problems (e.g., clients diagnosed with various *DSM* disorders). **Special Ethical Considerations Highlighted** Furthermore, the authors integrated into each of the twelve theory chapters those ethical considerations that are especially tied to a specific theoretical approach. For example, the possible ethical ramifications of countertransference situations where the psychoanalytic therapist's own formative family dynamics are re-created and distorts how the client is perceived by the therapist. Finally, even though differences in the organization and content can be found among the chapters due to the structural nature of certain theories, each theory chapter was arranged in a definite and consistent pattern of presentation. This uniform organization allows for easier comparison and discussion of different theories. Critical thinking questions appear at the end of each theory chapter and are designed to deepen students' understanding of important theoretical components. Boxes are inserted in each chapter that highlight certain remarks made by the originator(s) of a theory. These "quotation boxes" give a voice to the various theorists/therapists and provide a brief glimpse into how these provocative thinkers view(ed) the world. **Hoped for Outcome** The Indian philosopher and polymath Rabindranath Tagore stated that "we think that we think clearly, but that is only because we don't think clearly" (p. 14, as cited in Popova, 2015). The authors hope that they have proved all readers of this textbook the tools to think clearly about what they have read. The authors strove to cover the theories in a manner that would enable a reader to successfully walk the precarious length of the razor's edge that divides two requirements for thinking clearly: maintaining an open mind to each theory's position and ascertaining the true contribution made by each theory to present day therapy practice. To facilitate a successful journey of learning for both new and seasoned students the authors sought to provide a balanced, deliberate, and judicious coverage of the various theoretical approaches covered. This called for each author to keep his or her theoretical biases at bay, but in the end it is up to each of the readers to decide if the authors were successful at avoiding the adverse effects that can accompany unchecked theoretical favoritism. **Reference**

Popova, M. (2015, November 29). Force of impact. *The New York Times Book Review*, p.14.

Instructor and Companion Resources Instructor Resources include a **Test Bank** with a diverse range of pre-written options as well as the opportunity to edit any question and/or insert personalized questions to effectively assess students' progress and understanding. Editable, chapter-specific **PowerPointÂ® slides** offer complete flexibility for creating a multimedia presentation for the course. (http://study.sagepub.com/ginter) **Student Resources** provide a personalized approach to help students accomplish their coursework goals in an easy-to-use learning environment. That includes online **Learning Objectives** to study and reinforce the most important material, and **Multimedia** content that appeals to diverse learners. (http://study.sagepub.com/ginter)

Acknowledgments I am extremely thankful and proud of my three sons Matthew E. Ginter, Michael J. Ginter, and Mark D. Ginter for their art work that was included in this textbook. I want to especially recognize Garrison Bickerstaff, a longtime friend, whose linguistic expertise concerning the use, structure, and psychology of the English language proved to be invaluable in completing the chapters I wrote. There are no words I can call upon to capture the sort of gratitude that I harbor toward George M. Gazda for agreeing to review this textbook and write its foreword. I would be remiss if I did not mention the names of various individuals I encountered and interacted with over the years that significantly broadened my worldview of what does and does not define the theory and practice of counseling and psychotherapy. Their influence reverberates throughout the pages of this textbook. The names of those who helped to forge me as a theorist and practitioner are Ahmed M. Abdel-Khalek, Wayne

Antenen, Lois Bergen, Warren Bonney, Jerold Bozarth, John Dagley, Robert L. Dingman, Albert Ellis, Erik Homburger Erikson, Robert Erk, George M. Gazda, Lawrence (Larry) Gerstein, Brian A. Glaser, Ann Shanks Glauser, Roger D. Herring, Thomas (Tom) H. Hohenshil, Arthur (Andy) M. Horne, Don C. Locke, Dubi Lufi, J. B. Martin, F. G. Miller, Norman (Norm) Presse, Bert O. Richmond, Keith Runyon, Joseph J. Scalise, and Pansy and E. Paul Torrance. In addition to the aforementioned individuals, I also want to acknowledge the important contributions made by Jeffrey Cornelius White and Matthew E. Lemberger, co-writers of the person-centered theory chapter in this textbook and Chad Luke and Frederick Redekop, co-writers of the behavioral theory chapter. I want to thank four members of Sage Publications, Kassie Graves, who first proposed this textbook; Nathan Davidson, who provided sage advice to overcome a publication hurdle; Abbie Rickard, whose persistence and support proved inspiring; and Veronica Stapleton Hooper, whose efforts led to the conclusion of this ten-year project. Finally, I want to recognize Larry Gerstein's contributions toward completing the publication of this textbook. Even though Larry and I are long-standing professional colleagues, more importantly, I view Larry as a member of my own family—a brother whom I have always been able to call upon when needed. At one point during the writing phase of this project, for unexpected reasons, I experienced an unshakable form of frustration that caused me to seriously consider to stop working on this textbook. Larry reminded me of my decades-long interest in writing a theory textbook that would clearly communicate to interested parties, especially those new to the mental health field, the importance of developing a clear understanding of how various theories provide the support necessary for current day counseling and psychotherapy practice. Several years ago I summed up my explanation for why theory fulfills a critical role when I stated that *therapy cannot exist without theory*. I still believe this to be true. —Earl J. Ginter I want to thank my advisees, research assistants, and alumni psychologists, and members of the Department of Clinical Psychology at Antioch University New England who read and discussed the chapters and leaning objectives I wrote for this book and gave me feedback. As true scholar-practitioners, they helped me to ground my theoretical and research leanings in the realness of case-based clinical conceptualizations, assessment, and treatment. I am grateful that they requested readability and a straightforward writing style. My students returned the mentoring and editing I provided for their dissertations and doctoral scholarship. —Gargi Roysircar This project seemed to take an eternity to complete. I am extremely thankful to my wife, Dawa Lhamo; Earl Ginter's wife, Jackie Ginter; and my department chair, Sharon Bowman, for their continuous and strong support throughout the process of working on this book. I also want to thank Jeffrey Cornelius White and Matthew E. Lemberger for writing the initial draft of the *Person-Centered Theory* chapter and Chad Luke and Frederick Redekop for their draft of the *Behavioral Theory* chapter. I am appreciative as well to the many individuals that helped with gathering literature that I found useful when writing various sections of the chapters including Yamini Bellare, Alyssa Brown, Kelly Picard Clougher, Jessica Collins, Erin Davis, Mona Ghosheh, Joel Hartong, Ashley Hutchison, Matthew Jackson, Claire Kubiesa, Nicholas A. Lee, David Martin, Donald Nicholas, Gerald Novack, Michael O'Heron, Juno Park, Erin L. Sadler, Nehad Sandozi, Kyle P. Stepler, Holly Tenbrink, Rich Usdowski, Andy Walsh, Laila E. N. Sayyah, and Stefanía Ægisdóttir. Since the inception of this book, I have worked with three different Acquisitions Editors at Sage Publications, Kassie Graves, Nathan Davidson, and Abbie Rickard. Without your patience, commitment, and support for this project it would not have been completed. And for that, I am grateful. I am also appreciative of the excellent work performed by our Copy Editor, Colleen Brennan. My very good friend and go-to talented graphic designer, John Melvin, was responsible for accurately translating my vision for this book's front cover into an art form, and for this, I am very grateful! Finally, it has been 39 years since Earl Ginter and I first met as classmates in the doctoral program at the University of Georgia. Since then, we have been extremely close friends and, at times, collaborators on professional projects. This book stretched us to the max, but as always we had each other's back for which I am deeply appreciative. And, as always, Earl amazed me with the depth of his knowledge in counseling and psychology, and also the arts and movies. Luv ya Earl! —Lawrence H. Gerstein **About the Authors Earl J. Ginter, PhD, LMFT, LPC** is Professor Emeritus at The University of Georgia. Earlier in his career he worked

at Nicholls State University as a counselor, teacher, and researcher. He also has more than 38 years of experience working as a private practitioner. Before he retired on April 1, 2016, he served as the Director for the Division of Academic Enhancement at the University of Georgia. This academic unit worked with approximately 10,000 undergraduate, graduate, and international students each year offering them an array of skill-building services, academic courses designed to meet students' academic concerns, and counseling services which included treating dissertation anxiety. Ginter was also responsible for managing the Division's four federally funded TRiO programs for low-income and first-generation students; operation of the Division's learning center, peer tutoring program, satellite and outreach services; and a special program developed to increase retention and graduation rates at the university. The special retention/graduation program was utilized by 10 academic schools/colleges at the University of Georgia. Other professional experiences include having served as the editor for both the *Journal of Mental Health Counseling* and the *Journal of Counseling & Development*. The latter is the flagship journal of the American Counseling Association with approximately 55,000 subscribers. In addition, he served as the contributing editor for *National Association of Rehabilitation Professionals in the Private Sector* and the associate editor of the theory section of the *Journal of Mental Health Counseling*. Ginter has authored or coauthored numerous publications including journal articles, monographs, book chapters, and books, e.g., *Group Counseling and Group Psychotherapy: Theory and Application* by George M. Gazda, Earl J. Ginter, and Arthur M. Horne. Ginter's publications have focused on issues that comprise the theoretical and practice aspects of counseling and marriage and family therapy. His research and assessment interests pertain to the application of developmental-based approaches to working with individuals, couples, families, and groups. **Gargi Roysircar** received her doctorate in educational psychology with emphasis in counseling psychology at Texas Tech University. She is the Founding Director of the Antioch Multicultural Center for Research and Practice at Antioch University New England and Professor of Clinical Psychology. She conducts research on disaster outreach in international settings, the effects of acculturation and enculturation on immigrant mental health, multicultural competencies in practice and assessment, and training graduate students in culturally informed practice. She has authored more than 100 journal articles and chapters on these topics, with her most recent publications in *Traumatology, Counselling Psychology Quarterly, Professional Psychology: Research and Practice, The Journal of Black Psychology, Journal of Muslim Mental Health, Journal of Career Development, and The Oxford Handbook of Social Class in Counseling.* Dr. Roysircar has participated in mental health counseling in earthquake-destroyed Haiti, tsunami-affected fishing communities in Southern India; Hurricanes Katrina and Rita-affected communities and first responders in the United States Gulf Coast; and in Southern African orphanages that serve HIV/AIDS-infected and affected children and women. She has provided psychoeducation in flood-ravaged Villahermosa, Tabasco, Mexico. Dr. Roysircar trains her counseling teams in disaster trauma, culture-centered skills specific to a community disaster, and in clinician self-care and resilience. She is a grantee of the American Psychological Foundation for her research on her disaster mental health assessment and services. In 2001, Dr. Roysircar was elected as the first Asian president of the Association for Multicultural Counseling and Development, and was appointed as the first woman and first Asian editor of the *Journal of Multicultural Counseling and Development* from 2004–2011. Her awards include the 2002 Extended Research Award of the American Counseling Association (ACA) as well as ACA's 2007 Research Award. Her co-authored books are *Multicultural Assessment in Counseling and Clinical Psychology*, *Handbook of Social Justice in Counseling Psychology,* and the Spanish translation of *Multicultural Counseling Competencies (2003),* having previously co-authored this book in English. Her instrument, the Multicultural Counseling Inventory (MCI), is the most frequently cited instrument among published self-report multicultural competency scales. Her article (Sodowsky et al., 1998), which uses the MCI instrument, was ranked over the past decades among 25 most cited articles of the *Journal of Counseling Psychology.* Dr. Roysircar is ranked in productivity ratings of authors in 5 multicultural psychology journals. She is a fellow of the American Psychological Association (APA) and served on the APA Taskforce Re-envisioning the Multicultural Guidelines for the 21st Century, adopted by APA in August 2017 and titled Multicultural guidelines: An ecological approach to

context, identity, and intersectionality. Dr. Roysircar was the recipient of the 2017 Division 35 Psychology of Women Strickland Daniel Mentoring Award. Dr. Roysircar's 44-year teaching career has been spent in three countries across three continents. **Lawrence H. Gerstein** earned a B.B.A. in public administration and a Ph.D. in counseling and social psychology. He is a Ball State University George and Frances Ball Distinguished Professor of Psychology and Director of the Center for Peace and Conflict Studies, Fulbright Scholar, and a fellow of the American Psychological Association. Professor Gerstein is a co-editor of the *Journal for Social Action in Counseling and Psychology* and an editorial board member for the *Journal of Counseling Psychology*. He has published more than 100 scholarly articles and three books including the *International Handbook of Cross-Cultural Counseling* and the *Handbook for Social Justice in Counseling Psychology*. He is known for his research on cross-cultural methodology, nonviolence, social justice, emotions, and sports for youth development. Professor Gerstein has received more than two million dollars in funding including four U.S. State Department grants and one U.S. Institute of Peace grant. He has performed conflict prevention and resolution work and/or research with adults, children, and youth in the U.S.A, Jordan, Pakistan, Tajikistan, China, Hong Kong, Korea, Indonesia, Israel, Taiwan, and Burma. He has also trained Iraqi young leaders in social entrepreneurship. **Chapter 1 Introduction and Overview** iStockphoto.com/baramee2554

Learning Objectives After reading this chapter, each student should be able to: Compare the similarities and differences between the concepts "psychotherapy" and "counseling."Sketch the history of contemporary therapy and theory.Appraise therapy's relationship to theory.Critique attributes used to judge the soundness of a theory.Evaluate the strategies to assess the effectiveness of therapy.Explain the authors' approach to writing this textbook. **T**wo key terms found in the title of this textbook are *psychotherapy* and *counseling*. In the traditional sense of the term, *psychotherapy* was used to identify professionals who were trained to deal with serious mental or emotional disorders primarily through some form of psychological treatment; these professionals included clinically trained psychiatrists, clinical psychologists, and psychiatric social workers. The term *counseling* was used to identify professionals who worked with others to help them accomplish various outcomes, such as establishing vocational or career goals, learning needed skills (e.g., parenting), promoting changes that would allow them to overcome obstacles in academic and work settings, and assisting with less disruptive mental health–related issues. Psychotherapy and counseling started to acquire definite forms toward the end of the 1800s and the beginning of the 1900s, but after more than 100 years, the distinctions between the two had weakened considerably, and the crossover between each territory of work caused the distinctiveness of the two practice areas to disappear essentially. Even though the areas of psychotherapy and counseling are relatively recent, development from a historical perspective, including interest in promoting mental health, dates back eons. Because of such early occurrences, it is correct to state that psychotherapy and counseling have a long past but a short history. Throughout history many notable occurrences have clearly represented forward thinking in the providing of mental health assistance. One example of such forward thinking occurred with the Muslim scholar Abu Zayd Ahmad ibn Sahl al-Balkhi, who wrote *Sustenance for Body and Soul*, a thesis that addressed what constitutes mental health, why various forms of mental illness occur, and procedures that would enable a suffering person to gain mental health. Al-Balkhi provided a surprisingly contemporary view of what would be recognizable today as a form of cognitive therapy. Haque (2004) summarized al-Balkhi's basic treatment approach in these words, "He suggested that just as a healthy person keeps some drugs and First Aid medicine nearby for unexpected physical emergencies, he should also keep *healthy thoughts and feelings in his mind* [italics added] for unexpected emotional outbursts" (p. 362). Like many others, al-Balkhi understood that from time to time, everyone experiences the pain and disappointment that is associated with life's inevitable misfortunes, but al-Balkhi differed from others because he gave us a means to prevent such misfortunes from escalating into mental illness. His message was simple: We need to maintain a realistic and balanced perspective whenever we encounter the serrated edges of life. In *Sustenance for Body and Soul*, al-Balkhi distinguished between neuroses and psychoses and also explained the interaction of physiological mechanisms that led to

psychosomatic illnesses. Furthermore, al-Balkhi designated four diagnostic categories with connections to identifiable symptoms: (1) anger and aggression, (2) anxiety and fear (i.e., phobias), (3) obsession (i.e., obsessive-compulsive disorders), and (4) sadness and depression (Badri, 2013; Edson & Savage-Smith, 2004; Pickren, 2014). Al-Balkhi wrote extensively about this last diagnostic category. He asserted that disturbances in the area of sadness and depression take one of three forms (Haque, 2004). One form is normal depression that represents a *normal reaction* to daily life's struggles. Another form, *reactive depression*, originates from outside the person, for instance, when a person fails to fulfill a very important personal goal or when an individual suffers a significant loss of property or personal status. The, final type, *endogenous depression*, originates within the person and is marked by symptoms of incessant distress, profound unhappiness, and significant withdrawal from daily activities. Al-Balkhi believed endogenous depression has a strong body connection that requires a combination of medical and cognitive and/or affective-based treatment. Clearly an interest in mental illness and its treatment can be traced back through human history, which predates al-Balkhi by centuries. The lay psychoanalyst Sudhir Kakar (1991), for example, showed that India's earliest societies practiced shamanistic healing rituals that were applied to both physical and psychological problems. While we (the authors of this textbook) earnestly believe that the roots of psychotherapy and counseling extend deep into humanity's past, we also believe such prophetic thinkers as al-Balkhi were more the exception than the rule in terms of explaining key causes and viable treatments for mental illness. Such thinkers were often simply the victim of being in the wrong place at the wrong time. **The Start of Contemporary Therapy and Theory** Although various historical documents and practices of ancient cultures might seem synonymous with contemporary mental health practice, not until the 19th century did a persistent and significant shift in understanding mental disorders occur. This type of understanding, which had authentic focus, depth, and scope, had found its right time and place. In contrast to earlier times, we only have to look back approximately 200 years to appreciate the magnitude of this major shift in thinking. During the 18th century, the hospital-prison called Bedlam was regarded by the social vanguard of England as imbued with high amusement value and well worth the penny fee charged to enter this human zoo, so visitors could safely observe the mysteriously acting inmates who were placed on public display (Pickren, 2014). The 19th century marked the dividing line between rare and fleeting occurrences of humane treatment of people with mental illness and an explosion of widespread and sustained efforts to develop comprehensive approaches to help these people. The second half of this remarkable century is especially notable for a series of events that led to what we know today as psychotherapy. During the 19th century, a cadre of European healers and theorists emerged with a strong disdain for how mental problems had previously been handled and conceptualized. One measure of the fundamental change in approach to mental illness was the rise of the term *alienist* (an archaic term generally attributed to early practitioners of psychiatry). These professionals were called *alienists* because of the generally held opinion that those who suffered from mental disorders were basically alienated from themselves and from others. The term *alienist* can still be found in works of fiction, such as Caleb Carr's 1994 crime novel, *The Alienist*, in which the author used the term to contextualize the story shortly after the turn of the century. **Establishing a Foundation for New Theories and Therapies** The original group of "psychological" healers and theorists who are covered in this textbook can be thought of as frame-breakers. These individuals departed from the theoretical frameworks and approaches to treat mental disorders that dominated during their time. They accomplished this departure by presenting new discoveries and revolutionary ideas that provided the requisite support to make important advances in theory and practice. Two such frame-breakers who departed from the prominent, unquestioned beliefs of 19th century were Jean-Martin Charcot and Sigmund Freud. Charcot was a renowned French neurologist who established the first neurology clinic at the Pitié-Salpêtrière Hospital, Paris, France. The existence of this hospital allowed for the removal and isolation from society those individuals who were suffering from mental illness. Charcot used the controversial procedure of hypnosis to study and manipulate symptoms of hysteria, which was a common mental disorder in the late 1800s and was considered to be confined solely to women until Charcot argued otherwise (see Figure 1.1). During

Charcot's time, hysteria manifested in an array of conditions, including amnesia that was limited to forgetting specific events; emotional outbursts that could change rapidly and unpredictably; overdramatic displays of behavior and narcissistic monologues; and displays of anxiety or depression that were converted into some form of pseudo-illness, such as paralysis that did not match any known patterns of genuine paralysis (Oxford University, 1971).

Figure 1.1 Nineteenth Century Photographs of Women Diagnosed With Hysteria
Source: Photographs from *Iconographie Photographique de la Salpêtrière*. Upon learning of Charcot's work, Sigmund Freud traveled to Paris to observe and study his work. These pioneers not only significantly contributed to what would become contemporary forms of therapy, but their efforts eventually led to new methods of conceptualizing and treating mental disorders. This process did not progress easily or without complications. Such difficulties were reflected in Freud's years of concerted efforts to establish what was to become psychoanalysis. Although Freud's effort would eventually garner him worldwide recognition, he initially received considerable resistance and experienced years of isolation from Vienna's medical establishment. This was the case even among those professionals who were initially attracted to Freud's new treatment approach and became affiliated with him, for example, Carl Jung and Alfred Adler, among others, who eventually broke with Freud because of disagreements. These disagreements were often rooted in a difference of theoretical opinion, but in some cases they led to acrimony and a partisan type of contentious quarreling that persisted for decades between members of each theoretical camp (e.g., Jungian and Adlerian practitioners). Freud tended to categorize such departures and the resulting therapeutic approaches as misdirection that at best added little significance to the understanding of or treatment of mental disturbance; at worse, he felt these departures led to theoretical dead ends. In fact, the stories that surround the creation of psychoanalysis or the reasons for Carl Jung's break with Sigmund Freud have all the necessary ingredients to portray great literary or cinematic drama. (To appreciate the true nature of these stories of conflict or contrast of character, read Jean-Paul Sartre's screenplay *The Freud Scenario* [1984/2013], portions of which were used by the film director John Huston for his 1962 movie *Freud*, or watch David Cronenberg's 2011 movie *A Dangerous Method*, which vividly portrays the intense relationship that developed between Carl Jung and Sigmund Freud.) The various streams of thinking that led to the current forms of therapy represent fascinating endeavors that cannot be appreciated by reading a brief summary of a particular theory. **Therapyâ€™s Relationship to Theory** Since contemporary therapy's roots can be traced to the late 19th and early 20th century, one would assume sufficient time has elapsed for a single theory to arise that can explain the etiology and best means to treat mental disorders. However, a single explanation for why mental disorders occur has not emerged, nor has a single, best therapeutic approach emerged. In fact, Corsini and Wedding (2000) asserted that the term *therapy* cannot be defined to everyone's satisfaction because the word itself lacks the necessary exactness. These editors added that it is probable that more than 400 different therapies exist. Is it possible to tally what we cannot define? When these two seemingly contrary assertions are simultaneously considered, one may experience the sensation of having fallen into a bottomless pit. The authors of this textbook acknowledge the inherent difficulties in determining what should and should not be included in a representative list of therapeutic approaches, but we also feel that the task is feasible. Our starting point does not consider all of what might fall within the realm of the term *therapy*; the approach we take starts with the following question. Of the present therapies, which are the most likely to be encountered by today's clients? The answer is tied to what might be referred to as "major approaches," which is a much more manageable number than the hundreds of "therapies" identified by some professionals. Furthermore, we believe that to start the discussion by delineating the various types of available treatments is placing the proverbial carriage before the horse because all three authors of this textbook agree with the following statement: *Therapy cannot exist without theory*. This statement is consistent with the position held by Murray Bowen, a well-known family therapy practitioner who foremost regarded himself as a theorist: "Therapy and theory are part of the same fabric" (see Gladding, 2002, p. 127). Thus, before the widely used therapies can be understood, we must momentarily

sidestep the issue of what is and is not therapy and focus our attention on determining what constitutes a viable major theory of therapy (keeping in mind that each major theoretical approach defines what is and is not therapy). Each theory provides a therapist with a set of interconnected ideas that possess enough explanatory power to enable a therapist to hypothesize causes for a client's problem. Theory provides a springboard from which to decide the therapeutic course to take so that specific theory-forged techniques can be strategically enacted in ways to achieve a meaningful closure to the therapeutic process. A theory is a road map of sorts that gives direction from the start to the end of therapy. Even though we have significantly reduced the number of theories that will be covered in this textbook by narrowing our focus, it should be obvious at this point that having more than one major theory to consider means that the psychological territory presented by any one client can be traversed by using a number of different theoretical maps. In fact, the particular map selected by a therapist will determine to a large extent whether a client is perceived, for instance, as suffering from a mental disorder or in the midst of a developmental challenge, and if the client is even diagnosed as experiencing a mental disorder, and whether an appropriate diagnostic label should be applied. This process can be illustrated by contrasting the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) with the theoretical positions known as psychoanalysis and reality therapy. The fifth edition of the *DSM* (*DSM-5*, 2014) uses the term *psychosis* but not *neurosis* even though psychoanalysis relies upon a diagnostic continuum that includes the term *neurotic* (McWilliams, 2011), which is a term used in the 2015 version of the *International Classification of Diseases* (*ICD*) of the World Health Organization. Furthermore, although the *DSM*'s current and previous editions have recognized schizophrenia as a form of mental illness, William Glasser, who created reality therapy, rejected this assertion. Glasser shares company with several other prominent thinkers who also criticized the value or purpose of certain labels, such as Michel Foucault, who wrote *Madness and Civilization*. (Foucault argued that the label "madness" has been misused throughout history by powerful groups to isolate society's outcasts, misfits, and deviants; the label was used to "imprison" society's undesirables while the groups responsible maintained, at best, only a tepid interest in treating genuine mental illnesses.) Finally, the map analogy also serves to remind us that whatever theoretical chart we ultimately decide to rely upon, we should avoid becoming so enamored of a particular map that we mistake it for the actual territory; in other words, no map (or label) can capture the complete complexity and subtle nature of any client. The map analogy also helps us to remember that just like printed or GPS-generated road maps, maps can lose accuracy when they are not updated to reflect changes. Similarly, a therapist's theoretical map's accuracy is likely to change over time in light of new findings and advances in the field. Certain qualities typically characterize the major theories presented in this textbook; these qualities include robust concepts, consistency of treatment outcomes, and good applicability for the range of problems that individuals confront today, including a range from the relatively common relationship problems that can wreak havoc on a family's day-to-day existence to the less frequent but significant disturbances rendered by psychoses. Regrettably, instances have occurred in which a so-called theoretically based approach used to treat mental illness has not been adequately tested to determine the soundness of its conceptually derived assumptions, degree of outcome certainty, or level of treatment applicability—even in modern times. One case in point is the *transorbital lobotomy*, which is a form of psychosurgery that was introduced by Dr. Walter Freeman. The procedure was used as a remedy for conditions, such as aggressive tendencies, mild learning difficulties, delinquency, schizophrenia, postnatal depression, and unruliness—applications that could not be unequivocally justified. Freeman was a psychiatrist with no formal surgical training who created the procedure commonly referred to as the "ice pick lobotomy" because of the surgery instrument used, an orbitoclast, which resembled an ice pick. Freedman would insert an orbitoclast above a patient's eyeball, hammer it through the bone of the orbit into the frontal lobe (an area of the brain associated with the control and regulation of behavior and various abilities associated with executive functioning such as planning and retrieving memories), and move the orbitoclast in a manner to sever brain tissue. He then performed the same surgical procedure on the opposite frontal lobe. Considering that Freedman did not conduct animal studies to ascertain the effects of a

transorbital lobotomy, nor was he interested in doing so, he essentially introduced an extremely invasive procedure that was based on personally held beliefs that lacked evidence of validity. In addition, as evidence shows, the outcomes of this form of psychosurgery were not always predictable; scores of patients died, and others (such as President John F. Kennedy's sister, Rosemary Kennedy) became incapacitated for life. Amazingly, Freeman performed 2,500 transorbital lobotomies in 23 states at 55 different psychiatric hospitals. One of Freeman's patients, Howard Dully, was misdiagnosed by Freeman as suffering from schizophrenia (Dully & Fleming, 2008; National Public Radio, 2014). Other medical and psychiatric professionals, who had seen Dully prior to Dr. Freeman, had not detected a mental disorder. Based on available information, Dully was most likely reacting to both the death of his mother and the remarriage of his father a year later to a woman who had rejected Dully as a stepson (he described his stepmother as a person who "hated me"). Freeman performed a transorbital lobotomy on Dully at 12 years of age in 1960, years after the procedure had been discredited and replaced with breakthroughs in pharmacological treatments, such as the introduction of the antipsychotic drug chlorpromazine (brand name Thorazine). Dully described coming out of the surgery feeling as if he had been "zombified." Figure 1.2 shows Freeman performing Dully's psychosurgery. Specifically, Freeman is demonstrating the procedure he used to perform a transorbital lobotomy. **Attributes Used to Judge the Soundness of a Theory** What qualities make a particular major theory solid and strong? In addition to the need for factually based assumptions, reliable outcomes, and wide applicability, referential integrity is also extremely important to judging whether a theory is sound. Although no major theory completely fulfills all these qualities to the fullest degree, a major theory should be sufficiently strong in each area to justify its status as representing a major theory. These four qualities are defined and illustrated with references to psychoanalytic theory. *Structural Integrity:* Components of the theory are complete, coherent, and internally consistent. Structural integrity provides the conceptual glue that binds ideas and assumptions to form a unified whole. Such an explanation can be illustrated through Freud's theory of the dynamic unconscious. According to Freud, disturbing desires, feelings, and thoughts may be made to disappear from awareness through a mental process he termed *repression*, but he also asserted that what was repressed is likely to have a dynamic nature; that is, repressed experiences will continue to affect a person's behavior in various ways, such as when psychological symptoms develop. Freud spent decades forming a tightly constructed and elaborate theory of mental functioning that was based on his concept of the dynamic unconscious.*Explanatory Power:* The extent to which a theory can effectively explain the subject matter it encompasses (i.e., explanatory power) provides explanations for a wide array of mental processes and behaviors. Freudian *defense mechanisms* can be thought of as habitual strategies that are unconsciously activated for the purpose of distorting reality to protect us from any anxiety-provoking desires, feelings, or thoughts. If these occurrences were not controlled (which prevents us from consciously dwelling on them), our benignant self-image would reveal a repugnant brutish self.*Therapeutic Scope:* This quality specifically pertains to the degree that a theory's concepts and techniques are relevant for treating a range of mental disorders. Whereas Freud focused on treating conditions that fell under the umbrella term *neuroses* (e.g., anxiety disorders and dissociative disorders), contemporary versions of psychoanalysis have been developed that are designed to treat *borderline personality disorders* (serious conditions marked by unstable moods, behaviors, and relationships that are problematic) and psychoses (e.g., schizophrenia).*Referential Integrity:* This quality hinges upon establishing a correspondence between what the theory claims and what has been termed *bias-free objective reality*. Thus, regardless of how well Freud's theory explains human problems, holds together conceptually, or can be widely applied, ultimately the theory must be shown to match real-life situations; that is, reasonable proof for the existence of dynamic unconscious processes must be provided. One means for testing the quality of referential integrity is through empirical investigations. For example, in 2012, university-based researchers reported that empirical support had been found for the psychoanalytic assertion that a connection exists between unconscious conflicts and the conscious symptoms experienced by individuals diagnosed with an anxiety disorder (University of Michigan Health System, 2012).

Figure 1.2 Dr. Walter Freeman Performs a Lobotomy Using the "Ice Pick" Instrument He Created Bettmann/Getty Images These four qualities are closely related and even though they influence each other, each quality introduces an aspect about theories that none of the others fully addresses. Interestingly, pseudoscientific approaches to therapy continued to appear despite the establishment of standards to judge the soundness of such newly introduced "therapeutic approaches." In the book *Alternative Psychotherapies: Evaluating Unconventional Mental Health Treatments*, Mercer (2014) critiques various regression therapies along with other questionable therapies. According to Mercer, regression therapies focus on having someone drop back to an earlier time in their lives (literally becoming their former adolescent or child self again) that supposedly positions the person to overcome deeply disturbing early experiences. Mercer discussed how *adultomorphism* (the belief that infants and children share adult characteristics) can cloud the thinking of regression advocates, some of whom have asserted that birth itself is traumatic enough to cause psychological problems. Mercer referred to evidence that infants experience neither agitation nor distress during birth; nor do they make a physical effort to escape the experience. In fact, an infant's movement is inhibited by a paralysis reflex. Mercer further stated that "certainly an experience resembling birth would be agonizing for an adult, with fully developed, unbending skeleton, tight tendons, and fully formed skull, but the soft bones and malleable skull of the newborn ease the passage" (Mercer, 2014, p. 51). Mercer has reviewed a number of alternative therapies (e.g., energy therapies such as qigong and reiki; holding and attachment therapies; and *le packing*, which treats autistic children by tightly wrapping them in wet, chilled sheets for up to 6 hours) and has cogently argued that these alternative therapies are not in accordance with scientific views and lack sufficient evidentiary support for claims made by their advocates. **Assessing Effectiveness** Historically, theorists and researchers were curious about the effectiveness of therapy, with the earliest studies appearing in the literature in the 1920s (Lambert, 2011). Luminaries such as Sigmund Freud observed clients carefully and recorded notes about similarities and differences in patterns in clients' behaviors and their responses to treatment. Through qualitative methods reported by groups such as the Berlin Psychoanalytic Institute (Fenichel, 1930), various conceptualizations or diagnoses about individuals' psychological functioning were formed, and specific intervention strategies were introduced and employed. In addition, successful prototypical cases were shared with relevant professional communities as evidence of the effectiveness of psychotherapy. In the late 1940s, Carl Rogers, founder of the client-centered (person-centered) approach, introduced the new technology of audiotaping of therapy sessions, which allowed Rogers and others to review the interactions between a therapist and client. From this innovation (i.e., the utilization of systematic procedures to capture and assess clients' behaviors during a therapy session), an interest increased in tracking client–therapist interactions from the first session through the point of therapy's termination (Rogers & Dymond, 1954). Such attention also contributed directly to a new way of educating and supervising aspiring therapists who were interested in learning client-centered therapy. Like Freud and his colleagues, Rogers and his followers relied on a qualitative method to extract themes that they noticed in the audiotapes, and they modified their theories and strategies accordingly and also shared their case examples with the professional community. In the 1950s, a quantitative procedure was employed to investigate the effectiveness of therapy. Since then, a growing number of researchers have relied on a randomized control design to investigate the process and outcome of various therapy approaches. Hans Eysenck, a highly recognized scholar, reviewed many outcome studies and reported that therapy is not beneficial and potentially even harmful (Eysenck, 1952, 1961, 1966). Based on their review of the literature, other investigators arrived at a different conclusion and stated that therapy is effective (Bergin, 1971; Luborsky, Singer, & Luborsky, 1975). In addition, in a seminal meta-analysis of the effectiveness of psychotherapy, two other researchers found strong support for the effectiveness of therapy (Smith & Glass, 1977). Finally, since the 1970s, other individuals have argued that certain theoretically inspired approaches are best suited for certain types of client problems. On the other hand, Wampold et al. (1997) conducted a meta-analysis investigation and concluded that no evidence supports the claim that some forms of therapy are better than others. Other scholars found interesting results that have brought us to a much deeper

level of understanding of what exactly contributes to the effectiveness of therapy. This realization was accomplished by changing the focus from comparing various approaches to investigating the specific characteristics of three components of successful therapeutic outcomes; that is, the characteristics associated with the therapist, the client, and how the intervention approach is applied. Researchers found that regardless of the particular therapy approach, the effective therapist is aligned with other effective practitioners and appears to display what the researchers called common factors that are curative in nature (Norcross, 2002). Some of the common factors that were linked to effective therapists include exhibiting warmth, showing respect, possessing a capacity for empathy, displaying unconditional positive regard, presenting themselves in a genuine manner, and offering the client encouragement. Common factors associated with clients believed to be linked with successful outcomes include attributes such as having hope, being motivated, having a social support system in place, and having an expectation for a positive outcome due to participating in therapy. Common factors reported to be tied to positive outcomes of the therapy process are factors such as establishing a positive working alliance (the connection between the therapist and the client), agreement on treatment goals, and agreement on tasks to be employed during therapy (Horvath & Bedi, 2002; Wampold, 2001). Various professional organizations also have made concerted efforts to address factors that surround therapy's effectiveness. One such professional organization is the American Psychological Association (APA). The debate about the effectiveness of therapy reached a new level in 1995 when APA introduced the concept of empirically validated treatment (Task Force on Promotion and Dissemination, 1995). The APA Task Force on Promotion and Dissemination of Psychological Procedures was charged with identifying scientifically validated therapy approaches for specific problems, as determined by a particular mental disorder diagnosis (Garfield, 1996). In time, approximately 50 of more than 500 treatment approaches were considered effective (Wampold, 2010). As a result of strong criticism about the exclusionary nature of what was considered "validated" treatments (as if no other interventions had any validity), in 1998, the task force agreed to change the validated treatments label to "empirically supported treatments" (ESTs). It is interesting that, since 1996, the task force has not updated its report of ESTs (Wampold, 2010). More recently, in 2006, another APA task force (i.e., Task Force on Evidence-Based Practice) was formed to once again focus, in part, on the effectiveness of therapy. This committee defined what was termed *evidence-based practice* (EBP) in therapy as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (American Psychological Association, 2006, p. 273). Evidence for the efficacy of an intervention as defined earlier resulted in a designation of a treatment as an EBP (e.g., De Los Reyes & Kazdin, 2008). This task force defined best available research as scientific findings that were connected to assessment and intervention strategies for specific client problems and populations. Whereas the more recent EBP policy of the APA did not endorse ESTs (Wampold, 2010), the APA's Division of Clinical Psychology has identified what it considers to be the best research evidence available for effective approaches of therapy given a specific client problem, and this group of professionals has made the information that it gathered available at http://www.div12.org/psychological-treatments. Still, EBP and EST are not the same constructs. EBP is a much more comprehensive construct (APA, 2006) that is not confined solely to the profession of psychology. In fact, the original definition and practice of EBP was introduced by the Evidence-Based Medicine Working Group (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000), and, eventually, an official definition of EBP was endorsed by the Institute of Medicine (Institute of Medicine, 2001). In recent years, other health care disciplines (e.g., medicine, nursing, public health, physical, speech, and occupational therapy) also have endorsed the paradigm of evidence-based practice. Along with the best available research, the EBP approach to determining effectiveness also stresses the importance of clinical expertise (e.g., competencies such as assessment, diagnosis, case formulation, forming and maintaining the therapeutic relationship, treatment planning, clinical decision making, self-reflection) in the promotion of positive outcomes in therapy (APA, 2006). As mentioned earlier, client characteristics (e.g., presentation and severity of problem, personality traits, developmental functioning, gender, race, ethnicity, social class, gender identity, disability status, sexual orientation) and the client's culture (e.g., values, beliefs,

understanding of health and illness, help-seeking behaviors, expectations about therapy) are critical components of EBP as well (APA, 2006). Since therapeutic approaches were first conceptualized and put into practice during the late 19th century, much has changed, including judging what is and is not an effective application of theory. Today, therapists are required to obtain a complex understanding of human behavior and develop a keen ability to employ interventions that are suitable and appropriate for a particular individual's present and ongoing concerns. Although it is difficult to predict the direction that the study of therapy's effectiveness will take in the future, Ivey and Zalaquett (2011) argued that the effectiveness of various theory-derived therapies should be examined in ways that consider the link between psychological functioning and new discoveries taking place in modern neuroscience that have led to a greater understanding of the role that the nervous system plays in all forms of disease, which also includes mental illnesses. **The Authorsâ€™ Approach to Writing This Textbook Terminology** In writing this book, we sought clarity over relying on unnecessary terminology and, when possible, avoided using jargon in ways that might make a topic area needlessly difficult, if not unintelligible, for readers who are new to the field. Using specialized words or expressions to explain other specialized words or expressions does little more than create a theoretical quagmire that muddles understanding and drowns readers in enough confusion to extinguish their interest. Our primary aim in writing this textbook was to expose readers to the amount of conceptual terminology that would both allow them to differentiate among various theoretical approaches to therapy and grasp the unique contribution made by each of these approaches to the practice of therapy. In addition, we sought to use terminology in a consistent manner throughout the textbook when referring to practitioners and the client recipients of what practitioners have to offer. Thus, a decision was made to use the terms *therapist* and *therapy* (or *psychotherapist* and *psychotherapy*) and *client* in a generic manner throughout this textbook rather than alternating between terms, such as *client* or *patient*; *counselor*, *psychologist*, *psychiatrist*, *social worker*, or *therapist* (or its synonym *psychotherapist*); and *counseling*, *psychology*, *psychiatry*, *social work*. (Exceptions to this decision occur when, for the sake of clarity, another term is deemed more appropriate, such as in Chapter 2, where professional counseling and counseling psychology are discussed.) As mentioned at the beginning of this chapter, the terms *psychotherapy* and *counseling* were originally used to differentiate forms of treatment. For example, therapy was used to indicate the use of a long-term treatment approach designed to assist a person overcoming some form of a serious psychological disorder by fostering changes in the person's personality. Counseling was used to define short-term treatments that were much less intrusive in nature and sought a solution for what were generally thought of as everyday sorts of problems or concerns, such as the selection of a meaningful career path. As alluded to earlier, over time the distinctions that once existed began to blur when therapists developed and utilized short-term applications of their approaches, and counselors started to work with the full range of problem situations, including various mental disorders. One factor that contributed significantly to this melding of therapy and counseling was the contribution made by Carl Rogers. Rogers's client-centered approach was adopted by many counselors in training and is a good example of the movement toward the growing similarity of clients' needs. In 1962, Eugene T. Gendlin reported on how he had adapted Rogers's approach to assist individuals who suffered from schizophrenia. Eventually, the approach originally developed by Rogers was being used to treat a number of serious concerns, such as depression, alcohol abuse, cognitive dysfunction, and personality disorders. **Target Audiences** This textbook was designed to provide a comprehensive overview of those therapeutic approaches that emerged from what was to become a multitheoretical system whose origin could be traced back to the late 1800s. This textbook was also designed for readers who seek an introduction to the world of therapy, especially those enrolled in introductory undergraduate courses offered through counselor education, psychology, social work, and criminal justice departments or programs. Further, this textbook is appropriate for advanced curriculums, which reacquaint students with previously studied theories. In addition, certain paraprofessionals who have earned bachelor's degrees and plan to complete a training program that will certify them to work in mental health, for example, as a paraprofessional substance abuse counselor, may benefit from this textbook.

Many such trained paraprofessionals will also find this textbook suitable for their area of practice, broadening their understanding of how certain treatment approaches might interface with their treatment responsibilities, such as family therapy, which can make an invaluable contribution to the healing process for family members adversely affected by a family member's addiction. In addition, to the aforementioned audiences, numerous training programs exist outside the United States, programs that expect their students to be familiar with the theoretical approaches in this textbook. We believe the information contained in subsequent chapters can help such students in training to obtain a general foundation of knowledge that they can build upon as they advance in their specific areas of expertise. Even though differences exist in the training programs found among different countries and the theories and strategies employed in the therapeutic relationship, globalization is a force that affects much more than the exchange of consumable goods and has increasingly affected intangibles, such as ideas, world views, and other aspects of different cultures that are increasingly being "imported" and "exported" around the world. Such exchanges include important aspects of what comprises the ingredients for effective therapy. Bergin, Bigham, Ginter, and Scalise (2013), for instance, used stratified random sampling of marriage and family therapy practitioners who resided in either the United States or Canada and found an exceptionally high degree of similarity in the responses given by participants in both countries to more than 350 survey items that measured six categories of performance: the practice of systematic therapy; assessing, hypothesizing, and diagnosis; designing and conducting treatment; evaluating ongoing process and terminating treatment; managing crisis situations; and maintaining ethical, legal, and professional services. The globalization of knowledge is helping to spread and shape what therapy is today and what therapy will become in the future. **Foci of the 12 Theory Chapters** In addition to the current chapter, Chapter 2 covers topics such as the therapist as a person and a professional, and Chapter 15 summarizes commonalities and practice-related considerations. Other than Chapters 1, 2, and 15, the majority of chapters are devoted to examining the various theoretical foundations that support contemporary forms of therapy. Furthermore, the 12 theories or approaches reviewed were christened with names that are now widely known—psychoanalysis, Adlerian, existential, client-centered, gestalt, behavioral, cognitive-behavioral, reality, feminist, family systems, multicultural, and postmodern. Various other descriptors are also found throughout this textbook, including the identification of Albert Ellis's form of therapy as "rational-emotive behavior therapy," which can be logically paired with several other versions of what has generally become known as cognitive-behavioral approaches to therapy. The theories covered in this book span three centuries from the late 1800s to the present. Even though differences in the organization and content can be found among the 12 chapters of this textbook, each theory chapter was structured to encourage comparisons of theories. We used a rubric that organized each chapter into sections that provide the following information about a theoretical approach: biographical background on major proponent(s), basic theoretical concepts and assumptions, components of the therapeutic process (e.g., role of therapist and client, nature of the therapeutic relationship, how goals are established, therapeutic techniques that are commonly linked with the approach), theoretical explanation for client change, the role that assessment plays in therapy, unique ethical concerns, research support for a theory's approach, relevance to current mental health delivery systems (e.g., how the approach is suited for systems that rely on managed care, time limits, evidence to support its use of the approach in various mental health settings), critique of strengths and identification of shortcomings, client populations generally served, and an example of how the theoretical approach covered might be applied when working with actual clients. In addition to devoting an entire chapter to examining multiculturalism's role in today's therapies, all other theory chapters also contain a multicultural section that specifically calls attention to how multiculturalism interplays with the theory that is being reviewed. Another theoretical aspect that is emphasized is how each theoretical position considers the role of social justice. Finally, each of the 12 chapters closes with summary comments and critical thinking questions related to the chapter's content. Also, some recommended publications or websites are provided to enable the reader to acquire additional information and understanding of the key topics covered in each chapter. Each chapter concludes with a list of the

resources that were consulted and cited in that chapter. **Connecting the Dots: Seeing the Big Picture** Each theory molds and shapes the therapeutic approach that it has given birth to since each theory determines how a therapist is to explore a client's problem through maintaining a distinctive style of focus; helps to explain the reason why a therapist relying upon a certain theoretical approach would tackle a client's problem quite differently from a therapist relying on another theoretical position; motivates a therapist's actions and thoughts during therapy sessions and guides the therapist in ways to gauge the degree of progress made and when it is appropriate to terminate therapy; and provides the necessary raw material to construct and test the accuracy of hypotheses. Thus, an understanding of how various theoretical approaches function toward solving clients' problems lies at the heart of understanding more fully the different forms of therapy practiced today. An important aspect of every theory that deserves recognition is the philosophical position represented by a theory concerning the *fundamental nature of reality and human existence*. The latter raises a critical question related to whether human existence encompasses the attribute of free will. Specifically, to what degree can humans willfully affect who they become during the course of their lives? If humans lack a sufficient degree of free will, then attempting therapeutic change becomes futile because the power to act without the constraint of fate is impossible, and any changes thought to be the result of free will are an illusion. Concerning the issue of free will's role in affecting change, Carl Rogers (1951) stated:

I have yet to find the individual who, when he examines his situation deeply, and feels that he perceives it clearly, deliberately chooses dependence. Deliberately chooses to have the integrated direction of himself undertaken by another. When all the elements are clearly perceived, the balance seems invariably in the direction of the painful but ultimately rewarding path of self-actualization or growth. (p. 490) The power for humans to pursue their unique personal potential and actively construct who they will become without the constraints of fate is the meaning of *free will*. In addition to Carl Rogers's humanistic approach, which stresses a client's dignity and worth and capacity for self-realization, existentialism is another theoretical perspective that also highlights the central role of free will in therapeutic change. Created by Viktor Frankl, logotherapy (*logos* is Greek for "meaning") rests upon his belief that humans are free to search for a meaningful life (Devoe, 2012). Frankl is best known for his book *Man's Search for Meaning*, in which he outlines his existential position, a position that even the atrocities he encountered in a Nazi concentration camp were unable to alter. By the end of World War II, Frankl had survived a literal hell on earth. Later, he used his concentration camp experiences to further support the importance of free will to facilitate important therapeutic shifts in a client's life. One of existentialism's strongest advocates was Jean-Paul Sartre, whose work titled *Being and Nothingness* carefully presents the philosophical basis for this framework using terms such as *anguish, essence, existence*, and *responsibility*. The root phrase that best captures what Sartre was trying to communicate to the world is "Existence precedes essence." Sartre meant that a person's *existence* is a given, an outcome of birth, but that the person we ultimately become is ideally sculpted through meaningful choices we make to reach our potential, which Sartre called *essence*. Choice is an inescapable quality of living according to Sartre, for even if we consciously decide not to make a meaningful choice, we have still made a choice. Relying upon happenstance rather than our free will to self-determine our essence eventually leads to living a life driven by basic urges or one driven by radically conforming to others' expectations of who we should become. No matter how much we give in to our impulses or try to conform, any happiness that results is fleeting and leaves in its wake a sense of dread and lingering unhappiness. Personal happiness comes with assuming the responsibility that accompanies our becoming aware that we are meant to be the "incontestable author" of our own lives (Sartre, 1956/1974, p. 552). **Providing Greater Understanding by Moving Beyond Words** In keeping with our goal to write with clarity about complex theoretical perspectives and applications, we make use of other creative forms of expression, such as eye-catching symbols or visual illusions, works by painters and sculptors, segments of poems or musical lyrics that convey vivid images or elicit emotional reactions, portions of stage plays, snippets of scenes from movies, photographic images that tell a story, and

so forth. There are instances when the proverb "A picture is worth a thousand words" is true with regard to students who are genuinely grasping the meaning of an abstract or even some generic idea generated by a particular theoretical position. An example of how "moving beyond words" can be used to facilitate understanding is provided next by juxtaposing a technical definition for existential anguish with a widely recognized painting by Edvard Munch. Sartre (1956/1974) defines the term *anguish* this way:

> The reflective apprehension of the Self as freedom, the realization that a nothingness slips between my Self and my past and future so that nothing relieves me from the necessity of continually choosing myself and nothing guarantees the validity of the values which I choose. Fear is of something in the world, anguish is anguish before myself. (p. 547)

The essential meaning and relationship of this term to other key existential concepts would likely pose a challenge for anyone who lacks a general understanding of Sartre's form of existentialism, but what the experience of anguish means for one who experiences the dread that marks its presence is indubitably conveyed by Edvard Munch's painting *The Scream*. Chant (2003) wrote that Munch's famous painting was inspired by a personal experience, which Munch recorded in his journal in 1892. The journal entry read as follows:

> I was walking along the road with two friends. The sun was setting. I felt a breath of melancholy–Suddenly the sky turned blood-red. I stopped, and leaned against the railing, deathly tired–Looking out across the flaming clouds that hung like blood and a sword over the blue-black fjord and town. My friends walked on–I stood there trembling with fear. And I sensed a great, infinite scream pass through nature. (n.p.)

Munch's painting (Figure 1.3) portrays a felt experience without using a single word. It creates a powerful image that resonates with us by immediately communicating the horrible anguish felt by the depicted figure. Munch's creation has the power to linger long after we look away; this is an image that, once it is seen, cannot be "unseen" by the viewer. By contrast, at this point in the chapter, the exact wording used earlier to define *anguish* has probably already disappeared from the reader's mind. Certain images, such as the one created by Munch, have the power to persist and retain their effect long after the image's creator is gone. In addition, such powerful images can morph and find new expression in some alternate form. An example of such staying power coupled with the ability to change over time from one image into another is provided by Chant (2003), who referenced the intimidating mask worn by the two killers in Wesley "Wes" Craven's 1996 horror movie *Scream* (Figure 1.4). The mask worn in the movie seems to personify the existential notion of anguish, but in addition to taking on the qualities of being human anguish, the wearer of the mask in *Scream* carries a knife that possesses the potential power to threaten others with death or what might more appropriately be called existential nonexistence.

Figure 1.3 Munch's Painting *The Scream*
Source: The Scream (or The Cry) by Edvard Munch. Wikimedia Commons.

Reappearing Case Study Used in Each Theoretical Chapter Another way we, the authors, have been able to instill a greater appreciation of each theoretical area covered in this textbook is through the provision of case studies that highlight several key components of a particular theoretical approach. The case illustration found at the end of each theory chapter is based on the Case of Miguel Sanchez box on page 17. It should be noted that in some chapters new story elements are introduced into the Sanchez case information for the purpose of better illustrating the type of strategies relied on by a therapist who is affiliated with the theoretical model discussed in the specific chapter. This reexamination of the same case in each of the theory chapters is intended to enable a reader of this textbook to ascertain genuine differences and similarities among various therapeutic approaches. In addition to returning to the Sanchez case study in each of the 12 theory chapters, each of these chapters begins with a unique case not found in any of the other chapters. These unique cases embrace several different forms. For example, a case may represent an amalgamation of cases that the chapter's author(s) had experienced in a private practice setting,

or the case may take a more hypothetical form such as when a chapter's author explores how the progenitor of a certain approach might have worked with a client or situation that has been spawned by the author's imagination (such cases are found in the following chapters: psychoanalysis, Adlerian, gestalt, reality/choice, and family therapy). Regardless of the source of these unique cases, they all serve to provide another illustration of how the variety of theoretically oriented therapists would handle a therapeutic situation.

Figure 1.4 Mask used in the Movie *Scream*
Source: Konrad, C. and Woods, C. (Producer), & Craven, W. (Director). (1996). Scream [Motion Picture]. USA: Woods Entertainment. The Case of Miguel Sanchez **M**iguel Sanchez is a 14-year-old Mexican American male who emigrated from Mexico City to South Los Angeles with his family 6 years ago. His guidance counselor, Mrs. Torres, refers Miguel to receive psychological services and assessment. Mrs. Torres cites a decrease in Miguel's school attendance, a shift in gravitation toward a negative peer group, and potential substance abuse as reasons for her referral. Mrs. Torres reports her being particularly concerned about Miguel's recent negative behavior because he has a history of being a bright student who has been involved with various student organizations. Mrs. Torres calls a local community mental health agency and requests that Miguel be matched with a male clinician, preferably Hispanic. Miguel's mother, Mrs. Sanchez, agrees that it might be in her son's best interest to engage in psychological services and leaves a message at the agency that she would like to schedule an appointment. Dr. Ramirez is assigned to the case and contacts Mrs. Sanchez to schedule an initial assessment. Dr. Ramirez explains on the phone how he initially works with a new client and their family by discussing his theoretical orientation, the client's right to confidentiality, cancellation policy, sliding scale to receive reduced fee services, and how he may work collaboratively with the school and other providers. Mrs. Sanchez confirms that she has recently noticed a negative change in her son and agrees to bring him to see Dr. Ramirez in the following week. After the initial session, Dr. Ramirez could not help but wonder if the Sanchez family situation were more complicated than they originally presented. The Sanchez family spent the first session focusing on behaviors and expectations; however, Dr. Ramirez left the session feeling as if there might be underlying unresolved issues. He made a mental note to further explore how acculturation may be affecting the Sanchez family. In the following session, Dr. Ramirez helps to initiate a conversation between mother and son as to how their experiences of moving to the United States might be different as well as how it might be similar. During this session Mrs. Sanchez tearfully explains how she feels that her son is losing his heritage by wearing baggy clothes, listening to rap music, and refusing to participate in familial and cultural activities that he once enjoyed. In defense, Miguel loudly tells his mother that she embarrasses him because of the traditional clothing that she chooses to wear and by her refusing to learn to read or write in English. Miguel is noticeably agitated when the conversation moves to his decreased connection to his Mexican heritage. Miguel attempts to explain to his mother, in Spanish, that the only people that he can truly relate to are his new friends. A heated discussion then ensues about Mrs. Sanchez's view of Miguel's new friends' criminal mentality and lack of morals. Miguel shouts, "At least they give me respect" and storms out of the room. Dr. Ramirez is left with Mrs. Sanchez as she sobs in the room with her hands held over her face. At this point we hope that the current chapter piques the interest of the readers in a field of study and practice that has fascinated us throughout our careers. The theories covered in this textbook offer a wide range of therapeutic formulas designed to provide a therapist with the requisite structure and strategies to effectively work with a large array of client concerns, ranging from individuals interested in achieving personal growth to persons who are experiencing the serious ramification of a mental disorder. Further, we hope that upon reaching the end of this textbook, a reader will become aware of how the theories explored within its pages share divergent characteristics but also certain commonalities. One such commonality is that these theories offer much more than what is solely associated with processes that occur within the confines of a therapy room's four walls. These are theories that have general implications for how we are to live, love, and work. Such wide-ranging implications help to explain why Carl Rogers moved from calling his approach "client-centered" to

"person-centered" once he realized that his theoretical position offered transformative possibilities beyond what was taking place in traditional therapy settings (Rogers, 1980). Similar to Carl Rogers, the researcher B. F. Skinner, whose theory was deterministically driven rather than free will driven, also believed that his theory of operant conditioning had implications well beyond what was being applied in and outside his research laboratory; this belief prompted Skinner to write *Walden Two*, a novel that describes how behaviorism can serve as a blueprint for building a modern-day utopia (Skinner, 1962). The point is that the 12 theoretical areas covered in this textbook have much to offer anyone who is willing to immerse himself or herself in what is presented. We believe such immersion coupled with an open mind will allow the reader to reach the end of the last chapter having abstracted from this textbook what will be of greatest benefit in terms of how that reader chooses to live, love, and work in ways that are both meaningful and satisfying. **Ongoing Exercise That Concludes in Chapter 15** By this textbook's conclusion, readers should be able to express clearly what they believe are the elements that would comprise their own personal theoretical approach to therapy. In Chapter 15 we provide a method to achieve this important end goal. Table 1.1 is an example of how such a comparison method is intended to work. Specifically, the six rows in Table 1.1 depict how a reader might have responded when writing a comparison summary (e.g., "1. Theoretical perspective used to understand basic human nature") for each of the four theoretical approaches (i.e., feminist therapy, postmodern therapy, marriage and family therapy, and multicultural/cross-cultural therapy) selected to illustrate how a reader can establish similarities and dissimilarities among theories. After writing summary statements across all "Six Areas of Comparison" found in Table 1.1 for the four theoretical approaches listed across the top of the table, the reader will have filled 24 cells. The contents of these 24 cells reveal the prominent differences and similarities among the four theoretical approaches. As the reader looks across each row of written summary statements, a means for the reader to review six key points in which the listed theories diverge or converge with one another is presented. The concluding exercise found in Chapter 15 expects readers of this textbook to isolate from their own written summaries for each of the theoretical chapters read what they consider most meaningful to them for the purpose of constructing their own unique theoretical position. Furthermore, in Chapter 15 a number of important concepts are explained (e.g., syncretism, technique matching, theoretical frames, and common factors) that readers will be required to consider in light of the summaries they wrote. The information in Chapter 15 creates a structure for readers to achieve a critical assessment of the various theories in this textbook, the type of assessment that is necessary before a reader can clearly state what comprises his or her personal theory. Table 1.1 Four Therapies Juxtaposed on Six Areas

Six Areas of Comparison	Feminist Therapy	Postmodern Therapy (Narrative Therapy)	Marriage and Family Therapy	Multicultural/Cross-Cultural Therapy
1. **Theoretical perspective used to understand basic human nature**	The interplay of male and female perspectives, biological differences, and social expectations related to gender	Personal "stories" are what define an individual's or group's understanding of reality and the role they play in that reality	The family represents the fulcrum to understand individuals and various groupings of family members	Factors, such as racial and ethnic diversity, sexual orientation, disabilities, classism, and the history of marginalized groups
2. **Mental events, processes, or other attributes focused on**	Prejudice in favor of or against one gender in a way considered to be unfair and detrimental to mental health	Cognitively humans are driven to make meaning of the experiences encountered in their lives	What occurs within and between individuals is related to family dynamics	Factors that contribute to beliefs (positive, negative, or unbiased) about other individuals and groups
3. **General explanation given for client problems**	Thinking that reflects inherent privilege that leads to systemic gender inequalities within a society or culture	The way clients have interpreted and "written out" the events in their lives can create personal problems	Dysfunctional family systems originate in many possible ways, but all have a disruptive impact on family relationships	Attitudes, judgments, and behaviors reflect prejudice, stereotyping, and discrimination

4. **Emphasis placed on clientâ€™s past, present, or future**Depends on the particular form of feminist therapy referred to because theoretical views overlap and differFull range because the past, present, and future can all contribute to the deconstruction and reconstruction of a meaningful narrativeThe full range of time periods is utilized, but focus depends largely on the specific family therapy utilizedFull range referred to but can differ as a result of the particular theoretical position and a client's worldview
5. **The role that free agency plays in therapeutic change**Self-determination is a key aspect of feminist-oriented therapies in uncovering possible solutions for client concernsIndividuals, couples, and families possess the ability to rescript their lives through reinterpreting events in their livesDepends on the particular approach referred to because theoretical views differ concerning amount of free agency possessedIn general, the degree of free agency believed to exist allows for changes in the self, others, and systems to occur
6. **Theoretical developments**Other forms include Marxist feminism, radical feminism, ecofeminism, erotic feminism, and lesbian feminismPostmodern theory encompasses several conceptually important additions that continue to remain influential, such as hyper-realityEncompasses earlier approaches and newer approaches that operate from a systems perspectiveTheoretical developments include cultural identity development theory, integrative life pattern model, and feminist therapy Table 1.2 is a summary format that readers should use to collect the information they will need to complete the concluding exercise. Readers should photocopy, scan, or create their own version of the guide in Table 1.2 and use it to write summaries for each of the theoretical chapters they complete. Finally, users of this textbook are strongly encouraged to review those pages near the end of Chapter 15, which concern the final exercise discussed here. In reviewing those pages, readers will notice that the concluding exercise has three parts (and subparts) to complete. The last part, Part III, requires readers to write a detailed description of their own personal theoretical position. Their description must also incorporate what they learned by completing Parts I and II, including an explanation of how the knowledge gained from these two parts helped them construct their own unique theoretical approach to therapy. Table 1.2 Guide for Summarizing the 12 Areas
Name of Theoretical Approach Reviewed: _____
The 12 AreasSummary Statement for the Corresponding Area (Areas 1–12)
Area 1: Philosophy concerning basic human nature
Area 2: Role of therapist
Area 3: Key concepts
Area 4: Goals of therapy
Area 5: Therapeutic relationship described
Area 6: Techniques of therapy
Area 7: Applications of the approach
Area 8: Multicultural considerations
Area 9: Social justice consideration
Area 10: General contributions to the field
Area 11: General limitations
Area 12: General strengths **Chapter 2 Counselor Role and Functions, Professional Ethics, Stress, and Self-Care** iStockphoto.com/Steve Debenport
Learning Objectives After reading this chapter, each student should be able to:
Differentiate between professional counseling and counseling psychology by comparing their developmental history, professional organization, accreditation bodies, identities, and training.Evaluate one's own personal motivation, values, and responsibilities as a counselor to better understand professional ethics.Articulate the rationale and importance of informed consent and record keeping.Describe the differences and similarities between the ACA Code of Ethics and the APA Ethical Principles and Code of Conduct with regard to confidentiality, multiple roles, and competence.Recall ethical decision making when given examples of possible ethical dilemmas.Describe the definition of subjective and professional well-being and the risks of professional burnout.Identify the importance of self-care and its seven domains, and give

examples of self-care for each. **Introduction** In this chapter, *counselors* refers to practitioners in the distinct fields of *professional counseling* (i.e., professional counselors) and *counseling psychology* (i.e., counseling psychologists), which represent different professions; possess a different history of development; in most instances, have different professional organizations; and have separate accreditation bodies. Professional counseling and counseling psychology have different orientations to training and deliver education at different graduate levels and for a different number of years. The two professions have different licenses for practice and third-party/insurance payers. Because professional counselors and counseling psychologists have distinct identities and may even be competitive or adversarial with each other over professional standing issues and resources, the professions are addressed separately in this chapter. **A Brief History of Professional Counseling** The American Counseling Association (ACA) is the largest organization devoted to providing counseling services (Gladding, 2009). Initially, ACA was known as the American Personnel and Guidance Association (APGA; Ginter, 2002). Established in 1952 by a loose constellation of organizations, APGA was primarily "concerned with vocational guidance and other personnel activities" (Harold, 1985, p. 4). ACA has grown from its "guidance" infancy into a multifaceted profession of approximately 55,000 members and 20 chartered divisions (American Counseling Association, 2017; Cashwell, 2010). The State of Virginia passed the first counselor licensure law in 1976, followed by all 49 other states, Washington, D.C., and Puerto Rico. Professional counselors now bill private health insurance, and the U.S. Department of Veterans Affairs (VA) recently ruled that professional counselors can work in VA hospitals. There are about 635,000 counselors who work in a variety of settings, and this number is "expected to grow much faster than the average for all occupations through 2016" (Bureau of Labor Statistics, 2010–2011, p. 209). **Counselor Education and Accreditation.** Accreditation was a latecomer to the counseling profession, but in 1981 the Council for the Accreditation of Counseling and Related Programs (CACREP) was established (Hollis & Dodson, 2001). CACREP is now an independent organization recognized by the Council for Higher Education Accreditation to accredit the master's degree in eight counseling specialties (e.g., school counseling, clinical mental health counseling, addictions counseling) and doctoral programs in counselor education. Although counselor accreditation is voluntary for counseling programs, the CACREP accreditation requirements serve as the foundation for most state licensure laws (Remley & Herlihy, 2015). Because ACA has delegated accreditation responsibility to CACREP, this has created an identity issue for professional counselors. There has been an informal opinion within the counseling field that CACREP accreditation should be dropped in favor of ACA accreditation. Although some counseling professionals would like to see the change for clarity purposes, CACREP will likely remain the accrediting organization (Cashwell, 2010). **Licensure and Certification.** In the United States, professional counselors must become licensed to receive insurance reimbursement. To attain licensure, professional counselors must graduate from a master's-level counseling program, be supervised by a licensed professional for the period of time specified by the licensure board, and pass the licensure board's examination (e.g., National Clinical Mental Health Counselor Examination, National Counselor Examination, Certified Rehabilitation Counselor Examination). Licensure requirements are set by the individual state or territory and may vary considerably, making it difficult for a counselor who relocates from state to state. The professional counselor may have to take a second state examination, accrue more hours of supervision, and possibly complete additional coursework, as required by a particular state licensing body (Remley & Herlihy, 2015). The American Association of State Counseling Boards (AASCB) currently represents an effort to centralize disparate state licensure requirements (AASCB, 2017; Cashwell, 2010). Another complication regarding vagaries in counselor licensure lies in the various licensure names and acronyms. Names for licensed counselor vary among states, for example, Licensed Professional Counselor (LPC), Licensed Mental Health Counselor (LMHC), Licensed Clinical Mental Health Counselor (LCMHC), or Licensed Clinical Professional Counselor (LCPC). Furthermore, some states have a two-tiered licensure system, meaning initial licensure is given (1) at the completion of a master's degree and/or upon passing the state examination and (2) accumulation of the required supervised hours of counseling practice. Because the first tier is limited, professional

counselors must continue to be supervised by a counselor holding the higher tier license. Some states require the higher tiered license to bill health insurance. Most states have not instituted a tier system, but as the field matures, it may become more common. National certification is a voluntary credential, second in importance and function to state licensure. National certification is the purview of the National Board for Certified Counselors (NBCC), a separate credentialing organization overseeing national certification in a variety of specialty areas, including mental health counseling and school counseling, and others (NBCC, 2016). The coexistence of state licensure and national certification may be confusing to professionals outside the counseling field. NBCC offers several credentials, most notably the National Certified Counselor and the Certified Clinical Mental Health Counselor. For certification, a counselor must earn a master's degree and then pass the National Counselor Examination for Licensure and Certification to become certified as a National Certified Counselor or the National Clinical Mental Health Counselor Examination for certification as a Certified Clinical Mental Health Counselor. These examinations have also been adopted by numerous states as their licensure examination (National Board for Certified Counselors, 2017). Some counseling professionals have questioned the validity of a national certification because national certification does not provide counselors the vehicle to bill health insurance or supervise beginning counselors (Weinrach & Thomas, 1993). Remley (1995) contended that a license ought to be for general practice, whereas national certification ought to acknowledge specialty areas. The field has moved toward Remley's model although arguments regarding certifications' necessity persist.

A Brief History of Counseling Psychology

Counseling psychologists are doctorate-level psychologists (PhD, PsyD, or EdD) who have received general education in the core areas of psychology, specialized training in interventions and treatments, and extensive supervised practice and have completed a dissertation in the field of psychology. Counseling psychologists, in contrast to clinical psychologists, focus on the adaptive functioning of individuals in their personal and interpersonal lives across the life span. In particular, counseling psychologists focus on emotional, social, vocational, developmental, organizational, and health-related adaptation problems. The settings in which their education, research, or application of therapy occur include colleges and universities, local hospitals, veterans hospitals, community clinics, and private practices. Although both clinical and counseling psychologists provide psychotherapy, they differ in the means they utilize to deliver treatment. When the two subfields were developed, clinical psychologists focused on the care of the ill or bedridden. (The term *clinical* derives from the Greek word *kline*, which means bed.) Counseling psychologists focused on consultation with those who were generally well. (*Counsel* comes from the Latin word *consulere*, which means to consult, advise, or deliberate.) Currently, clinical psychologists typically use more assessment and treatment methods linked to psychopathology than do counseling psychologists, who use more developmental and prevention methods. Counseling psychology as a formal discipline in the United States is about 100 years old, being launched by the movements of mental hygiene (1920s), vocational guidance (1940s), and psychometrics (1940s). Its professional affiliation with the American Psychological Association (APA) started in 1946, with the founding of the Personnel and Guidance Psychology Division, Division 17 of APA. Division 17 subsequently had two name changes: Counseling Psychology and, since 2002, Society of Counseling Psychology. Division 17 has evolved beyond one organization and includes collaborative relations with the Council of Counseling Psychology Training Programs (CCPTP) and the Association of Counseling Center Training Agencies (ACCTA). Both of these organizations are strong forces within professional psychology and university-based accredited bodies. The 1980s were wrought with societal changes in the field of psychology in the United States. National training conferences as well as groups and task forces (e.g., Task Force on the Scope and Criteria for Accreditation of the APA) proposed a shift in pedagogy, expanding curricula to include diversity issues, consultation, policy formation, supervision, and program development. Psychology was written into Medicare statutes, which ultimately intensified battles between medicine/psychiatry and psychology. Ethical complaints about dual relationships (i.e., sexual relationships with clients), diversity, and HIV/AIDS status became obvious. Also, for the first time, attention was given to the distressed psychologist because it was naive and dangerous to ignore

the stressors counseling psychologists faced in their work and personal lives. **APAâ€™s Evidence-Based Policy.** Counseling psychology's parent body, APA, has been compelled to remain current. At the turn of this century, APA responded to two different pressures: (1) the increasing force of government funding agencies and managed care companies to verify the utility and necessity of psychotherapeutic interventions and (2) additional forces as from the practitioners of psychology (cf. Fox, 1995; Lichtenberg, Goodyear, & Genther, 2008; Roysircar, 2009b). Levant (APA, 2005) officially endorsed a policy statement advocating the use of evidence-based practice (EBP) as a means for delivering quality and cost-effective treatment for mental disorders (Council for Training in Evidence-Based Behavioral Practice, 2008). As defined by APA (APA, 2005), "Evidence-based practice in psychology is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 271). The EBP process thus integrates the best available evidence with regard to practitioners' expertise, empirical research, and scholarship with the cultural and economic conditions, needs, values, and preferences of clients who are served and affected (Council for Training in Evidence-Based Behavioral Practice, 2008). Types of research evidence to support decision making in practice include clinical observation, qualitative research, systematic case studies, single-case experimental designs, public health and ethnographic research, process-outcome studies, studies of interventions as they are delivered in naturalistic settings (effectiveness research), basic psychological and health science, and meta-analysis (APA Presidential Task Force on Evidence-Based Practice, 2006). Experimental studies are read critically with regard to the constitution of experimental and control groups, methodology, threats to validity, and effect sizes (Wampold & Bhati, 2004). When drawing conclusions used for making decisions, psychologists ask whether a study's methods and findings justify causal explanations, particularly as applied in a local context (Shedler, 2015). In evaluating the evidence used in clinical decision making, psychologists pay particular attention to issues related to social justice and cultural relevance, view evidence as ecologically or systemically embedded as well as historical, and evaluate it accordingly (APA, 2017). **The Council for Counseling Psychology Training Programs Competency Benchmarks for Doctoral Training.** The benchmark training document (For a comprehensive review, see Fouad et al., 2009.) outlines the necessary competencies that counseling psychology students must have when they enter practicum, internship, and finally doctoral-level practice. It is believed that these three developmental levels are necessary for trainees to become effective and competent psychologists. Overall, counseling psychology students must have foundational competencies that are apparent in their behavior and comportment, reflecting the ethics, integrity, values, and responsibility of the profession. Students must have professional as well as personal self-awareness and reflexivity. They must have skills to reflect on professional practice (reflection-on-action). Students are expected to problem-solve, think critically, and have intellectual curiosity and flexibility. Self-assessment involves determining one's knowledge of core competencies. Self-care involves attending to one's well-being and personal health to ensure effective functioning as a professional. **Practicum-Level Skills.** Students who do doctoral practicum training for two to three years must have a basic understanding of (a) research, including methodology and procedures for collecting data and conducting analysis; (b) development across the life span; and (c) biological and cognitive–affective bases of behavior. Also, students must relate meaningfully and effectively with individuals, groups, and/or communities. They must have interpersonal skills such as the ability to listen and be empathic with others, show respect for and interest in others' experiences and cultures, and demonstrate knowledge and awareness of various aspects of their own diversity and their attitudes about diverse others. Emotional maturity and effective expressive skills are essential. Students must have a basic understanding of the APA Ethical Principles and Code of Conduct (APA, 2002, including 2010 and 2016 amendments). They must have the ability to comply with regulations and, at the same time, make autonomous judgment within an organization's management and leadership. In addition, they must be capable of working in interdisciplinary teams. In addition to being able to administrate and score traditional assessment instruments, students must be knowledgeable of assessment practices stemming from a basic understanding of the theoretical, contextual, and

scientific bases of test construction and interviewing. Assessment mastery should result in formulating diagnoses, linking assessment and intervention, and effectively writing reports and notes. Finally, supervision is crucial for practicum students. Therefore, they must have a basic understanding of the expectations of supervision and process of supervision, interpersonal skills of communication and openness to feedback, and the awareness of the need to be truthful, respectful, and straightforward in their communication with their supervisor. **Managed Care Demands** The evolution of professional counseling and counseling psychology has changed with the increase in managed care. Previously, counseling psychologists' professional roles were equally divided between academician (40.2%) and clinical practitioner (39.7%), with less self-report for administrator (14.1%) and other work (6.0%) (Lichtenberg et al., 2008). Counseling psychologists have now begun to move from the relative security of salaried, academic, or administrative positions to work as independent, fee-for-service professionals. Professional counselors are also in private practice. So counseling psychologists and professional counselors need to deal with managed care, for which they were not prepared by their prevention-, developmental-, and academic-focused training programs. Managed care began in 1929 (National Council on Disability, 2013), but it did not begin to have a broad impact on health care delivery until health care costs skyrocketed. Managed care organizations' increasing focus on improving the quality of care is one of the major trends shaping the delivery of mental health services. There is an interest in rewarding therapists for quality performance. The Centers for Medicare and Medicaid Services for the retired/elderly (i.e., Medicare) and indigent populations (i.e., Medicaid) are working with at least several states to implement pay-for-performance (or quality-based purchasing) Medicaid programs. (For more information, visit https://www.ced.org/blog/entry/top-healthcare-stories-for-2016-pay-for-performance.) Quality performance might be measured, for instance, by client satisfaction, symptom reduction, and indexing the client's subsequent health care usage. As a result, there has been increasing emphasis on medically necessary treatments, reducing services overall, and restricting reimbursement rates. The cost of health care and the fact that millions of people have no health insurance create a problem for health care providers whose goal is it to ensure access to care and also contradicts professional counseling's and counseling psychology's multicultural and social justice advocacy. An added concern harbored by professional counselors and counseling psychologists pertains to ethical issues related to working with managed care organizations, a concern that further complicates clinical practice. This concern relates to how professional ethical codes and managed care policies do not always agree with one another, creating ethical challenges for mental health providers. Furthermore, practicum students may be afforded fewer training opportunities as managed care directs who can provide treatment to clientele. Moreover, with budgetary cuts being made across the mental health sector (e.g., community mental health centers, hospitals, jails, residential treatment), training opportunities for students will continue to dwindle while there is an increased enrollment of students in professional counseling and professional psychology training programs. **Professional Ethics** Professional counselors and counseling psychologists must abide by professional ethical guidelines that are designed to ensure beneficence to clients. Ethical dilemmas with clients are frequently due to the paradoxical nature of a counselor's personal or community life and professional practice. (Note. The term *counselor[s]* is used to indicate that a section's information applies to both professional counselors and counseling psychologists.) This chapter examines counselors' role and functions as well as their encounters with stressful ethical dilemmas. Ethical decision making helps counselors maintain ethical practice and relieves them of inner conflicts, while their practice of self-care enhances their well-being so that they meet the demands of a challenging profession. To effectively help their clients, counselors need to have an understanding of their personal motivation for pursuing this profession, as well as the values and responsibilities inherent in being a counselor. **Personal Motivation of a Counselor** Counselors have an obligation to be aware of their own issues in life, such as their personal motivation for becoming counselors. If counselors fail to bring awareness to their personal needs, they may obstruct client progress as counseling shifts from meeting the client's needs to meeting the counselor's needs. For example, counselors may be motivated to

pursue work in a helping profession because of a need to be appreciated by others; a need to nurture, save, or protect others; or a need to feel powerful. Counselors need to be aware of these personal needs, so that these needs do not assume priority over the client's well-being. Progress in counseling can be impeded if counselors use their clients to fulfill their own needs, even if unconsciously. **Values and Responsibility of a Counselor** Counselors must take an honest look at their professional identity, personal identity, and personal life to gain self-awareness of the influence of their needs, goals, job stress, impairment, personality traits, personal dynamics, countertransference, the importance of self-care, and the challenge in balancing life roles (Corey, Corey, & Callanan, 2007). Counselors must examine any unresolved conflicts that may show up in the therapy room, as well as their personal reactions to the client. Counselors must also make every effort to balance stress and self-care to avoid work burnout (Roysircar, 2008). Research has discredited the previous notion that counselors can keep their personal values out of the therapeutic environment (Richards, Rector, & Tjeltveit, 1999). Research has also revealed that counselors' values affect every phase of the counseling relationship, such as assessment strategies, goals, intervention techniques, and evaluation of therapeutic techniques (Roysircar, Arredondo, Fuertes, Ponterotto, & Toporek, 2003; Roysircar, Dobbins, & Malloy, 2009). Finally, many value conflicts can occur regarding gender identity, sexual orientation and behavior, abortion, religiosity and spirituality, and end-of-life decisions. Counselors must consider the role of personal influence in their practice, even their unconscious, implicit, and subtle biases. **Informed Consent** Counselors have the ethical responsibility to talk to their clients about their rights, so that their clients have enough information to render informed choices about entering and continuing in the counselor–client relationship (Corey et al., 2007). Many clients do not realize that they have rights, especially those in crisis who unquestioningly accept whatever the counselor says or does. The purpose of informed consent is to improve the probability that the client will become educated, involved, and willing to participate in counseling. Informed consent documents should clearly outline the counselor's twofold responsibility: to protect other individuals from potentially dangerous clients and to protect clients from themselves with respect to self-harm and suicide (refer to Laura Brown Psychotherapy Information Disclosure Statement, http://www.drlaurabrown.com/media/PsychotherapyConsentForm.pdf; Fisher & Oransky, 2008; Pope & Vasquez, 2016). Clients should be informed of all risks, benefits, and alternatives to the proposed treatment. However, counselors should observe a balance between providing too much professional information at the start of therapy, thus scaring off or confusing clients, and informing too little. It can be detrimental to clients' mental health to overwhelm them with information at the start of therapy. **Record Keeping** Counselors also have a prominent responsibility to keep adequate records on their clients. Record keeping serves multiple purposes: It helps to structure quality care, decrease liability exposure, and fulfill requirements for reimbursement (Rivas-Vasquez, Blais, Rey, & Rivas-Vasquez, 2001). Records can also serve as a counselor's defense against a malpractice claim or an ethical violation charge. Record keeping is especially helpful when clients are transferred to new counselors. Counselors are legally and ethically obligated to maintain client records in a secure fashion and to protect their clients' confidentiality. **ACA Code of Ethics** The ACA recently published a revised code of ethical guidelines (i.e., the Code of Ethics; ACA, 2014). There are nine sections in the Code of Ethics that provide ethical guidance on topics ranging from the counseling relationship to distance counseling, technology, and social media. The 2014 Code of Ethics also clarifies the ethical responsibilities of the ACA. Among other objectives, the Code of Ethics stipulates the ethical obligations of ACA members, assists members in constructing a course of ethical action, establishes expectations of professional counselor conduct, and serves as the foundation for processing ethical complaints made against ACA members. Thus, the primary purpose of the ACA Code of Ethics is to protect the welfare of clients by detailing what is in their best interest. Three guidelines of the Code of Ethics—confidentiality, multiple role relationships, and competence—are discussed next. **Confidentiality** Confidentiality refers to respecting and safeguarding the client's right to privacy (ACA, 2014). As a rule, professional counselors are not permitted to disclose confidential communications to a third party unless they obtain permission

from the client or are mandated by law to do so. Confidentiality is related to one of the fundamental guidelines in the Code of Ethics, that is, fidelity, which entails honoring commitments to and trust in the therapeutic relationship (ACA, 2014). Honoring a client's privacy means that a professional counselor is protecting the integrity of the client–counselor relationship. The guideline of confidentiality is covered in sections A and B of the ACA Code of Ethics. **Section A.** Section A outlines the counseling relationship and refers to confidentiality in several areas: (a) safeguarding documentation of clients and ensuring that all documentation accurately reflects client progress, (b) discussing limitations to confidentiality for mandated clients (such as those referred by the law enforcement or judicial system), and (c) obtaining the client's consent before engaging in advocacy efforts on behalf of a client (ACA, 2014). **Section B.** Section B focuses exclusively on confidentiality and privacy in the therapeutic relationship. As trust is the foundation of the counseling relationship, professional counselors should communicate the parameters of confidentiality and privacy in a culturally competent manner because multicultural clients may not be familiar with the notion of professional counselor confidentiality. Section B highlights (a) respecting client rights (e.g., having an awareness of and sensitivity to cultural meanings of privacy, inquiring about private information from clients only when therapeutically useful, obtaining consent when disclosing information); (b) knowing exceptions to confidentiality (e.g., disclosing to protect others or clients from harm, end-of-life issues, contagious life-threatening diseases, court-ordered disclosure); (c) sharing information with others (e.g., disclosing client information to training supervisors, subordinates, interdisciplinary team members, third-party payers, and protecting information of deceased clients); (d) understanding confidentiality differences in group, family, and couples therapies; (e) recognizing that certain clients lack capacity to give consent (e.g., minors or the elderly with cognitive difficulties, responsibilities of confidentiality to parents of minor children); (f) utilizing records and documentation (e.g., seeking permission to record information in session, providing client access to records, and seeking permission to transfer records to third parties); and (g) doing case consultation (ACA, 2014). **Section D, G, and H.** Section D (relationships with other professionals), section G (research and publication), and section H (distance counseling, technology, and social media) in the ACA Code of Ethics also touch on issues of confidentiality (ACA, 2014). Section D outlines the importance of professional counselors clarifying role expectations and the boundaries of confidentiality with their coworkers when obligated by law to serve in judicial proceedings. Section G outlines the importance of keeping information about research participants confidential and the procedures implemented to protect participant privacy. Last, section H outlines the limitations of maintaining the confidentiality of electronic transmissions and records. **An Illustration of Confidentiality.** An illustration of confidentiality includes treating a client in the VA health care system. Client records are available to all professional counselors and medical professionals in the form of electronic medical records. Professional counselors must explain to clients that relevant professionals engaged in their mental and medical health care can view their records. Professional counselors should explain about the client-centered system of VA hospitals and how an interdisciplinary team uses access to records to provide collaborative care to the client. Clients with symptoms of paranoia may have difficulty understanding and accepting electronic medical records. Professional counselors should take precaution with these clients and spend extra time outlining the benefits of an electronic medical record system. Professional counselors should also explain security measures set in place (e.g., the security setting on the electronic medical records that provides an alert when staff members without authorized access try to view a client's record).

Multiple Role Relationships Another principle in the ACA Code of Ethics is multiple role relationships, also known as dual relationships. This refers to any situation where multiple roles exist between a professional counselor and a client in counseling. Another way of saying this is that a professional counselor enters into a dual relationship whenever the professional counselor has another, significantly different association with a student, client, or a supervisee (Herlihy & Corey, 2006). Multiple role relationships also include offering counseling to a relative or a friend's relative, socializing with clients, becoming emotionally or sexually involved with a client (or former client), combining the roles of counselor and supervisor, having a business association with a

client, loaning money to a client, or borrowing money from a client (Corey et al., 2007). Professional counselors also could serve different roles when providing assessment services, psychological consultation to courts, or switching from individual therapy to couples therapy with a client. In some cases, multiple role relationships cannot be avoided and professional counselors need to manage rather than avoid these relationships (Herlihy & Corey, 2006). An example where multiple role relationships may be unavoidable is in isolated rural settings, where the local minister, merchant, beautician, banker, pharmacist, and mechanic might all be the clients of one professional counselor. In this setting, the professional counselor may have to engage in several multiple role relationships. (This situation is addressed further when discussing the APA Ethical Principles and Code of Conduct later in this section.) **Boundary Crossing Versus Boundary Violation.** Related to multiple role relationships are boundary crossings and violations, which refer to any departure from the traditional forms of counseling. Boundary violations refer to when professional counselors exploit their clients, whereas boundary crossing may involve clinically effective interventions like home-visits, receiving gifts, nonsexual touch, self-disclosure, or bartering for services (Gutheil & Gabbard, 1993; Zur, 2015). Sexual relationships with clients are considered the most severe of all boundary violations because they involve a betrayal of trust and an abuse of power that can have disastrous effects on clients (Simon, 1998). Figure 2.1, while exaggerated, does point to behaviors that can lead to a boundary violation. Boundary crossings are not prohibited by the ACA Code of Ethics. Several examples of boundary crossings from evidence-based treatment plans include going for a walk with a client suffering from depression, flying in a plane with a client who suffers from a phobia of planes, or going to a coffee shop or mall with a person who tends to avoid crowds (Zur, 2015). Other activities may include attending a wedding, lending a book, or attending a client performance in a show.

Figure 2.1 Problematic Behaviors
Source: © 2006, Harry Bliss. Used with permission of Pippin Properties, Inc. **Section A.** Section A outlines several aspects of multiple role relationships. Section A prohibits noncounseling roles and relationships with current clients, their romantic partners, or family members (ACA, 2014). This prohibition also extends to electronic interactions. Professional counselors should not counsel clients with whom they have had a previous relationship such as a friendship or who are family members. Last, professional counselors should address any role changes in the professional relationship with clients and obtain informed consent from the client to continue therapy (ACA, 2014). Examples of professional counselor role changes include (a) changing from one-on-one to couples therapy or vice versa, (b) changing from an evaluative role to a professional counselor role or vice versa, and (c) changing from a professional counselor to a mediator role or vice versa (Kitchener, 1988; Kocet, 2006; Reamer, 1998, as cited in Pugh, 2007). **An Illustration of Multiple Role Relationships.** An illustration of a multiple role relationship includes a professional counselor who switches from providing individual therapy for a client to providing couples counseling to the client and his wife. In this situation, the wife attends one session with the client and requests that they attend couples therapy to work on their relationship. The professional counselor should obtain informed consent from the client, in the absence of his wife, to switch from providing individual therapy to couples counseling. The professional counselor should outline the changing nature of the therapeutic relationship and give the client the opportunity to accept or reject the professional counselor's new role in couples therapy. **Professional Counselor Competence** A third principle in the ACA Code of Ethics is counselor competence. This refers to practicing in a competent and ethical manner (ACA, 2014). Competence is an ethical as well as legal concept because a lack of competence is a significant contributing factor in harm done to clients, and incompetent professional counselors are vulnerable to malpractice suits (Corey et al., 2007). Professional counselors need to demonstrate competence with the many forms of diversity, including gender, age, race, ethnicity, socioeconomic status, sexual orientation, religiosity and spirituality, physical ability, and educational status (Roysircar et al., 2009). Thus, multicultural competence is a necessary prerequisite to providing effective therapy. Multicultural counseling competency refers to "having good self-awareness of attitudes and worldviews into

which the counselor has been socialized, in addition to recognizing and being sensitive to a client's worldview and attitudes" (Roysircar, 2003, p. 18). This multicultural counseling competencies framework suggests that professional counselors must have knowledge of the client's culture, while also understanding their own background, biases, and values. **APA Ethical Principles of Psychologists and Code of Conduct** Members of APA are expected to comply with the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2016). Numerous ethical dilemmas of counseling psychologists are the result of disparities in what is ethically expected in the profession and what is conceivable when counseling psychologists balance their personal or community life with professional practice. The APA general principles, five in number, guide psychologists to the highest ethical aspirations of the profession. These are Principle A: Beneficence and Non-maleficence; Principle B: Fidelity and Responsibility; Principle C: Integrity; Principle D: Justice; and Principle E: Respect for People's Rights and Dignity. For instance, Principle E encourages counseling psychologists to be aware that special protections may be necessary to protect the welfare and rights of persons or communities. In addition, counseling psychologists try to prevent the influence of biases in their work, and they do not knowingly take part in or condone activities of others based upon prejudice. Although biases and prejudices are common in all persons, they become unethical when counseling psychologists do not attempt to prevent their effects. The APA ethical standards, on the other hand, represent organizational obligations and form the basis for imposing sanctions on psychologists. Select standards are explained here with the example of a White counseling psychologist working with a Black client. Although there are no specific ethics for conducting counseling with consideration for the dynamics of mixed racial dyads, Standard 2.01 Boundaries of Competence states, (a) Psychologists provide services "with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study or professional experience" (APA, 2016; p. 4). The second criterion of Standard 2.01 states, (b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with "race, ethnicity, culture . . . or socioeconomic status is essential for effective implementation of their services . . . psychologists have or [should] obtain the training, experience, consultation or supervision necessary to ensure the competence of their services, or they make appropriate referrals" (APA, 2016; p. 5). Much of the discussion on mixed racial dyads is that White counseling psychologists who have not understood their own racial identity may not know whether or not the services they provide are helpful or effective. Consequently, developing one's racial identity is a precursor to being aware of whether Standard 2.01 is being followed when providing therapy for people with various racial, ethnic, and cultural backgrounds. Counseling psychologists could place an appropriate referral for any potential Black American client to ensure they follow Standard 3.04 Avoiding Harm, which details that (a) "Psychologists take reasonable steps to avoid harming their clients . . . and to minimize harm where it is foreseeable and unavoidable" (APA, 2016; p. 6). However, counseling psychologists who may refer out their Black clients may avoid, refuse, or repress the need to gain competence in treating Black Americans because the process involves difficult self-reflection about their racial identity, biases, and socialization in privilege. Prolonged difficulty with this professional developmental task may fall under Standard 3.01 Unfair Discrimination, which stipulates that, "in their work-related activities, psychologists do not engage in unfair discrimination based on . . . race, ethnicity, culture . . . or socioeconomic status" (APA, 2016; p. 6). **Confidentiality** Confidentiality is viewed as particularly important for gaining and maintaining the trust of a client, as well as allowing a client to be forthcoming in counseling. The APA ethical Standard 4.01 stipulates that a psychologist engages in measures to protect the confidential information of all clients, while acknowledging the contradiction that confidentiality may be regulated outside of the profession by local laws, federal laws, and institutional rules. Even though the client has the freedom to disclose information about his treatment, it is not permissible for the counseling psychologist to do so (Nagy, 2011). Werth, Hastings, and Riding-Malon (2010) stated, however, that citizens of small towns may be aware when clients' cars are parked in front of a counseling psychologist's office or may see them walk in, and so in settings where everyone knows everyone, confidentiality is limited. Many people hold a

stigma about psychological help, making confidentiality even more important to both the client and the counseling psychologist. Helbok (2003) argued that residents in rural areas might be hesitant to enter group therapy because they may know other group members. The counseling psychologist should be particularly mindful of where she has acquired information when participating in social conversations within one's local community to avoid a breach of confidentiality of information learned within therapy. A referral source, such as a school administrator or a minister, may wish to be apprised of the progress of a person whom he referred to a counseling psychologist, although the standard of confidentiality does not allow such communication without the informed consent in writing of the client. A challenge occurs since a counseling psychologist risks alienating sources of referrals and the potential loss of referrals (Helbok, 2003). A counseling psychologist cannot change either a community's culture or the professional code of ethics, which places the counseling psychologist in a double bind ("damned if you do, damned if you don't"), which is a professional stressor. **Multiple Role Relationships** The topic of multiple relationships is addressed by Standard 3.05 and is frequently discussed in the clinical practice literature. All definitions of multiple role relationships first necessitate that a counseling psychologist be in a professional relationship with a client. The first kind of multiple role relationship happens when the counseling psychologist is involved with the same client in another role such as being a client's neighbor. The second kind happens when a counseling psychologist has an association with a person closely tied to a client, such as a relative of the client who works at the school served by the psychologist. Third, a counseling psychologist can promise to be involved in a future relationship with a client or an individual with whom that client is closely associated, such as playing on a basketball team at the invitation of the client who serves as the team coach (APA, 2002; Schank & Skovholt, 2006; Zur, 2015). Nonsexual multiple role relationships can differ in complexity and take on a variety of forms (Pugh, 2007). An example would be a counseling psychologist engaging in a relationship whose sole aim is to attain benefits such as material goods, for example, by purchasing groceries from a client's store, the only grocery store in the counseling psychologist's neighborhood. A counseling psychologist may fulfill the needs of a client through altruistic acts (Pope & Vasquez, 2016; Sonne, 2006; Zur, 2015), such as helping a stranded client whose ride has not shown up. Counseling psychologists and their current or former clients may connect through happenstance, for example, by running into each other at a café or standing in line together at the bank. Multiple role relationships are proscribed when such associations present a risk to the counseling psychologist's objectivity, helpfulness to clients, and effective clinical judgment (Hargrove, 1986). Counseling psychologists experience an increased probability of inner struggles because of dilemmas in multiple role relationships, a major professional stressor. There are times when a counseling psychologist may recognize that a multiple role relationship dilemma has occurred unexpectedly and that it will probably cause harm (Younggren & Gottlieb, 2004). Should this occur, "the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the ethics code" (APA, 2002, p. 6). Other situations may arise whereby, because of legal or institutional requirements, the counseling psychologist is obligated to assume various roles (e.g., expert witness) as part of legal proceedings. In these cases, it is recommended that the counseling psychologist be open about the limits of confidentiality and her obligations. At the beginning and during the process of counseling, psychologists must be clear with their clients about such obligations (APA, 2002; Nagy 2011; Pope & Vasquez, 2016). There may be a tendency in some clients to seek psychological services from a person they know. In communities where outsiders are not trusted, a counseling psychologist's involvement with her community is beneficial to establishing trust (Schank & Skovholt, 1997). As such, multiple role relationships can be challenging to prevent if the counseling psychologist wants to build a client base in her community. A counseling psychologist may encounter a situation where he assists a client who is a child and attending the same class as the counseling psychologist's child, and a situation where this child's mother is employed as the check-out person at a drive-through coffee shop often visited by the counseling psychologist (Campbell & Gordon, 2003). Evaluating the potential affect of these situations on the counseling relationship would be essential prior to the psychologist

agreeing to see the child in counseling (Sonne, 2006). As Erickson (2001) noted, the burden of making the correct decision about multiple role relationships is on the counseling psychologist rather than the client. Therapist–client interactions also may change considerably over time. For instance, relationships that at the onset of counseling were not perceived to be harmful may change. A counseling psychologist must be cognizant of all multiple role relationships to guard against possible harm (Erickson, 2001; Gottlieb, 1993; Kitchener, 1988; Nagy, 2011). This is a heavy work-related and personal burden for the counseling psychologist. **Competence** In situations where a counseling psychologist is asked to help a client for whom no other counseling is available, APA Standard 2.01 notes (d) that counseling psychologists may offer services to ensure that treatment is not denied. The counseling psychologist, however, must make an effort to obtain the needed competence through, for example, engaging in literature reviews, consultation, or other strategies (Barnett, Behnke, Rosenthal, & Koocher, 2007). For instance, consider a counseling psychologist who has expertise in couples counseling. If this person is the only mental health professional available in her community and is asked to work with a 6-year-old child, the counseling psychologist would need to determine whether it is ethically feasible to help the child or whether the child should be referred to the nearest counseling psychologist 120 miles away, which carries the risk of the child not securing the needed treatment (Sobel, 1992). Thus, the APA ethical standards for maintaining and practicing according to one's expertise can be challenging for counseling psychologists in particular settings. For instance, counseling psychologists might need to work as a generalist, instead of employing their skills to engage in a specific form of practice (Helbok, 2003). Even though trained as a generalist and practicing so, a counseling psychologist may need to make a decision about whether to offer services that might be at the boundary of his expertise (Schank & Skovholt, 2006). To further complicate the situation, the necessary training to obtain competence may be far away. Additionally, if a counseling psychologist is isolated in his practice, there is a greater probability that his judgment will be compromised. Without obtaining feedback from colleagues, the counseling psychologist may be inclined to minimize complicated ethical situations and deliver services beyond his expertise and lack awareness that this is occurring (Helbok, 2003). A further complication involves the fact that expertise is not operationalized clearly in the APA code of conduct (Helbok, 2003). The code fails to stipulate the number of clients or years of preparation a counseling psychologist must accumulate with a particular disorder or treatment to be deemed competent. APA's *Dictionary of Psychology* defines *competence*, in part, as "one's developed repertoire of skills, especially as it is applied to a task or set of tasks" (VandenBos, 2007, p. 204). This definition, however, does not elucidate or quantify how a person might know when a counseling psychologist has achieved the appropriate level of competence. Because the degree of competence is not clearly stipulated, it is likely to result in varied interpretations and to contribute to the ambiguity when faced with ethical challenges. For instance, a counseling psychologist may be promoted to a leadership position early in her career by becoming director of mental health services in a hospital. Obtaining this promotion can generate anxiety for the novice counseling psychologist who may view herself as unprepared to assume a senior administrative position. This counseling psychologist may be the sole provider or one of a few counseling psychologists in the locale with the necessary qualifications. Some possible strategies to address challenges involving competencies have been offered (Schank & Skovholt, 2006). First, counseling psychologists may use distance learning tools such as Internet resources, webinars, and consultation by telephone to obtain support and knowledge if they are not able to acquire the appropriate expertise through continuing education. Second, a counseling psychologist may tell the client at the onset of counseling of his concerns about treating the client and express the potential of needing to refer the client to another provider, should their interventions not appear to be effective. A counseling psychologist would employ general counseling strategies to help the client and, at the same time, try to acquire further information about the client's initial presenting concerns and other issues for which the counseling psychologist thinks he is not appropriately prepared. Third, some individuals may be willing to drive a long distance to obtain the most appropriate mental health care that is available (Barnett, Baker, Elman, & Schoener, 2007; Nagy, 2011; Pope & Vasquez, 2016; Schank & Skovholt,

2006). **Ethical Decision Making: Professional Counselors and Counseling Psychologists** When therapists experience complicated ethical dilemmas, they also are required to undertake a process of ethical decision making, consulting available resources (e.g., the ACA Code of Ethics, the APA Ethical Principles and Code of Conduct) as needed. These professional codes, however, are not intended to be the framework for ethical reasoning. It is critical to mention that the ACA Code of Ethics tends to be reactive rather than proactive. This means that the ACA Code of Ethics is not a preventive measure, and many counselors consult the Code of Ethics after an ethical dilemma has occurred. The APA Ethical Principles are aspirations and are not intended to offer solutions to ethical dilemmas. Practitioners who rigidly follow the APA ethical standards and principles are likely to miss the complex nature of ethical issues (Ridley, Liddle, Hill, & Li, 2001). Counselors must recognize that there may be some gray area in many situations with client problems that are not easily solved by looking through professional ethical guidelines. Counselors must use an active, deliberative, and creative approach that involves consultation (Corey et al., 2007; Ridley et al., 2001). **Steps in Ethical Decision Making** The first step in addressing an ethical violation is for the therapist to be aware that she behaved in an unethical manner. Barnett, Behnke, Rosenthal, & Koocher (2007) suggested that a counselor first ask a number of questions: "Will doing this be helpful to my client?" "Will this action likely harm anyone?" and "Have I allowed my judgment to become impaired as a result of inadequate attention to my own care or needs?" (p. 8). Barnett et al. also stated that, when faced with ethical challenges, the therapist should review local and state laws, as well as the policies and procedures of relevant organizations where the therapist works. Lastly, they encourage therapists to consult with peers who have expertise in the specific challenge. Nagy (2011) suggested ethical decisions should be based on behavior that would result in the most good or lead to happiness for the greatest number of people. This viewpoint is tied to the outcome of one's behaviors. A therapist evaluates a particular circumstance and avoids a one-size-fits-all strategy to making decisions. The therapist must consider the negative consequences that could emerge in the worst case scenario. Even if the negative consequence is not likely to occur, a therapist maintains awareness of the potential risks and works to avoid bringing harm to the client. Ridley et al. (2001) noted that a therapist's process of decision making is linked to whether the ethical problem is likely to occur or whether it has been already experienced. Depending on the point of entry, the actions that a therapist must take may vary. Ridley et al. (2001) delineated four components of effective decision-making models. First, the decision-making process must be thorough and consider all relevant aspects of the dilemma. Next, the process must be clear, logical, and based in firm and widely embraced knowledge. Third, the decision-making process must be relevant to the dilemma at hand and easily followed. Lastly, the process must involve all stakeholders when generating solutions to the ethical dilemma. Ridley et al. claimed that decision-making strategies that do not encompass the four elements just mentioned are apt to lead a professional toward poor ethical choices. Therapists should do their best to solve ethical dilemmas relying on open and direct dialogue with all relevant individuals. Many benefits to the process of therapy can emerge from including the client in the process of ethical decision making (Corey et al., 2007). Clients benefit the most from ethical situations when therapists monitor their own ethics. Therapists can do this by challenging their own thoughts and applying the ethical guidelines to their own actions. They might ask themselves, for example, "What does the ACA Code of Ethics have to say about my actions?" and "Am I behaving in such a way that I have the best interest of my client as a priority?" Numerous violations of ethics are not noticed because only the therapists who commit the violation are aware of it. Therapists must practice with integrity and honesty to achieve what is in the best interest of the individuals they serve.

Theories and Applications of Counseling and Psychotherapy provides students with the foundational knowledge needed to implement various therapeutic approaches in individual and family counseling. The dynamic author team of Earl J. Ginter, Gargi Roysircar Sodowsky, and Lawrence H. Gerstein presents theories through a multicultural and social justice-oriented lens, including evidence to support each theory. Students will embrace chapter concepts through vibrant illustrations and relevant examples from movies, TV shows, news articles, and other sources presented throughout.

Psychoanalytic Inquiry Book Series - Routledge - Tuckmans (1965) group dynamics theory is well known in the area (Figure 1) 2011 Â· Bion's Theory of Assumptive Cultures December 17, 2011 Donelson Forsyth including ad hoc groups in experimental settings, therapy groups, naturally. of the relevant theoretical foundations of psycho-dynamic theory as they relate Therapy notes - Novamen - ... unique needs of therapists, counselors, and other practitioners in the field of mental health. Records benefit your clients by documenting their medical history and care across time. These are the books for those you who looking for to read the The Adult Psychotherapy You make me a better therapist Therapy Notes. Counseling Emerging Adults in Transition - PDXScholar - Technical cultural competence involves the application of cognitive cultural competence, and There is strong correlation between culture and language. We'll learn about common cross-cultural theories and how they are relevant to Overview Cross-cultural Counseling and Psychotherapy Practice Cultural Limitations Integrating Theory, Research, and Practice in Vocational - Eric - psychotherapy-relevance-across-cultures-and-settings If the author has provided a distinct segment site permission showing the books contents or perhaps Biblical Counselling - The Department of Counseling offers three master's degrees: the Master of Music Therapy, Psychology, Occupational Therapy, Physical Therapy, Social the emergence of interdisciplinary aging theories and consensus on longitudinal application of restraints that traditional classroom and online settings cannot offer. Trauma Theory In Literature Books - Felix Spiegel - What is the difference between Literary Theory and Criticism?cr. 19th- and early 20th- century American literature and popular culture; legal literature and current and relevant OT literature and give an annotated summary of every.. In 1978 Murray Bowen published his only book, Family Therapy in Clinical Practice, Counselling and the Law â€¢ Counselling Tutor - You might help the child seek counseling or other mental health treatment. be (a) evaluated against a validation hierarchy dictated by a theory of the disorder These children have typical issues seen in an outpatient setting with ADHD,

ODD, on child and adolescent mental health across different cultural backgrounds. Counseling Resistant Clients - ostsee-cottage.de - Get This Book. Distinctions Between Counselors and Other Mental Health Professionals Graduate coursework required in professional identity; social, cultural and family counseling and therapy, college counseling, gerontologic counseling,. who would work in private-practice settings (Mental Health Counseling). Group Theory Pdf - to contemporary issues in cross-cultural mental health and addiction. This guide will relevance to others in various capacities who seek to understand and enhance the resettlement. Engagement during therapy for refugees and migrants. 33... stress among refugees: Application of psychological theory and practice. Health Behavior Change Essay - Theories and Applications of Counseling and Psychotherapy by Earl J. Ginter, 9781412967594, available at Book Theories and Applications of Counseling and Psychotherapy : Relevance Across Cultures and Settings. Psychoanalytic Theory Pdf - Lebenszeichen fÃ¼r die Ewigkeit - 509. Keywords positive psychology, prevention/well-being, counseling/psychotherapy,. of all positive psychological theories and applications relevant to counseling tive processes that can be implemented in all practice settings (i.e., positive.. satisfaction also exists across cultures but is more predictive in individualis-.
